Seeing and being seen: An investigation of video guidance processes with vulnerable parents of infants

Indra Laetitia Simhan

Thesis for the degree of Philosophiae Doctor (PhD)
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This research project is a cooperative venture between the Research Unit and the Infant Mental Health Team (IMHT), Department for Child and Adolescent Mental Health, Sørlandet Hospital Trust, Kristiansand, Norway and the Center for Clinical and Developmental Psychology, Department of Clinical Psychology, at the University of Bergen, Norway.

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Abstract

The psychosocial development of infants is closely interrelated with the relationship with their caregivers, especially with the caregivers' capacity to emotionally attune themselves to and mentalize the infants. Parents' difficulties to mentalize and remain emotionally connected with their infants are therefore a central focus for infant mental health interventions. Marte Meo video guidance supports infant development, interaction quality, parental mentalizing and sensitivity. Yet, there is a lack of knowledge about using the method with parents thus challenged and in specialized clinical work.

The present thesis explored video guidance for parents with difficulties mentalizing and remaining emotionally connected with their infants. Which psychological and therapeutic processes were involved in the guidance? The thesis comprises two separate studies presented in Papers 1- 3. Study 1 (Paper 1) aimed to analyze how Marte Meo therapists experienced and handled challenging guidance processes with parent-infant dyads. Study 2, a cooperation with a specialized infant mental health team, investigated how parents who struggled to mentalize and remain emotionally connected with their infants experienced video guidance. Two separate analyses were presented in Papers 2 and 3. Paper 2 aimed to explore what the parents experienced as supportive and challenging elements in video guidance as a method. Paper 3 aimed to investigate the parents' experiences of change during video guidance.

Both studies were based on a phenomenological-hermeneutic approach using team-based reflexive thematic analysis. Study 1 explored focus group interviews of a purposive sample of thirteen Marte Meo therapists with experience in guiding parent-infant dyads. Study 2 investigated in-depth interviews of a strategically recruited sample of twelve parents referred to specialized treatment who had difficulties mentalizing and remaining emotionally connected with their infants. Strategic recruitment by criterion sampling was based on a narrative interview with attachment-focus.

In Paper 1, four main themes were drawn from therapists' experiences and handling of challenging guidance processes with parent-infant dyads: 1) promoting relational growth in a coercive context; 2) building an alliance that feels safe for the parents; 3) looking at positive moments in difficult lives; 4) handling intense feelings as a therapist. In Paper 2, we identified four main themes describing parents' experiences of challenging and helpful elements in video guidance: a) handling initial feelings of fear and loss of control; b) filming as a disturbing or agentic experience; c) feeling validated or devalued in the therapeutic relationship; and d) bringing insights from video guidance into everyday life. In Paper 3, four main themes summarized parents' experience of the change process: a) feeling inadequate or disconnected as a parent; b) discovering the infant as a relating and intentional person; c) becoming more agentic and interconnected, and d) still feeling challenged by personal mental health issues.

The overall results indicate that Marte Meo can assist profound change processes for parents with difficulties mentalizing the infants and manifest mental health problems. Video could create an opening that made parents accessible to new experiences and ideas about themselves. Feeling connected was a key ingredient for further changes in interacting, mentalizing, and feeling more confident and self-efficacious, centrally supported by the therapeutic relationship. Our findings suggest further research topics for video guidance with these vulnerable parents. Their requirements should be recognized by clinical practice and met with structural and method development. A rationale for Marte Meo in child protective contexts, cooperation with parents' mental health treatment, therapist supervision, and expansion of training curriculum seem indicated. Early systematic assessment of parents' vulnerabilities and child protective issues could facilitate an adapted guidance process, attending to parents' health struggles, self-conscious emotions, and need for recognition. Our findings indicate that Marte Meo guidance can strengthen vulnerable parents' connectedness, mentalization and self-regulation, and self-efficacy, both as parents and in other areas of life.

List of Publications

Paper 1

Simhan I., Veseth M., Vik K., and Hjeltnes A. (2020). Finding focus in a difficult landscape: Therapists' Experiences with Challenging Video Guidance Processes for Parent–Infant Dyads. *Infant Mental Health Journal*. DOI: 10.1002/imhj.21884

Paper 2

Simhan I., Vik K., Veseth M. and Hjeltnes A. (2021). Like Taking a Magnifying Glass into Everyday Life: Vulnerable Parents' Experiences with Video Guidance in an Infant Mental Health Clinic. *Frontiers in Psychology*. DOI: 10.3389/fpsyg.2021.542716

Paper 3

Simhan I., Vik K., Veseth M. and Hjeltnes A. (2021). Learning to mentalize: Exploring parents' experiences of change during video guidance in an infant mental health clinic. *BMC Psychiatry*. DOI: 10.1186/s12888-021-03398-6

Table of contents

Abbreviations

ABUP	Department of Child and Adolescent Mental Health, Sørlandet Hospital Trust, Norway
CPS	Child Protective Services
IMHT	Infant Mental Health Team
M	mean value
PDI-R	Parent Development Interview, short-revised version
PRF	parental reflective functioning
RF	reflective functioning
RF-scale	reflective functioning scale
TA	Thematic Analysis
VIG	Video Interaction Guidance
VIPI	Video-feedback of Parent–Infant Interaction
VIPP	Video-feedback Intervention to Promote Positive Parenting

1. Introduction

> […] change is based on lived experience. In and of itself, verbally understanding, explaining or narrating something is not sufficient to bring about change. There must be an actual experience, a subjectively lived happening. An event must be *lived*, with feelings and actions taking place in real time, in the real world, with real people, in a moment of presentness.
>
> Daniel Stern (2005), "The present moment in psychotherapy and everyday life", p.xiii

In this thesis, I present the findings of a research project exploring the video guidance method 'Marte Meo' about its use in the field of infant mental health. The purpose of the project was to investigate and describe psychological and therapeutic processes involved in the guidance of parents who are especially challenged in that they have difficulties mentalizing and remaining emotionally connected with their infants. The interest in this phenomenon originated from my clinical work in a specialized outpatient unit for parent-infant dyads at the child psychiatric department at a large regional hospital in South Norway. Most infants are referred based on their developmental and health risks linked to their parents' psychosocial and psychological challenges. I wondered how the vulnerable parents we worked with experienced Marte Meo, how the guidance worked for them, and how we could use it in a way that was most helpful for them.

There were two perspectives involved in the psychological and therapeutic processes in video guidance: on the one hand, and centrally, that of the parents and their experiences of Marte Meo, its helping and hindering elements and, potentially, the change process assisted by the guidance. On the other hand, there was the experience of the therapists who administered video guidance to highly challenged parents. Understanding guidance processes meant exploring these perspectives. Therefore, the

project's objectives were expanded to an empirical investigation of both outlooks, the lived experience of parents and therapists during video guidance.

The inquiry into this also became a personal journey for myself and how I understand myself as a researcher and clinician working with parent-infant dyads. During the research, I developed more security in venturing into the landscape of lived experiences of the parents and greater openness towards their position. The project draws on the lived experiences and voices both of parents who underwent video guidance and Marte Meo therapists who work with parent-infant dyads. There is one voice that is not represented, which is that of the infants. Their language is that of nonverbal, embodied communication, which holds a central position in the video guidance processes themselves and is mentioned by parents and therapists in the interviews, yet has not been translated into direct research data in the present inquiry.

1.1. Infant mental health as a field for inquiry

The infant mental health field is concerned with the social and emotional wellbeing and development of infants in the first three years of life, in recent years often extended to the first five years. It aims to prevent and treat disturbances to infants' mental health (Clinton, Feller, & Williams, 2016; Lyons-Ruth et al., 2017). Healthcare in this age group is largely formed and challenged by what Winnicott described as there being "no such thing as a baby ... a baby cannot exist alone but is essentially part of a relationship" (1957, p. 88). Infant mental health is thus per se concerned with the two-person psychology of the infant, the caregiver and their relationship. Assessments and interventions introduce a third person, the therapist, and thus new relationships and interactive fields between parent and therapist, and infant and therapist (Pawl, 1995; Weatherston, 2000; Weatherston, Kaplan-Estrin, & Goldberg, 2009). Research inquiry, in turn, adds a fourth person, the investigator. In other words, clinical work and research in this field unfold in a complex nexus of persons, relationships and experiences.

Infants and parents being interconnected becomes especially tangible in the infant mental health field (Mullin, 2012). The fact that parents' mental health problems

present a serious risk factor for infant mental health (Binion & Zalewski, 2018; Eyden, Winsper, Wolke, Broome, & MacCallum, 2016; Hipwell, Goossens, Melhuish, & Kumar, 2000; Reedtz et al., 2019; Schechter & Willheim, 2009; van Santvoort et al., 2015; Vaughan, Feinn, Bernard, Brereton, & Kaufman, 2013) intertwines adult and infant perspectives. The fact that many interventions to promote infant mental health actually target parenting functions (Bernard, Simons, & Dozier, 2015; Nijssens, Luyten, & Bale, 2012; Powell, Cooper, Hoffman, & Marvin, 2013; Rosenblum et al., 2018; Slade, 2008b), and that the outcome for the infant largely depends on the parents' ability and cooperation to change (Shulman, 2007; Slade, 2007a), opens for professional ethical dilemmas. Many clinicians in infant mental health will experience the strain between infant and parent perspectives and needs (Baistow & Hetherington, 2004; Spiegelhoff & Ahia, 2011). Yet this problem seems little addressed in the scientific or psychiatric literature (Grosfjeld, 2004; Tchernegovski, Hine, Reupert, & Maybery, 2018). Examinations of ensuing ethical problems seem to be even more scarce. The topic is mentioned in research publications on child welfare (Lange & Williams, 2011; Marcellus, 2005) and research ethics (Gorin, Hooper, Dyson, & Cabral, 2008; Herbert, Harvey, & Halgin, 2015).

Moreover, focus has mostly been directed on the risks and consequences of parental mental health for infants and infant mental health approaches. The lived experience of the parents and the therapists involved with the parents or the parent-infant dyads have received less attention (Blegen, Eriksson, & Bondas, 2016; Dolman, Jones, & Howard, 2013; Lumsden, Kerr, & Feigenbaum, 2018; Tchernegovski et al., 2018).

1.2. Parent-infant relationship and interaction

The interconnectedness of infant and parent is played out in the relationship between them. This relationship is a vital matrix for infant nurture and development both on a neurobiological and psychological level. It is central in the formation and organization of self-development, intersubjectivity, attachment, and advanced social functioning (Parsons, Young, Stein, & Kringelbach, 2017; Rutherford, Maupin, Landi, Potenza, & Mayes, 2017; Zeegers, Colonnesi, Stams, & Meins, 2017). In the interaction between infants and parents, their relationship manifests itself on a concrete, physical plane

through proximity, physical contact, gaze contacts, shared attention and shared objectives (Piazza, Hasenfratz, Hasson, & Lew-Williams, 2020). At the same time, these manifestations of the relationship also have psychological meaning and impact (Costantini, Akehurst, Reddy, & Fasulo, 2017; Licata, Kristen, & Sodian, 2016; Reddy, 2015) and are tightly connected with intersubjectivity (Ammaniti & Ferrari, 2013; Fotopoulou & Tsakiris, 2017).

While the interaction occurs in the present moment, the caregivers' implicit representations of their own early caregiving experiences mediate how the interaction is experienced and interpreted (Camoirano, 2017; Grienenberger, Kelly, & Slade, 2005). Implicit representations have been described in different theoretical frameworks as internal working models of attachment (Bretherton & Munholland, 2008), as integrated representations of self and others, or self and objects (Blatt, 2008), or as implicit intersubjective attachment transactions (J. R. Schore & Schore, 2008). Their neurobiology has been ascribed to regulatory patterns in subcortical systems of mainly the right hemisphere, which have been critically imprinted by early caregiving and attachment experiences (Liotti, 2017). These systems non-consciously mediate and give affective value to essential functions in mothering and primary caregiving, such as the perception of emotions, facial expressions, sounds, intonation and tactile information (Rutherford, Wallace, Laurent, & Mayes, 2015; A. N. Schore, 2012, 2015). Caregivers with a strained or dysfunctional attachment history have therefore more problematic implicit representations that can render it difficult to stay in attuned and sensitive interaction with their infants (Hobson, Patrick, Crandell, García-Pérez, & Lee, 2005; Rutherford et al., 2015; Strathearn, Fonagy, Amico, & Montague, 2009; Vulliez-Coadya, Solheim, Nahum, & Lyons-Ruth, 2016).

Interaction is thus a direct link between the representations of the parents and their regulatory and reflective capacity and the developing regulatory and reflective capacity and representations of the infants. It connects the parent's internalized caregiving experiences of the past, the present moment, and the future internalized caregiving experiences of the infant (Grienenberger et al., 2005; Shai & Fonagy, 2014).

1.3. Parental mentalizing and reflective functioning in interaction and clinical work

Reflecting on how their own and the infants' internal mental states influence the interaction, mentalizing (Fonagy & Target, 2005), allows caregivers more insight and distance to their implicit processes. It enables them to perceive and conduct interaction differently, more attuned and sensitively (Iyengar, Rajhans, Fonagy, Strathearn, & Kim, 2019; Sadler, Slade, & Mayes, 2006). Parents with dysfunctional caregiving representations often are limited and uncertain in their capacity to mentalize, especially in close relations like with their infants (Brune, Walden, Edel, & Dimaggio, 2016; Handeland, Kristiansen, Lau, Håkansson, & Øie, 2019; Mohaupt & Duckert, 2016). To increase these parents' capacity to mentalize the interaction and develop new interactional representations is, therefore, a key factor for change and the target for effective interventions (Iyengar et al., 2019; Slade, 2008a).

As a psychological function, mentalizing is the capacity to perceive and interpret the other as an intentional being, with mental states underlying overt behaviour (Fonagy & Allison, 2012). On an embodied level, it is expressed through mutual attunement and dyadic synchrony in the interaction (Shai & Fonagy, 2014), on a psychological level in the capacity to see the child as an intentional, subjective agent (Sharp & Fonagy, 2008), and on a narrative level in the capacity to maintain coherence and a reflective stance when talking about affectively charged material from attachment relationships (George, 2003). The psychological and narrative expression of mentalizing has been operationalized as reflective functioning (RF), which is the "overt manifestation, in the narrative, of an individual's mentalizing capacity" (Slade, 2005, p. 2). RF represents the function to perceive and interpret own and others' behaviour in terms of underlying intentional mental states. More simply stated, RF means a reflective stance towards behaviour that enables one to understand that behaviour is linked to emotions, thoughts, motives, desires (Slade, Grienenberger, Bernbach, Levy, & Locker, 2005; Sleed, Slade, & Fonagy, 2018). For example, in a caregiver, so-called parental RF (PRF) allows perceiving "fussy and whiny" behaviour in the infant to be caused by frustration or even overstimulation. This reflective stance facilitates the regulation of affect and stress (Rutherford et al., 2015) and has a central role in self-awareness and

social interaction. Limited PRF increases the use of affectively-charged, dysfunctional interaction patterns that are stressful and potentially traumatic for the infant (Grienenberger et al., 2005; Madigan, Moran, & Pederson, 2006).

Caregivers with personality disorders (Berg-Nielsen & Wichstrom, 2012; Macfie, Swan, Fitzpatrick, Watkins, & Rivas, 2014; Stewart-Brown & Schrader-Mcmillan, 2011) and substance use disorders (Handeland et al., 2019; Roth & Buchheim, 2010; Suchman, DeCoste, Leigh, & Borelli, 2010) often have limited PRF. Moreover, PRF can be limited in parents with other psychiatric disorders or more diffuse psychosocial problems (Mohaupt & Duckert, 2016; Suchman, Pajulo, Kalland, DeCoste, & Mayes, 2012). In Norway, more than 12 per cent of the children have at least one parent with a more severe psychiatric illness or alcohol dependency (Torvik & Rognmo, 2011). Studies find the general prevalence of personality disorders to be at least 12 per cent, and a prevalence of up to 70 per cent for patients at outpatient clinics for substance use or psychiatry (Karterud, Wilberg , & Urnes, 2010). Research shows that as a group, parents of infants referred to specialist services may often be challenged in their reflective functioning (Dollberg, Feldman, & Keren, 2009). The data indicate that limited PRF is a significant risk for many infants in Norway, calling for prevention and early intervention (Berg-Nielsen & Wichstrom, 2012).

However, therapy research shows that interventions for parents with limited RF require particular concern. As RF has a central function in self-awareness and social interaction, common therapeutic approaches without a specific focus on RF limitations are often challenged by misunderstandings, negative emotions, social avoidance and ruptures in the therapeutic alliance. This context applies to interventions for adults and parents, frequently leading to insufficient response or early termination (Bateman & Fonagy, 2012; Bateman, Fonagy, & Allen, 2009; Slade, 2007b).

Several therapeutic elements have been identified as helping parents with limited RF respond to interventions: a reflective focus, using the therapeutic relationship as a learning model for reflection and affect regulation, activating the parents' existing positive coping strategies, and helping the parents focus on the here-now concerning

the infant and the emotion he or she evokes (Neander & Engstrom, 2009; Sadler et al., 2013).

Thus, interventions used with caregivers with a higher probability for limited PRF - as in specialized infant mental health settings or the presence of parental mental health problems - and parents with known limited PRF should focus on the therapeutic requirements for limited RF. Existing methods should be examined for their adaptability to the requirements of parents with limited RF.

1.4. Video guidance approaches and the Marte Meo method

A range of infant mental health interventions focus on parent–infant interaction and the parent-infant relationship (Barlow, Bennett, Midgley, Larkin, & Wei, 2015; Wright & Edginton, 2016). The focus can be raised during or directly after the interaction (Cohen, Lojkasek, & Muir, 2006; Sadler et al., 2013) through using videos from the interaction in separate guidance sessions (Fukkink, 2008; Powell et al., 2013) or as a combination of both (Bernard et al., 2012; Doesum, Riksen-Walraven, Hosman, & Hoefnagels, 2008). Video guidance approaches, also called video feedback, use filmed everyday interactions of the actual dyad in the guidance of parents. Filming often occurs during home visits, while the revised films are later shown in specific guidance sessions. Several distinct methods have been developed (Balldin, Fisher, & Wirtberg, 2018), including Marte Meo (Aarts, 2008) and its manualized variant called video-feedback of parent–infant interaction (VIPI) (Onsoien, Drugli, & Hansen, 2015). The term Marte Meo is the ablative form of Latin “Mars meus” (Mars being the god of war and battle) and translates as “by my own exertions” (Perseus, 2017). Marte Meo is used on several continents and is more widely implemented in several European countries, Australia and India. It originated out of an intersubjective perspective and, like video-interaction guidance (VIG) (Kennedy, Landor, & Todd, 2011), has a decidedly solution-focused stance, omitting material showing negative or ineffectual interaction (Hedenbro & Wirtberg, 2012; Aarts, 2008). This stance has been cited as a key difference to many other methods (Landor & Ljungquist, 2018) and conceptually

linked to resource-orientedness (Bunder, 2011; Kiamanesh, Olafsen, & Drozd, 2018), salutogenesis and family resilience (Hedenbro & Wirtberg, 2012).

Based on the child's focus expressed as signals, or "initiatives", Marte Meo identifies eight developmentally supportive dialogue elements structuring the interaction: 1) the caregiver seeks to locate the child's focus of attention or initiatives; 2) the caregiver (verbally or nonverbally) confirms the child's focus of attention or initiatives, and responds with own reaction; 3) the caregiver actively awaits the child's reaction; 4) the caregiver names ongoing and forthcoming actions, events, experiences, feelings, and anticipated experience in an affirmative way; 5) the caregiver takes responsibility for the interaction, furthering mutuality; 6) the caregiver confirms desired behaviour approvingly; 7) the caregiver triangulates the child in relation to 'the world' by introducing persons, objects and phenomena to the child; 8) the caregiver takes responsibility for an adjusted and reciprocal ending (Axberg, Hansson, Broberg, & Wirtberg, 2006; Hedenbro & Wirtberg, 2012).

The therapist and caregiver agree upon a working goal, for example, "better contact". The therapist films everyday interaction of the dyad analyses the film and identifies the dialogue element that needs developing. For example, "the caregiver seeks to locate the child's focus of attention". For the review sessions with the caregiver, the therapist chooses clips that show developmentally supportive interaction or an interactional opportunity for it related to the dialogue element in question. The review makes use of micro-interaction sequences and stills (Vik & Rohde, 2014). The therapists monitor progress by looking for changes in the parents' interactions and the child's behaviour and signals. Several components in the filming and the video feedback are variable and determined by the therapist, based on the individual case and in consensus with the caregiver. This comprises the location of filming (at home versus at the clinic), filming structured (mealtime, diaper change, bath) versus unstructured interaction (play), the choice of thematic focus, the extent to which the parent is visible in the revised film, how actively the therapist structures and leads the guidance session, and the number of sessions (Hedenbro & Wirtberg, 2012; Aarts, 2008).

The child's focus and experience are arguably the conceptual core around which the guidance is centered. The role of the caregiver is to be attentive to the child's internal states and overt behaviour and structure and organize the interaction (Hedenbro & Wirtberg, 2012). This stance is in line with inherently mentalizing and regulating caregiving principles (Slade, 2008a) and also aligns with attachment perspectives of the caregiver as the organizing and supporting "secure base" for exploration and regulation (Grossmann, Grossmann, & Zimmermann, 1999). Although Marte Meo was developed out of observational and therapeutic fieldwork with developmentally challenged children and their parents (Hedenbro & Wirtberg, 2012; Aarts, 2008), it is thus compatible with attachment and mentalizing (Vik & Hafting, 2009) as central psychological concepts of the relationship and interaction between infant and caregiver. The use of Marte Meo has been expanded to the fields of education (Balldin, Bergström, Wirtberg, & Axberg, 2019) and dementia care (Lykkeslet, Gjengedal, Skrondal, & Storjord, 2016). A mixed-method study evaluating the application of Marte Meo in counselling and therapy in Germany, Switzerland and Austria is under way (Rohr, Nettersheim, Deutsch, & Meiners, 2021).

1.5. Current state of research and knowledge need about Marte Meo

Some video guidance methods have been comprehensively documented (Balldin et al., 2018), such as VIPP (Juffer, Bakermans-Kranenburg, & Van Ijzendoorn, 2018) or VIG (Kennedy, Ball, & Barlow, 2017). For Marte Meo, which was developed in the 1980s, there was an earlier gap between the ready acceptance of the method by the field and the lack of scientific evidence (Osterman, Möller, & Wirtberg, 2010). Over the last fifteen years or so, quantitative studies have looked at the effectiveness of the method for parents and children in different contexts and age groups, and at therapist skills. Qualitative studies have developed conceptualizations and added to the knowledge about user and therapist experience in parallel. The studies are mainly based on community samples, with some including psychosocially challenged caregivers.

A quantitative milestone was the RCT of a manualized Marte Meo variant, VIPI, for parent-infant dyads with interactional problems, recruited from community health and

family guidance services (Hoivik et al., 2015). It showed that the method significantly improved infant development and parent–infant interaction and had the most effect in families who initially had the lowest parenting measures. Although less than a quarter of the parents had previous psychiatric illnesses, the study investigated the influence of parental personality disorder traits and found that parents with dependent and paranoid traits significantly responded to VIPI. In contrast, those with narcissistic traits did not. In a quasi-experimental study on a community sample first-time mothers with vulnerabilities, defined as low parenting confidence, moderate preterm birth, or subclinical mood score, but without manifest mental health problems, the Marte Meo intervention showed significantly higher dyadic synchrony, maternal sensitivity, and confidence, and lower parental stress (Kristensen, Simonsen, Trillingsgaard, & Kronborg, 2017). A quasi-experimental study on change in psychosocially overburdened parents in an institutional setting found that Marte Meo helped the parents develop more positive structuring and especially more emotional connection to their children aged zero to six years (Bunder, 2011). A longitudinal study on families in social welfare or in child psychiatric treatment assessed self-report measures before and after interventions, including Marte Meo, and found positive change in parental stress, mental health, social support, life satisfaction, and perceived child difficulties (Neander & Engstrom, 2009). A quasi-experimental pilot study of divorced fathers of children aged six to twelve found that Marte Meo reduced harsh discipline and inept parenting and improved parental efficacy, as well as changes in father identity (DeGarmo, Jones, & Rains, 2019). A cross-sectional study examined group differences between experienced health visitors with or without Marte Meo training regarding Marte Meo therapists. It found that video guidance training and experience led to significantly more knowledge about the parent-infant relationship, infant self-regulation, and higher assessment skills regarding maternal sensitivity and dyadic synchrony (Kristensen, Trillingsgaard, Simonsen, & Kronborg, 2017).

Several qualitative studies have addressed the theoretical development of Marte Meo and added knowledge about its practice. The conceptualization was driven by Vik and colleagues' studies exploring the experiences made by mothers with postnatal depressive symptoms. They showed how the viewing of the interaction facilitated self-

reflection and the recognition of the infants as a person, thus increasing mentalized affectivity. It also enhanced the mothers' sense of vitality and increased sensitive interaction with the infants (Vik & Hafting, 2009). The mothers' transcendence of their self-centered state was embodied in changes in the therapeutic relationship and the holding behaviour towards the child (Vik & Braten, 2009). Vik and Rohde related the methodology to Stern's developmental model and the emergence of new "schemas of being-with". They underlined the usefulness of Marte Meo for postnatally depressed mothers both in community and specialist health services and envisioned video guidance for new mothers with more severe psychopathology in combination with their primary pharmacological and psychotherapeutic treatment (2014). A piloting exploration of parents in specialized treatment indicated that video guidance embedded in a therapeutic context enhanced parental sensitivity and coping and increased their self-confidence and self-esteem (Gill, Thorød, & Vik, 2019). On a more concrete level, Osterman and colleagues (2010) described how Marte Meo assisted new adoptive parents in adjusting their interactions to their adopted infants. An investigation in an East African institutional setting for infants indicated that Marte Meo enhanced professional caregivers' sensitivity (Vik, Helgeland, Daudi, & Freuchen, 2020). Combined explorations of therapists and parents have investigated the guidance processes in a child protective treatment unit (Hemmingsson & Ahlinder, 2013) and developed practice recommendations for Marte Meo for families with developmentally challenged children (Clarke, Corcoran, & Duffy, 2011). A structured analysis of therapists' experiences in the CPS described predominantly positive aspects of Marte Meo. At the same time, unaddressed issues of trust and coercion and lack of structure were identified as weaknesses of the method (Kiamanesh et al., 2018). As part of a longitudinal study mentioned in more detail in the last paragraph (Neander & Engstrom, 2009), an exploration of how parents and therapists experienced successful treatment processes, including Marte Meo, showed them to be co-created by parents and therapists alike, underlining the importance of the therapeutic relationship (Neander & Skott, 2008). The authors highlighted the need for empirical research on unsuccessful guidance processes. However, an investigation of the challenges that therapists experience in Marte Meo processes to develop both

practice and conceptualizations of the method was lacking in the research literature and is one of the aims of the present thesis.

Moreover, existing research on Marte Meo in parent-child interaction is on the whole based on community-based caregiver samples, except for three parents from a psychiatric outpatient clinic included in a pilot study (Vik & Hafting, 2006) and a three-case study from an infant psychiatric clinic (Gill et al., 2019). Studies on more vulnerable community samples indicated positive changes in mothers' vitality and mentalization (Vik & Hafting, 2009), sensitivity and dyadic synchrony (Kristensen, Simonsen, et al., 2017). To this date, database searches (in Medline and Ovid) do not reveal other quantitative or qualitative studies on Marte Meo based on clinical parent samples. Empirical knowledge about the use of the method with clinical-range high-risk caregivers is therefore still marginal and unsystematic. Parents in specialized infant-psychiatric treatment are characterized by more serious or long-term mental health problems and related psychosocial stress. They suffer frequently from recurrent affective disorders, anxiety disorders, substance misuse, personality disorders, and others (Anke et al., 2019; Berg-Nielsen, Vikan, & Dahl, 2002; Pajulo et al., 2011). Often, their intuitive parenting capacity is weakened (Papousek & De Chuquisengo, 2006). They have difficulties establishing and regulating their emotional connection to the infant and discovering and mentalizing the infant's signals (Binion & Zalewski, 2018; Freeman, 2016). The probability that their PRF might be limited is therefore considerable (see also 1.3). As described above, these psychological and psychosocial challenges pose a substantial risk for the parent-infant relationship and the infants' mental health. Moreover, the challenges of the parents and the complexities of parents' and infants' needs and demands are likely to make video guidance processes more challenging.

While research from communal settings had shown promising results for parents with depression and some personality disorder traits (Hoivik et al., 2015) and high psychosocial risk (Bunder, 2011), which the piloting qualitative explorations supported (Gill et al., 2019; Vik & Hafting, 2006), there was a need for more systematic knowledge about Marte Meo guidance for psychologically and relationally

challenged parents in specialized infant mental health services. How could Marte Meo be used with highly challenged parents, and how did these parents experience and respond to the method? The present thesis aimed to contribute to these critical questions by investigating and describing processes involved in the guidance of these parents. A qualitative approach was chosen to explore the phenomena and elicit valuable descriptions of the lived experience of video guidance in this context comprehensively and thoroughly.

1.6. Aims and research questions

The main aim of this research project was to investigate and describe processes involved in the Marte Meo video guidance of parents who are especially challenged in that they have difficulties mentalizing and remaining emotionally connected with their infants. To this end, we conducted two qualitative interview-based studies.

Study 1 investigated the experiences of a purposive sample of Marte Meo therapists with challenging guidance processes of parent-infant dyads. The resulting focus group and individual interviews were the basis for Paper 1, which aimed to explore the following research questions: What do therapists experience as challenging when conducting Marte Meo video interaction guidance with parent-infant dyads? How do they handle these challenges?

Study 2 investigated parents' experiences of undergoing Marte Meo video guidance. We recruited a strategic sample of parents who were knowledgeable about the phenomenon of struggling to mentalize and connect with their infants and of receiving video guidance. They were interviewed in-depth. Study 2 consisted of two separate analyses presented in Paper 2 and Paper 3. It aimed to explore the following research questions: What did the parents experience as helping and challenging elements in video guidance? (Paper 2). How did the parents experience the change process, or lack of change, during the guidance? (Paper 3).

2. Methods

2.1.1. Setting

We designed two separate qualitative studies. Study 1 was an interview study with Marte Meo therapists and supervisors in Norway and Europe. Study 2 was an interview study with parents, implemented at a specialized Infant Mental Health Team at a large regional hospital in South Norway.

2.1.2. Researchers

The researchers involved in the present project included the main supervisor, Aslak Hjeltnes, co-supervisors Kari Vik and Marius Veseth, and myself as a research candidate. Hjeltnes and Veseth are associate professors at the Department of Clinical Psychology, University of Bergen, and clinical psychologists. Vik is a sociologist and senior research fellow at Sørlandet Hospital Trust Kristiansand, a Marte Meo therapist and mentalization-based therapist. The supervisors have experience with qualitative research on a range of topics within mental health. I am a child and adolescent psychiatrist at Sørlandet Hospital Trust Kristiansand specialized in infant mental health (see also 4.4.). I am a Marte Meo therapist and mentalization-based therapist. I have earlier research experience with sero-epidemiological studies within public health. Together, the research team has experience with psychoanalysis, mentalization-based therapy, emotion-focused therapy, video guidance, mindfulness-based interventions, and recovery processes in mental health.

2.1.3. Qualitative methodology

Both studies aimed at a qualitative investigation of experiences made with video guidance processes. Qualitative methods are research strategies that produce “living knowledge” by investigating human experience, meaning, and dynamic processes of interaction (K. Malterud, 1996, p. 30). They involve “the systematic collection, organization and interpretation of textual material derived from talk or observation” to explore “meanings of social phenomena as experienced by individuals themselves, in their natural context” (Kirsti Malterud, 2001, p. 483). Qualitative perspectives thus have a different epistemology than positivistic approaches that aim at examining an

objective reality or world separate from the person (Laverty, 2003). There is a growing consensus that qualitative research methods "enable health sciences researchers to delve into questions of meaning, examine institutional and social practices and processes, identify barriers and facilitators to change, and discover the reasons for the success or failure of interventions" (Starks & Trinidad, 2007, p. 1372). While there are different traditions of thinking about what compounds experience and what can be known about it, a common ground is the idea that experience as a phenomenon can be studied. Phenomenology, as the study of experience as "the thing itself", is concerned with what Davidsen describes as "the fundamental phenomenological task: the descriptive investigation of the phenomena, both objective and subjective, in their fullest breadth and depth" (2013, p. 320) . Preunderstanding is suspended, or bracketed, to make room for the phenomenon as it presents itself to achieve this task. However, hermeneutic phenomenology sees a suspension of preunderstanding as futile since all experience and understanding is situated in a historical context, and interpretation and preunderstanding are unavoidable. In the spiralling movement of interpretation between the parts and the whole of experience called the hermeneutic circle, one must therefore account for the preunderstanding and situatedness that influences our understanding (Laverty, 2003). The present project was designed as an experience-near investigation of the experiences of both parents and therapists to understand more of the processes involved in Marte Meo guidance.

In other words, we aimed to explore particular, personal experiences to grasp similarities and differences between participants and formulate more general descriptions about the guidance. We collected participants' descriptions of their experiences by in-depth and focus-group research interviews, respectively, transcribed to text. We chose a hermeneutic-phenomenological methodology proposed by Binder and colleagues (2012) as the basis for our investigation, in conjunction with Braun and Clarke's reflexive thematic analysis method (2012, 2019). Addressing the "tension" between the personal, particular and the generating of patterns and generalized statements, Binder and colleagues' approach balances "phenomenological immersion" with "context-sensitive theoretical and reflective interpretation" to generate relevant knowledge about, for example, therapeutic processes (2012, p. 104). Dialogic

engagement through the empathic presence in the research interviews with the participants and empathic use of imagination when reading the transcripts helps to get near the phenomenon. The aim is to obtain accurate descriptions of the participants' experiences while being aware of their otherness. This position of thoughtful closeness is balanced by the researcher's reflective awareness of own preconceptions and what the authors call "the 'me-ness' of the researcher's own contributions to the act of giving meaning and understanding". They suggest a team-based use of thematic analysis that further strengthens the "reflexive and hermeneutic pole" (2012, p. 106) of the investigation by collaboration and critical auditing in the research team.

2.1.4. Team-based reflexive Thematic Analysis

Braun and Clarke (2012, 2019) developed a method for thematic analysis that they later termed "reflexive" to connote the thoughtful research stance necessary for the analysis and stress the engagement with the data and generation of themes as an interactive process. They placed the method firmly in qualitative, hermeneutic, reflective terrain, underlining the difference to other more positivist thematic analysis approaches (Braun, Clarke, & Hayfield, 2019). Binder and colleagues (2012, p. 103) noted that their "explorative-reflective" approach outlined in the previous section was well compatible with the method detailed by Brown and Clarke. The present project leaned on both descriptions. Reflexive Thematic Analysis (TA) was carried out by myself as the main researcher, together with Hjeltnes and Veseth, in a collaborative process consisting of seven steps:

1) All collaborators familiarized themselves with the data and noted their first impressions and reflections about the experience related to each interview. 2) The main researcher reread each interview, identifying meaning units and generating initial codes. Meaning units were understood as features of the data that appeared interesting or seemed to convey meaning regarding the phenomenon. Existing codes were used across interviews only if they were considered a suitable description. 3) The main researcher reported the coded meaning units back to the group. Meaning patterns and main themes for the meaning units were formulated in a collaborative process. 4) The main researcher and the group summarized and reviewed themes in a back-and-forth

process to define the most important and relevant themes. 5) The main researcher refined the themes and wrote an analysis of each. 6) The themes were drawn together in writing by the main researcher related to the research questions. 7) The research team formed a consensus on the formulation of the main thematic categories. In the formulation, conceptualizing and conceptual language were consciously set aside to arrive at experience-near descriptions.

2.2. Study 1

Study 1 explored what skilled Marte Meo therapists experience during video guidance processes they perceive as challenging.

2.2.1. Recruitment

We used key persons in the Norwegian and International Marte Meo network (www.martemeo.com) to recruit a purposive sample of Marte Meo therapists and Licensed Supervisors with experience in parent-infant guidance. Therapists had undergone a two-year postgraduate, part-time supervised training and certification. They had several years' experience with parent-infant dyads, varied professional backgrounds and affiliations, trained at different training sites, and came from different geographical regions of Norway. Licensed supervisors were therapists with additional extensive experience in the training and supervision of therapists and training supervisors, representing the highest level of training in Marte Meo (Marte Meo International, 2020). Eighteen participants were contacted through training supervisors or directly by the first author. All contacted therapists and Licensed supervisors gave written informed consent to participate in the study.

2.2.2. Data collection

We developed a semi-structured interview guide to assist the exploration of the lived experience of therapists during challenging video guidance processes (See also appendix A). It was used for both therapists and supervisors, but additionally, the supervisors were asked about their experiences from training and supervision regarding therapist challenges. The questions were broad, allowing varied and personal descriptions. Participants were encouraged to engage actively in the discussion, pursue

topics they found relevant and supply concrete examples from guidance processes and their personal reflections.

The therapists were interviewed in three focus groups, but the supervisors were interviewed individually for practical reasons. The first author conducted all interviews between November 2016 and January 2018. The focus group interviews lasted 80 to 116 minutes (M = 98 minutes). The individual interviews lasted 60 to 100 minutes (M = 79 minutes). Interviews were audio-recorded, the focus group interviews were also video-recorded, and transcribed verbatim. One focus group interview with five participants (therapists) was not included in the analysis because of research ethics and confidentiality; i.e., we reconsidered including one of the researchers, Vik, as a participant in the focus group, and therefore excluded that group from analysis.

2.2.3. Participants

Thirteen participants were included in the analysis. Nine of them were video guidance therapists, two of whom also were training supervisors. Four participants were Licensed supervisors, three from Norway and one from Germany. Therapists and Licensed supervisors had backgrounds in social work, pedagogy and family therapy. Some worked in primary health services or family guidance, some in specialized health services, some directly or through commissions for the CPS.

2.2.4. Data analysis

Data analysis was assisted by NVivo 11 software (QSR-International, 2015). Reflexive thematic analysis was carried out in a collaborative process (Binder et al., 2012; Braun & Clarke, 2012) by the first, second and last author (see also under 2.1.2.). We generated 145 initial codes, then formulated four main themes and 42 patterns or sub-themes. The analysis resulted in four main themes and 17 most relevant sub-themes.

2.3. Study 2

The aim of Study 2 was to explore the lived experience of parents from clinically referred dyads with difficulties mentalizing and maintaining an emotional connection with their infants. The exploration covered two distinct focal themes, with one theme addressing experiences with video guidance as a method, whereas the other looked at change experiences during video guidance. Therefore, the research data analysis was divided into two separate analyses resulting in two separate research articles. Levitt and Piazza-Bonin (2017) and Råbu and McLeod (2018) pointed out that qualitative investigations of complex processes may necessitate presenting the material in more than one article to explore different and distinct foci and do justice to rich and intricate data. We performed two separate analyses guided by the following two research questions: 1. What did the parents experience as helpful and unhelpful aspects of the guidance? 2. How did the parents experience the change process, or lack of change, during video guidance? The results were presented in Papers 2 and 3.

The study was implemented jointly by the Research Unit and the Infant Mental Health Team (IMHT), a specialized outpatient unit at ABUP, Sørlandet Hospital Trust Kristiansand, Norway, a large regional hospital tending to a population of ca. 150.000 inhabitants. The IMHT gives assessment and treatment to children from 0 to 5 years of age and their families. It receives on average 70 referrals per year from general practitioners, other specialist health services, or the CPS. Treatment options include Marte Meo video guidance.

2.3.1. Recruitment of a Strategic Sample of Participants

To recruit a strategic sample of parents of infants referred to the IMHT who had difficulties mentalizing or maintaining an emotional connection with their infant, we employed criterion sampling (Sandelowski, 2000), assisted by the Parent Development Interview, revised version (PDI-R). The PDI-R is a 45-item semi-structured narrative interview about parents' representations of their children, themselves as parents, and the parent-child relationship (Slade, Aber, Bresgi, Berger, & Kaplan, 2004). A subset of twelve items can be rated for reflective functioning (RF), an operationalized measure of mentalization manifesting in speech, or the capacity to recognize and

understand internal experience in terms of underlying mental states (Sleed et al., 2018). The sampling criterion was either a) limited RF in the PDI-R or b) explicitly stated difficulties to emotionally connect with the infant and maintain the connection under affective stress. Based on the concept of information power (K. Malterud, Siersma, & Guassora, 2016) and considering aim, framework, specificity of experience and expected quality of dialogue, we targeted a sample of 10-15 participants.

The PDI-R was administered to 30 consenting parents where video guidance was clinically indicated for the dyad. Exclusion criteria for strategic recruitment were psychiatric hospitalization or ongoing abuse of psychotropic substances on the parent's side during the guidance and known cerebral defects or congenital syndromes in the infant as they could reduce the infants' ability to communicate. The interviews were digitally recorded, transcribed verbatim, and read by the first author, a certified rater, who coded the subset of items on the 11-point RF-scale from limited to high RF (Fonagy, Target, Steele, & Steele, 1998). An overall score of 4 or less represented limited RF. Thirty per cent of the PDI-R were double-coded by two certified, blinded external raters, with an intraclass-correlation of 0.89 (95%-confidence interval 0.58 to 0.97) (Gwet, 2018).

2.3.2. Participants in the strategic sample

The recruitment yielded a strategic sample of 15 parents. The parents received Marte Meo video guidance and were afterwards interviewed in-depth about their experiences. One parent was excluded because the infant was removed from care during the guidance, and two parents declined participation in the research interview for personal reasons. We conducted in-depth interviews with twelve parents, eleven mothers and one father, from 23 to 34 years of age (M= 27). All had been referred to specialized treatment based on the risk to the infant linked to parental functioning or mental health problems. The infants were six males and six females. Infant age ranged from 2 to 27 months at the start of the guidance (M= 9 months). Ten parents met criterion a), limited mentalization capacity, with RF between 1 and 4 (M= 3.2). Two met criterion b), experiencing lack of emotional connection. All parents reported mental health problems, mostly of a long-term or recurrent nature, including posttraumatic stress

disorder, personality disorders, uni- and bipolar affective episodes, obsessive-compulsive disorder, and substance abuse disorder. Eight parents reported adverse or traumatic childhood experiences.

2.3.3. Intervention

Marte Meo video guidance (Aarts, 2008) was tailored to each individual dyad as to, for example, the number of filmings and viewings, the location, the type of interaction filmed, and the thematic focus of the guidance. Four Marte Meo therapists from the IMHT with extensive experience with parent-infant dyads administered the guidance. Filming sessions generally took place during home visits. The parents received 3-7 guidance sessions (M= 4 sessions).

2.3.4. Data collection

We devised a semi-structured interview guide to assist in interviewing. Questions covered the participants' experiences with the video guidance, the therapeutic relationship, particular helpful or hindering aspects, and changes that might have occurred regarding their thoughts about the infant and the parent-infant relationship (see Appendix B). We used the guide to structure the interviews but encouraged participants to pursue topics that they found relevant. The first author conducted all interviews (n = 12) from November 2016 to June 2019, lasting between 23 and 89 minutes (*M* = 61 minutes). The interviews took place 2–6 months after the end of the guidance (*M*= 3 months). They were digitally recorded and transcribed verbatim.

2.3.5. Data analysis

We used NVivo 11 qualitative data analysis software (QSR-International, 2015) for technical assistance. For the analyses for Paper 2 and Paper 3, Reflexive TA was carried out in seven steps by the first, third and last author in a collaborative process by the first author, Veseth and Hjeltnes (Binder et al., 2012; Braun & Clarke, 2012). For details of the process, read 2.1.4. In the analysis for Paper 2, we generated 52 initial codes, then formulated four main themes and 44 patterns or sub-themes. The analysis finally resulted in four main themes and 17 most relevant sub-themes. In the

analysis for Paper 3, 40 initial codes were generated. We then identified 34 meaning patterns, or sub-themes, and four main themes. The analysis finally derived four main themes and 21 most relevant sub-themes.

2.4. Ethical considerations

Study 1 was registered and approved by the Norwegian Federal Center for Research Data (NSD), with registration No. 50546. We obtained written informed consent from all participants. See also Appendix C.

Study 2 was approved by the Norwegian Regional Council for Research Ethics (No. 2014/474). The clinicians at the IMHT gave oral and written information about the study to suitable parents and obtained written informed consent for their participation and publication from all participants. Participants could withdraw from the study without consequences for treatment. See also appendix D. The researchers were aware of the vulnerable positions of both the parents and infants involved in the research (Brandon, Shivakumar, Lee, Inrig, & Sadler, 2009; Kendall & Halliday, 2014) and were actively concerned with preserving the dignity of the participants in the interviews and subsequent research process.

3. Results

The results of studies 1 and 2 were presented in three articles. Paper 1 reported results from study 1. Study 2 consisted of two separate analyses resulting in two separate research articles, Paper 2 and Paper 3.

Summary of Paper 1

The first paper is called "Finding focus in a difficult landscape: Therapists' Experiences with Challenging Video Guidance Processes for Parent-Infant Dyads". This interview-based qualitative study investigated the experiences of thirteen practised Marte Meo therapists with guidance processes with parent-infant dyads that they found challenging; how they handled these processes, what they experienced as helpful or not helpful, and how they were affected as therapists. We analyzed the interviews using a team-based reflexive thematic analysis method. We identified four main themes in the therapists' experiences and handling of challenging guidance processes: 1) promoting relational growth in a coercive context; 2) building an alliance that feels safe for the parents; 3) looking at positive moments in difficult lives; 4) handling intense feelings as a therapist. We determined specific therapeutic and ethical challenges with a vulnerable subgroup of parent-infant dyads. In these dyads, child protective issues arise, caregivers' insecurities impede the therapeutic relationship, or they have unresolved relational or mental health problems. Our findings suggest early identification of these dyads to facilitate better adaptation of video guidance. They also imply a need for supporting structures, clinical supervision and training for therapists addressing these challenges. The paper has been published in the *Infant Mental Health Journal*.

Summary of Paper 2

The second article is called "Like taking a magnifying glass into everyday life: Vulnerable parents' experiences with video guidance in an infant mental health clinic". The paper explores first-person accounts of parents with difficulties mentalizing and maintaining an emotional connection with their infants of Marte Meo video guidance. The aim was to understand the helping and hindering elements of the guidance

process. The in-depth interviews were analyzed with a team-based reflexive thematic analysis method. We identified four main themes: a) Handling initial feelings of fear and loss of control; b) Filming as a disturbing or agentic experience; c) Feeling validated or devalued in the therapeutic relationship; and d) Bringing insights from video guidance into everyday life. We identified therapeutic and existential factors that were important in the main themes of adjustment to the guidance, experiences with filming, the therapeutic relationship and integration of new experiences. Crucially, the parents' sense of agency, dignity and shame seemed to mediate their ability to integrate new ideas about themselves. Therefore, video guidance for vulnerable parents in specialized treatment should address relational challenges, parental mental health, and recognition issues. The paper has been published in *Frontiers in Psychology*.

Summary of Paper 3

The third paper, "Learning to mentalize: Exploring parents' experiences of change during video guidance in an infant mental health clinic", explores the lived experience of parents with difficulties mentalizing and maintaining an emotional connection with their infants, of the change process during video guidance. We employed a team-based reflexive thematic analysis method to analyze their in-depth interviews. We identified four themes: a) feeling inadequate or disconnected as a parent; b) discovering the infant as a relating and intentional person; c) becoming more agentic and interconnected; d) still feeling challenged by personal mental health issues. The parents described positive changes in the interaction, mentalizing the infants, the relationship and themselves as parents, their experience of self-efficacy, and on a representational level. They also described increased confidence and coping despite ongoing personal mental health challenges. The findings suggest that video guidance can be a pivotal intervention for vulnerable parents but should be coordinated with the parents' primary treatment when complex parental mental health problems are involved. The paper has been published in *BMC Psychiatry*.

4. Discussion

The overarching aim of this thesis is to investigate and describe processes involved in Marte Meo video guidance when used with parents who struggled to mentalize and remain emotionally connected with their infants. To this aim, the three research papers investigated and discussed three more specific research aims. Paper 1 explored therapists' experiences with challenging video guidance processes for parent-infant dyads, with a focus both on the method and the guidance process itself. The investigation of parents' experiences was expounded in Papers 2 and 3, with Paper 2 having a method-related focus, while Paper 3 focused on change processes.

In the following discussion, I will consider central results through the lens of the overarching aim in sections 4.1.-4.3. In 4.1., processes leading to new experiences and changes in the parents' ideas about themselves are discussed. In 4.2., I expound on changes in the parents' relatedness facilitating mentalization and self-efficacy. In section 4.3., I consider the role of the therapeutic relationship in Marte Meo. I then discuss aspects of reflexivity (4.4.) and limitations of the thesis (4.5.) and finally consider its implications for future research (4.6.) and clinical practice (4.7.).

4.1. Parents becoming accessible to new experiences and ideas about themselves

The parents included in study 2 were not only characterized by their struggles to mentalize and remain emotionally connected with their infants, but also by diverse mental health problems, mostly of a recurring or long-term nature. Most parents narrated changes in the way they felt and thought about themselves during the guidance. These changes were facilitated by video filming and viewing, which created an aperture in the fixed ideas the parents had about themselves, allowing them to make new experiences and begin to think differently.

Their descriptions of themselves at the start of the guidance showed most parents to feel lonely, preoccupied with their own shortcomings, and struggling to reconcile themselves to having mental health problems and experiencing problems as caregivers. This aligns with the lived experiences of parents with mental health problems (Ali,

2018; Bartsch, Roberts, Davies, & Proeve, 2016; Blegen et al., 2016; Johansson, Benderix, & Svensson, 2020; Rørtveit, Aström, & Severinsson, 2010). From their initial perspective, the parents often did not perceive the infants as relational counterparts but as sending negative signals, making unfathomable demands, limiting personal freedom, even negatively influencing their lives. Our findings can be seen as first-person accounts of the self-absorbed state described for caregivers with diverse mental health problems (Beebe et al., 2011; Radke-Yarrow, 1998; Vik & Braten, 2009) and by the therapists investigated in this thesis. While the state may be characterized as non-mentalizing (Sadler, Novick, & Meadows-Oliver, 2016), there is another, striking, feature of most parents' internal dialogues, perception of the infants and of health professionals, in what appeared as relational insecurity and a general lack of trust in a benevolent relational "other". Their descriptions show that the parents had insecure, apprehensive and negative expectations of relationships that indicated corresponding internal representations of being related.

The experience of video disrupted this self-absorbed, relationally insecure state. The disrupting, surprising, change-inspiring properties of video-viewing have been described for Marte Meo and other video guidance formats. From a comparable video intervention, Beebe has described the experience of seeing oneself interacting on video as a kind of facilitating "'shock' to the unconscious, 'perturbing' the system" (2003, p. 45). Conceptualizing video guidance more generally, Steele and colleagues have also related this to the "surprise to the unconscious" aimed at by the Adult Attachment Interview (Steele et al., 2015). Postnatally depressed mothers have described and stressed that Marte Meo guidance promoted an "outside view" that facilitated new ideas of the self and enhanced their capacity to mentalize (Vik & Braten, 2009; Vik & Hafting, 2006, 2009). Conceptualizations of VIG, a video guidance method with similarities to Marte Meo (Landor & Ljungquist, 2018), have posited that the discrepancy between parents' old, negative beliefs about themselves and the evidence of positive interaction presented in the video feedback creates a cognitive dissonance that promotes their metacognitive capacity, or mentalization (Cross & H, 2011; Doria, Kennedy, Strathie, & Strathie, 2014). Most parents in the present sample also described that the use of video in the guidance led them to disconnect from their usual

perception of themselves. Filming made the parents feel self-conscious, artificial and remote, and viewing made them feel distanced and alien, while the positive stance collided with their self-critical ideas. Their accounts, however, seem to capture initial aspects of the change process that pertain more to overcoming avoidance, or fears, of relationally connecting. A shift occurred when the parents became aware of how relationally interested the infants were in them (see also Vik & Rohde (2014)), epitomized by the infants' gaze as shown to them on video. Repeated close-up viewing of the infants' benign, steadfast focus on the parents then gradually changed how the parents perceived themselves. They describe feeling more lovable and good enough as humans and parents, more interesting and important, and more able to create a relationship and make an impact. These specific changes regarding the formation of parents' ideas of themselves point to a reciprocity of feeling relationally connected and having improved ideas about oneself.

The reciprocity of these experiences can perhaps best be understood out of the developmental framework of interpersonal relatedness and self-definition as interconnected but polar opposite dimensions (Keller, 2016; Luyten & Blatt, 2013). Relatedness, springing from the "need for closeness with others" (Keller, 2016, p. 2), is described as a developmental and maturational process that generates "a sense of self in relation to others that has been established in earlier interpersonal experiences of trust and cooperation" (Blatt & Blass, 1996, p. 325) Self-definition, on the other hand, is seen as the development of "independent mental states with a focus on choice, individual preferences, self-maximization and self-fulfillment […] best captured as psychological autonomy" (Keller, 2016, p. 2). It is achieved as "a capacity for autonomy and initiative […] eventually lead[ing] to the formation of an identity on the separateness developmental line as capable and functional." Developing and integrating experiences of relatedness and self-definition is a lifelong dialectic process of balancing an "identity as a separate and capable individual who has positive and constructive relations with others" (Blatt & Blass, 1996, p. 325). From infancy, experiences of relatedness conduce to the development of the sense of self, which again supports the development and maturation of interpersonal relatedness. Whereas positive experiences lead to the development of an adaptive balance between the

dimensions, more problematic early experiences can result in an inflexible, lopsided balance. In this perspective, therapeutic change is seen as furthering "synergistic interaction of [these] experiences" (Luyten & Blatt, 2013, p. 175), or even as a "reactivation of the dialectic" between positive relatedness and a positive sense of self (Luyten, Campbell, & Fonagy, 2019, p. 9) when the lopsidedness between the dimensions has become entrenched.

Our findings show that video guidance facilitated a positive experience of relational connection for the parents, which, in turn, opened for improved ideas of themselves, which again more profoundly changed their relatedness. The guidance could thus be seen as furthering synergistic processes between these dimensions. Interestingly, the catalyst for change seemed to be the infants' relational competence when it reached the parents through the gap created by video.

The parents' accounts describe in detail how they acquired improved ideas about themselves in the conjunction of video and the relationship with the infants. Although first perceived as alien and distancing, the films still served as concrete proof of a different reality. They raised parents' awareness of the interaction with the infants, leading them to discover instances that matched the videos. Conceptualizing psychoanalytically-informed brief video feedback, Beebe has pointed out that viewing makes the interaction seem at the same time both immediate and more removed. It can focus on a single or few modalities instead of "flood[ing] the senses", and decelerate the interplay (Beebe, 2003, p. 45). The parents in the present sample related how the ideas from the films increasingly merged with their own new experiences, leading to new, improved ideas of the self. Their descriptions may also connect with conceptualizations of successful change processes as an assistance to become "unstuck" from earlier, less functional self-images or representations of relatedness (Luyten et al., 2019, p. 10).

The synergism of relatedness and self-definition could also help explain that most parents' new relational experiences expanded, making them more generally secure and confident, in other relationships and the face of challenges. Their perceptions of their

mental health problems changed as well, from defining and limiting conditions to being part of who they were and what they could handle. In this way, changes in the parents' relatedness and representations about themselves correspond with perspectives of recovery (Davidson, Rakfeldt, & Strauss, 2010). See also 4.2.

Explorations of the practice of Marte Meo (Paper 1) show that the therapists' strategies matched the vulnerable parents' needs: They were aware of the parents' initial preoccupation, emotional distance, and lack of relational trust. They deliberately used film and the therapeutic alliance (see also 4.3.) to engage and reassure the parents. As a central avenue to change, they tried to forge an emotional connection between the parents and the infants. As a central tool, they showed video clips of contact moments, lingering especially on the infants' face, gaze, smile and reactions to the parents, thus using "the baby's face as an affective stimulus" (Ammaniti, 2014). Therapists held a purposeful balance between showing film and giving room to reflect, so as not to overwhelm relationally insecure parents. They specifically enhanced subtle aspects of the interaction such as rhythm, prosody and minute movements for emotionally distant parents. We suggested that this deliberate presentation of "visual-facial, auditory-prosodic and tactile-gestural communications" (A. N. Schore, 2012, p. 56) aims to activate the "implicit relational knowing" of these parents (Stern, 2010, p. 111). It may thus facilitate an emotional connection that is not defensively warded off. Parents' descriptions (Paper 2) of how they became especially aware of the minute, embodied aspects of the interaction could support this idea.

4.2. Feeling connected as a central ingredient for change

Section 4.1. showed how video supported changes in the parents' relatedness and self-representations. This section discusses how these changes, in turn, altered both how the parents' interacted, how they reflected about the infants, the interaction and themselves, and how confident and competent they felt. A crucial shift occurred when the parents became aware of the infants' relational interest, especially gazes, smiles, and proximity-seeking. While this had profound implications for the parents' ideas and feelings about themselves (see 4.1.), the shift also led to several subsequent changes in how the parents saw, acted and thought about the infants and themselves relating.

As a first change, the parents' newfound awareness of the infants' contact initiatives led to an increased attentiveness towards them. This increase, in turn, led to the discovery that the infants' actions were intentional and meaningful. This discovery represented an important widening of the parents' initial, more self-absorbed perspective, which often failed to regard the infants as relational counterparts and ascribe intentions and significance to their actions. Similar experiences have been described for postnatally depressed mothers (Vik & Hafting, 2009) and the parents explored by Gill and colleagues (2019). Recognizing the infants as "psychological agents" (Sharp & Fonagy, 2008) can be seen as a pivotal shift towards a mentalizing stance. When the parents started to regard the infants as intentional and their actions as significant, they became more aware of the interplay between the infants and themselves. Thus, they began to realize how interconnected their own and the infants' actions and reactions were. It can be argued that this signifies the development of a truly intersubjective matrix between the parents and the infants (Lyons-Ruth, 1999; Stern, 2007).

This intersubjective shift changed several features of the interaction and the parent-infant relationship. For one thing, it led to prolonged and more complex exchanges and circles of positive mutuality (Papousek & De Chuquisengo, 2006). The parents' awareness of interconnectedness also led to the more active involvement of the parents in stressful situations. They contained themselves more when stressed, as they now perceived how their own calming helped calm the infants. They also experienced more confidence about boundaries and actively structured the interaction more. These developments represent crucial changes in the degree of regulating the infants and themselves, and in the attachment relationship (Rutherford et al., 2015; J. R. Schore & Schore, 2008).

Concomitantly, the parents' degree of reflection about the infants and the interaction also widened and deepened. They were now actively trying to figure out the internal state of the infants, became aware of how the infants' and their own internal states affected each other and reflected about the infants' developmental abilities and needs. These are hallmarks of parental reflective functioning, signifying a profound increase

in the parents' mentalizing, or PRF (Slade, 2005). They represent a crucial change for our strategically sampled parents who initially had difficulties mentalizing and maintaining an emotional connection with their infants. Our findings indicate that video guidance supports these processes in this central client group in infant mental health. The parents' detailed description of the process involved in and leading to enhanced mentalizing emphasize that reflective functioning is embedded in experiences of relatedness and relational competence. This result may connect with research placing mentalizing and difficulties mentalizing in the dialectic between relatedness and self-definition (Luyten & Blatt, 2013).

Most parents developed more flexible ideas of themselves as caregivers, with a strengthened experience of connection and self-confidence even in the face of challenges. This development suggests a more fluid shifting between representations, between past and present, and between self and infant (Stern, 1995). They were better able to navigate conflicts, which can be understood as an increase in their relational security (Bretherton & Munholland, 2008; Iyengar et al., 2019). Their view of everyday life with the infants was more relaxed and balanced, and thus more normalized, as ambivalence and insecurity are normal, fleeting states in parenting (Stern, 1995). Their confidence expanded to other situations, other relationships, and even the handling of persisting mental health problems, which most of them still experienced more or less frequently. This increase in agency, flexibility and confidence as parents and in other areas of life, including their own mental health challenges, suggests a pivotal increase in the parents' experience of self-efficacy (Ozer & Bandura, 1990), not only in the domain of parenting but also on a general level. Parental self-efficacy is defined as "the confidence about their ability to successfully raise children" (Wittkowski, Garrett, Calam, & Weisberg, 2017, p. 2) and is linked to several positive parenting functions. General self-efficacy more broadly involves positive self-perceptions of one's agency, competency and influence over events (Coleman & Karraker, 1998; Jones & Prinz, 2005). Our findings imply that Marte Meo guidance may increase parents' self-efficacy, sparking relatedness, affect regulation, mentalization and intuitive parenting competency, and extending more generally to coping with mental health problems. They relate well to knowledge from the recovery

movement in mental health (see also 4.1.), which has repeatedly demonstrated how people are able to find ways of leading meaningful lives in the face of a wide range of different mental illnesses (Priebe, Omer, Giacco, & Slade, 2014). Following this line of knowledge, Davidson et al. have defined recovery as "a process of restoring a meaningful sense of belonging to one's community and positive sense of identity apart from one's condition while rebuilding a life despite or within the limitations imposed by that condition" (Davidson et al., 2010, p. 25). The findings support earlier conceptualizations placing Marte Meo among resource-oriented methods (Hedenbro & Wirtberg, 2012). They align with research from community samples showing symptom reduction in depressed parents (Hoivik et al., 2015) and increased maternal confidence among more vulnerable mothers (Kristensen, Simonsen, et al., 2017).

4.3. **Supporting and reflecting change: the role of the therapeutic relationship**

As shown in Sections 4.1 and 4.2., video guidance can assist parents in relevant change processes that can be understood out of the dialectic between relatedness and self-definition. This section discusses the specific role of the therapeutic relationship in these processes based on the experiences made by both parents and therapists. The therapeutic relationship supported parents' commitment and immersion in the guidance, their making new relational experiences and handling strong emotions, and their feeling comprehensively recognized with both strengths and challenges. Commitment to and immersion in the guidance were particularly relevant issues at the beginning of the process. Parents could be considerably torn and conflicted about counselling and feel intensely apprehensive and insecure about filming. Such degrees of conflicted, anxious and insecure parental experiences may be more typical for clinically referred dyads. In community settings, moderate stress before the intervention has been described as common (Clarke et al., 2011), for CPS contexts also construed as the expression of power differentials (Kiamanesh et al., 2018). The findings from our parent sample align with the therapists' experiences and suggest that highly challenged caregivers have distinct experiences and needs in Marte Meo.

As described in 4.1., therapists were aware of vulnerably parents' initial distance, preoccupation and lack of relational trust. They aimed at building a secure alliance

with the parents while introducing filming as early as possible in the process. They described the positive, resource-oriented focus of the films as both epitomizing and enhancing their therapeutic stance towards the parents. This matches with how the parent participants noted this stance in their respective therapists. Many described how they grappled with the experience of this external, reliably positive perspective, represented by the therapist and the films, as opposed to their internal critical and self-doubting stance. Vik and Rohde (2014) have emphasized that therapists' level of positivity needs to be adapted to the parents' state of mind and emotional level, as with mothers with postnatal depressive symptoms who would not tolerate high levels of optimism. Our parents' experiences expand this notion by describing the process of seeing, doubting, receiving reassurance, and gradually accepting the positive perspective as a distinctly relationally embedded process. New "schemas of being with" (Vik & Rohde, 2014) were not merely supported by the therapist stance but generated by the conjunction of the film reviews and the therapeutic relationship. Repeated experiences of the therapists' calming and benevolent presence were an important part of the process. The integration of new, positive representations of themselves was also described as an embodied, lingering experience of being soothed.

Our findings may suggest that while the films presented the concrete visual proof of a different reality of being a caregiver (see 4.1.), the therapists offered the experience of being seen with a benevolent gaze and receiving regulation, as concrete evidence or blueprint of a different relational reality. The interplay of these experiences may then have supported the development of new relational representations. This interplay could link to Luyten and colleagues' idea that "an intersubjective process where […] rigid patterns are examined in the context of a relationship with an empathic and understanding person […] holds the key to therapeutic change" (2019, p. 242) and concepts positing intrinsic, embodied exchanges as central in therapeutic processes (A. N. Schore, 2014). It aligns with therapists' descriptions of the triangle between themselves, the parents and the interaction in the film as the central arena of the guidance process (Paper 1).

Another facet of the therapeutic relationship was how vulnerable parents experienced issues of being valued and recognized for having personal worth in the therapeutic process. For many parents, filming and guidance elicited at times intense feelings of inadequacy and shame. As a counterweight, being acknowledged as sharing a common humanity with the therapist was described as particularly important. Parents needed their struggles recognized, yet they also needed to be recognized as persons in their own right and competent caregivers. For mothers with postnatal depressive symptoms, the need to be seen as depressed and as caregivers has been described (Vik & Hafting, 2009). In our data, this twofold recognition of the parents supported a shift of focus, from their feeling as the object of scrutiny to their engagement as caregivers, stressing issues of acknowledgement and value to be an important factor in Marte Meo. These parents' experiences expand a method-related focus towards a broader therapeutic perspective (Gelso, 2002), highlighting the need for recognition as an existential condition (Houston, 2016).

Systemic factors like the lack of family- and parenting-oriented perspectives in adult mental health services (Strand, Boström, & Grip, 2020; Tchernegovski et al., 2018) and mental health professionals' lack of knowledge about addressing parenting as a topic (Maybery & Reupert, 2009; Shah-Anwar, Gumley, & Hunter, 2019) may enhance vulnerable parents' need to be acknowledged (Blegen et al., 2016; Johansson et al., 2020). Recognition can be seen as part of their struggle to remain a person in a potentially reifying process (Falkum, Hytten, & Olavesen, 2011). Psychologically, it may be related to issues of shame, as a need to balance the narcissistic wound of being found wanting as a parent. These issues may align with data showing that narcissistic personality traits in parents hinder the effect of video guidance (Hoivik et al., 2015).

Conversely, therapists described the requirements for offering the kind of support they felt vulnerable parents needed. They found the resource-oriented focus of Marte Meo crucial to emotionally engage with vulnerable families and lend importance to their concerns, focusing on and highlighting resources in the interaction, however minute. They needed optimism and stability when parents' caregiving was marginal (Conen et al., 2011, p. 142), and at times handled considerable uncertainty as well as intense

feelings in the therapeutic relationship. Therapists described how their stance towards the parents became challenged when they experienced concern for the welfare of the infants, who, while not actively involved in the guidance, yet were in focus, often magnified, during filming and reviewing. These issues could pose therapeutic and ethical dilemmas that were difficult to handle. We have earlier suggested that therapists themselves become emotionally activated by their exposure to infant video material, an assumption supported by research on adult neurobiological responses to infant faces (Ammaniti, 2014, p. 115). Research shows that Marte Meo therapists have especially high observational skills regarding sensitivity and synchrony, or lack of it, in parent-infant interaction (Kristensen, Trillingsgaard, et al., 2017). Such dynamics may make these dilemmas more pressing and burdensome. Our results indicate that therapists need specific training, support and supervision when working with highly vulnerable parents, especially when mental health problems or CPS perspectives are involved and ethical problems may ensue. Our findings suggest that clear structures and boundaries, and a specific rationale for video guidance in a CPS context are required. This finding aligns with research on Marte Meo in the CPS, highlighting the need for structure, learning and support (Kiamanesh et al., 2018).

4.4. Reflexivity

Reflexivity is an important part of qualitative research. It means consciously and critically considering how the research conducted and the knowledge produced are shaped by contextual factors, including the researcher (Lazard & McAvoy, 2020). Wilkinson (1988) suggested a differentiation between three levels of reflexivity: personal, functional and disciplinary, which will be employed in the following discussion.

Personal reflexivity

Personal reflexivity refers to how the "researcher's own identity" and concerns have influenced the choice of the topic as "research often [is] an expression of personal interest and values" (Wilkinson, 1988, p. 494). Psychoanalytic thinking and ideas about unconscious processes have long been of particular interest to me. Becoming a mother and a child psychiatrist turned my interest towards developmental psychology

and attachment and their connection with mentalizing. I also became fascinated by micro-interactions and video guidance and what I perceived as its strong intersubjective leanings. I received training in psychoanalytic child therapy from 2008 to 2010, as a mentalization-based therapist in 2010, and as Marte Meo therapist from 2010 to 2012. To me, these perspectives are interlinked, and I try to combine them in my clinical practice. In thirteen years on the infant mental health team, I have met many vulnerable dyads. I have worked with parents burdened by mental health problems and psychosocial marginalization, parents who struggled to mentalize their children and others, parents who at times rejected mentalizing and the possibility that people, especially their infants, could make sense. Experiencing breakdowns of intersubjectivity in therapy and seeing how this affected the infants could be intense and painful. I could feel torn between my role in counselling the parents, who often had their own history of trauma and loss, and my role as a child psychiatrist, focusing on the infants' wellbeing. Investigating how Marte Meo and its use of micro-interaction feedback worked for parents who struggled to mentalize and maintain the emotional connection to their infants was, therefore, a topic of great interest to me.

Functional reflexivity

Functional reflexivity is closely connected with personal reflexivity. It examines "how the form of the research [is] […] shaped by our values, life circumstances, role in society […], ideology […]?; and further, what part the form of our research (and particularly the methods we chose) [does] play in creating our concepts and hence constructing our knowledge?" (Wilkinson, 1988, p. 495). Reflexivity here can both consist of internal dialogue and discussions with colleagues, importantly also people with different ideas and perspectives (Lazard & McAvoy, 2020). I found that divergent strands of my personal and professional thinking interplayed and contended in the design and conducting of the research. My genuine interest was to approach the phenomenon from nearby, yet I also felt the weight of the distanced position brought in by psychiatric theory and the assessment of mentalizing. One way of achieving a balance was the decision to include an investigation of therapists' experiences with video guidance in the research design. A further important help in the handling of these influences was the reflective qualitative approach that was chosen, with its

emphasis on empathic and thoughtful closeness and the team-based analysis process. The members of the research team brought in perspectives from sociology and psychology, especially symbolic interactionism, recovery, and user involvement, which had bearings both on therapeutic processes and qualitative analysis. Consciously setting aside conceptualizing, including conceptual language, during the engagement with the narratives facilitated an experience-near description of the participants' experiences. These were then the basis for a contextualization with the current state of knowledge and relevant theoretical concepts. In this way, I found that my personal and professional thinking could be a basis for insight, not merely a barrier to understanding experiences with video guidance (Lazard & McAvoy, 2020).

Disciplinary reflexivity

Disciplinary reflexivity is concerned with how research is informed and influenced by the scientific field and its dominant paradigm (Wilkinson, 1988, pp. 495-497) and our stance towards this (Gough, 2017). The development of infant mental health interventions increased in the last two decades, with a predominant focus on attachment-based interventions and a research focus on establishing quantitative evidence about their effects. The developments of these methods could be described as top-down, from theory to applied interventions (Barlow et al., 2015; C. H. Zeanah, 2018; P. Zeanah, Stafford, & Zeanah, 2005). Marte Meo, on the other hand, was developed empirically in the field much earlier, and only later linked to theoretical concepts. Practitioners accepted it while scientific evidence was still lacking (Osterman et al., 2010), which in my view, added to the seeming isolation of the method in the field. Eventually, the RCT (Hoivik et al., 2015) and several quasi-experimental studies (Bunder, 2011; DeGarmo et al., 2019; Kristensen, Simonsen, et al., 2017) supplied quantitative evaluations, flanked by qualitative investigations driving conceptualization of the method (Kiamanesh et al., 2018; Vik & Braten, 2009; Vik & Hafting, 2009; Vik & Rohde, 2014). Albeit studying a community sample, the RCT also acquired data on parental personality disorder traits in their study. This closer look at parents' mental health issues was in line with an increasing focus on the development of children of parents with mental illnesses (Campbell et al., 2021; Dean et al., 2018; Hosman, van Doesum, & van Santvoort, 2009; Maybery & Reupert, 2018;

Metz & Jungbauer, 2021). As outlined in the introduction, this focus has to a larger extent been directed at the developmental risk for the children, with less attention to the lived experience of parents or to the clinical, and ethical, conundrum of the interlinked perspectives of children and parents. The present thesis placed itself in this focal area, with a qualitative, reflective and practice-near perspective. While conducting this research, I have, through dialogue and reflection, sought to account for and handle the personal and functional influences on it, as well as the pressure for quantitative evidence dominant in therapy research.

4.5. Limitations of the thesis

There are several methodological limitations in the present study. While more specific methodological limitations are discussed in the individual papers, in this section, I will discuss limitations that span over individual papers. The discussion will focus on two main limitations regarding Study 2, namely the heterogeneity of the strategic sample and problems with RF as a construct, and on the thematic focus of the thesis as a whole.

One of the main limitations was the heterogeneity of the sample of participants for Study 2 (Papers 2 and 3). The criterion sampling (Sandelowski, 2000) assisted by PDI-R interview (Slade et al., 2004; Sleed et al., 2018) aimed at a strategic sample of parents of referred infants with difficulties to mentalize and be in attuned connection with their infants under (affective) stress. The sample structure was heterogeneous in several aspects. While all participants were recruited from a specialist clinic and had a history of mental health problems as assessed by self-reporting, the nature of these disorders was heterogeneous. They included posttraumatic stress, personality disorders, affective and obsessive-compulsive disorders and substance misuse. While supplying rich and varied data, our sample allows neither focus on one predominant nor discrimination between different mental health conditions. As well, participants were heterogeneous as to psychosocial resources. Another aspect was sample size and composition. We interviewed a strategic sample of twelve parents because of the attrition of 3 participants. The interviews varied in length, possibly leading to more dismissing parents having a less prominent voice in the data. The three parents who

were lost due to attrition might have been divergent voices informing the research missing in the overall findings. Among our participants, women were overrepresented, with the risk of a skewed description of parenting experiences. As research has shown, women and men can have different experiences of similar mental health and parenting problems (Price-Robertson, Reupert, & Maybery, 2015). These limitations raise the question of the transferability of the findings to other contexts and populations.

Criterion sampling also led to variations between participants in RF scores assessed by PDI-R. Ten parents were rated to an RF of 4 or less, which corresponded to grades of limited RF. Two parents scored to an RF of 5, or average, while describing considerable difficulties maintaining an emotional connection with their infants under stress. These RF differences at the outset may have corresponded with different needs and led to diverse experiences of the guidance process, which the study did not address. On the whole, basing the strategic sampling on the PDI-R with its stress on narratively expressed mentalizing (Slade, 2005; Sleed et al., 2018) can be seen as an underlying methodological limitation, or lopsidedness. Embodied expressions of mentalizing were not in focus during strategic sampling (Shai & Fonagy, 2014) even though video guidance as the research topic can be argued to focus on embodied mentalizing through its attention to movement, sound, rhythm and synchrony. An interesting aspect of the findings was, however, that most parents reported changes both in how they responded to the infants' embodied expressions and in more cognitive aspects of mentalizing. This twofoldness suggests that both embodied and more cognized aspects of reflective functioning were relevant in the process and possibly interconnected. However, our qualitative approach investigated the parents' subjective experience of participating in Marte Meo video guidance and cannot determine causal relations between the described phenomena.

A third limitation concerns the thematic focus of the thesis as a whole. Its main aim was to explore and describe processes involved in Marte Meo video guidance of parents with difficulties to mentalize or maintain the emotional connection with their infants. To this aim, experiences with guidance processes of both parents (Study 2) and therapists (Study 1) were investigated. The strategic sampling of parents aimed to

recruit participants who were knowledgeable about the phenomenon. They were recruited from one outpatient unit and received Marte Meo from four different therapists. On the other hand, to explore therapist experiences, we recruited on a broader basis, in different geographical locations and from different training sites. As well, the interviews were not designed to specifically inquire about guiding parents with difficulties to mentalize or maintain the emotional connection with their infants. This design was chosen because these criteria were deemed imprecise, so that inquiring directly about them would have posed a risk for semantic blurredness and misalignment between therapists. Hence, a different approach was chosen. Drawing on own clinical experience, it was considered that Marte Meo therapists with several years' experience with parent-infant dyads would be knowledgeable about the phenomenon of guiding these parents, and moreover, that these guidance processes could be challenging. We, therefore, asked about processes with parent-infant dyads that the therapists themselves experienced as challenging or difficult. The results supported the research design in the high degree of consensus across all interviews describing guidance processes with these parents as challenging. However, the thematic blurredness between the phenomena investigated in the parent interviews and the therapist interviews remains as a limitation.

The methodological and conceptual limitations in this study stress the need for consideration and caution as to the trustworthiness and generalizability of the results. Relevant implications for future research and clinical practice can nevertheless be drawn from the findings of this project bearing these issues in mind.

4.6. Implications for further research

The findings from this research project have relevant implications for future research. Our results indicate that video guidance using the Marte Meo method can stimulate a profound change in clinically vulnerable parents of dyads referred to specialized treatment. This important client group should be further investigated.

As the parents mostly struggle with heterogeneous mental health problems, one line of research could differentiate between defined parental health problems, such as

personality disorders, recurrent depression, anxiety disorders or posttraumatic disorders. These investigations should include changes in mentalization capacity and self-efficacy. Our findings suggest that change is facilitated as a reciprocal process between the parents becoming and feeling better related and acquiring improved ideas about themselves. Therefore, a useful line of further research could be to differentiate between parents struggling more with connectedness or with self-definition and assessing potential differences in their requirements for video guidance. Another relevant topic would be to investigate a combination of parental video guidance and the parents' primary therapeutic treatment.

Additionally, more research on fathers as a parent group would be important. Moreover, future research should cover parents of older children with more deeply engrained patterns of interacting and more developed verbal communication to see if their change processes differ from those of infant parents.

Research on the video material itself by methods such as Interpersonal Process Recall (Elliott, 1986) or Conversation Analysis (Fogtmann Fosgerau, Schöps, Bak, & Davidsen, 2018), including an investigation of embodied mentalization (Shai & Fonagy, 2014), could further expand knowledge about the processes. Our findings show the need for further conceptual development that includes emotional regulation in the therapeutic relationship and through the medium of video for vulnerable dyads.

4.7. Implications for clinical practice

For clinical work, our findings suggest that video guidance using the Marte Meo method can be useful in the specialized treatment of dyads where parents have complex psychosocial or mental health problems and difficulties mentalizing the infants.

Therapists' experiences emphasize that vulnerable dyads present specific challenges for video guidance, including ethical dilemmas, with corresponding requirements. These results should lead to recognizing this client group and the implications for structural and method development. Structurally, a rationale for Marte Meo in CPS contexts, cooperation with parents' mental health treatment, therapist supervision, and

expansion of training curriculum seem indicated. For the guidance itself, early systematic assessment of the parents' vulnerabilities and child protective issues could facilitate an adapted guidance process. This means that therapists need to be aware of and able to handle these possible challenges, with consequences for practice and training. Finally, further development of the method could incorporate more explicitly mentalization-based techniques.

The vulnerable parents' experiences imply concrete suggestions for video guidance practice: For them, video guidance seems closely interwoven with their psychosocial health and vulnerabilities, a psychotherapy of the parent-infant relationship more than a training program. Therapists need to be attentive to parents' health struggles, need for recognition, and self-conscious emotions during guidance. To initiate change, review sessions should focus on the infants' contact initiatives and the infants' gaze. Especially for insecure parents, these moments should be shown repeatedly. When parents have become engaged, film clips showing mutuality and interconnectedness in the interaction can stimulate further awareness and reflection. As parents' own challenges and parenting seem closely interconnected, and as the experience of agency and confidence seem central focus points, a combination of the guidance with parents' primary treatment could be considered. A combination may be particularly indicated when a more thorough working-through of internal representations or follow-up of mental health challenges is needed. Our findings imply that the change process involved development both at the levels of the actual parent-infant interaction and of the parents' internal representations of interacting and being related.

5. Conclusion

The findings indicate that Marte Meo can support change processes for parents with difficulties mentalizing the infants and manifest psychosocial or mental health problems. As a central tool of the guidance, video filming and reviewing made parents accessible to new experiences and ideas about themselves. They described a shift in how they experienced a connection with their infants and others and how this affected their sense of self. Feeling related, or relatedness and sense of self were described as mutually influencing each other. Feeling more connected was also a key ingredient for further changes in how the parents conducted and mentalized the interaction, how confident and self-efficacious they felt, and how this affected other areas of their lives. These processes were centrally supported by the therapeutic relationship that made the parents feel secure, connected and recognized. The change involved development both at the levels of the actual parent-infant interaction and of the parents' representations. Our findings suggest the value of further research on video guidance for these vulnerable parents regarding their mental health problems, cooperation with their primary treatment, fathers, and dyads with older children. Video guidance practice should recognize the requirements of this client group, with implications for structural and method development. Structurally, a rationale for Marte Meo in CPS contexts, cooperation with parents' mental health treatment, therapist supervision, and expansion of training curriculum seem indicated. Early systematic assessment of parents' vulnerabilities and child protective issues could facilitate an adapted guidance process for the guidance. Parents' mental health struggles, need for recognition, and self-conscious emotions should be attended to during guidance. Our findings imply that Marte Meo guidance can strengthen vulnerable parents' connectedness, mentalization and self-regulation as well as self-efficacy, both as parents and in other areas of life.

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ARTICLE

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Finding focus in a difficult landscape: Therapists' experiences with challenging video guidance processes for parent–infant dyads

Indra Simhan[1,2] | **Marius Veseth**[2] | **Kari Vik**[1] | **Aslak Hjeltnes**[2]

[1] Department of Child and Adolescent Mental Health, Southern Norway Hospital Trust, Kristiansand, Norway

[2] Department of Clinical Psychology, Faculty of Psychology, University of Bergen, Bergen, Norway

Correspondence
Indra Simhan, Department of Child and Adolescent Mental Health, Southern Norway Hospital Trust, PO Box 416, N-4604 Kristiansand, Norway.
Email: indra.simhan@sshf.no

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ABSTRACT

Marte Meo video guidance uses filmed interaction of the actual parent–infant dyad in the guidance of caregivers. Exploring the challenges that therapists meet in the guidance of parent–infant dyads may illuminate important aspects of the method itself as well as the therapists' role and requirements. This could lead to method development and improved practice, but is hitherto little addressed. In this paper, we explore how skilled therapists experience and handle challenging or failing guidance processes with parent–infant dyads. We analyzed interviews with 13 Marte Meo therapists/supervisors using team-based reflexive thematic analysis. Four main themes were identified: promoting relational growth in a coercive context, building an alliance that feels safe for the parents, looking at positive moments in difficult lives, and handling intense feelings as a therapist. Our findings show that therapists experience specific therapeutic and ethical challenges with a vulnerable subgroup of parent–infant dyads where child protective issues arise, where caregivers' insecurities impede the therapeutic relationship, and where caregivers have unsolved relational or mental health problems. The therapists' role becomes pivotal and demanding with regard to the therapeutic alliance, the therapeutic interventions in the guidance process, and their own need for regulation, supervision, and structure. Identification of these vulnerable dyads early in the process could facilitate a better adaptation and practice of video guidance. Our findings suggest a need for supporting structures, clinical supervision, and training that address these challenges.

KEYWORDS

Marte Meo, parent–infant interaction, reflexive thematic analysis, therapist perspective, video guidance

1 | INTRODUCTION

What is it like for therapists to give video interaction guidance to parents who struggle to understand and interact with their infants? What do their experiences with challenging video guidance processes tell us about the guidance of these dyads itself, and the therapists' role and requirements? In this article, we explore the challenges

that therapists encounter in Marte Meo video guidance with parent–infant dyads, and how these challenges shape the process, their use of the method, and their own role as therapists.

The quality of interaction between infant and caregiver is central for the support of development and attachment (Ainsworth, Bell, & Stayton, 1974; Meins, 2013; Van IJzendoorn, 2004), and disturbances in the parent–infant relationship are a risk factor for child mental health problems (Lyons-Ruth et al., 2017; Rask, Ornbol, Olsen, Fink, & Skovgaard, 2013; von Klitzing, Döhnert, Kroll, & Grube, 2015). About 9% of infants live within clinically disturbed parent–infant relationships (Skovgaard et al., 2007), which have been linked to both negative expectations from the parents as well as deviant handling and reactions to the child. Parent–infant interaction and the parent–infant relationship are therefore the focus of a range of guidance and treatment approaches (Barlow, Bennett, Midgley, Larkin, & Wei, 2015; Wright & Edginton, 2016). Guiding the caregiver to reflect on the interaction can take place while the interaction is unfolding (Cohen, Lojkasek, & Muir, 2006; Sadler et al., 2013), through the use of video material from the interaction (Fukkink, 2008; Powell, Cooper, Hoffman, & Marvin, 2013), or both (Bernard et al., 2012; Doesum, Riksen-Walraven, Hosman, & Hoefnagels, 2008).

Video guidance uses filmed everyday interaction of the actual dyad in the guidance of parents, often during home visits. Its effect and function have been widely documented (Balldin, Fisher, & Wirtberg, 2016) and to some extent conceptualized, especially for parent–child dyads (Hedenbro & Wirtberg, 2012; Steele et al., 2015). Several distinct methods have been developed, among them Marte Meo and its manualized variant called video feedback of parent–infant interaction (VIPI) (Onsoien, Drugli, & Hansen, 2015). Marte Meo is used in four continents, and more widely implemented in several European countries as well as Australia, and improves parent–infant interaction, parental sensitivity, and infant development also in more vulnerable dyads (Gill, Thorød, & Vik, 2019; Høivik et al., 2015; Kristensen, Simonsen, Trillingsgaard, & Kronborg, 2017). It originated out of an intersubjective perspective and, like video-interaction guidance (VIG) (Kennedy, Landor, & Todd, 2011), has a decidedly solution-focused stance, omitting material that shows negative or ineffectual interaction. This stance has been cited as a key difference to many other methods (Landor & Ljungquist, 2018) and conceptually linked to resource-orientedness (Bunder, 2011; Kiamanesh, Olafsen, & Drozd, 2018), salutogenesis and family resilience (Hedenbro & Wirtberg, 2012). Marte Meo has also been related to Stern's developmental model, and mentalization (Vik & Hafting, 2009; Vik & Rohde, 2014). Based on the child's focus expressed as signals, or "initiatives," the method identifies so-called "dialogue ele-

Three key findings and implications

1. Therapists describe a vulnerable subgroup of parent–infant dyads as posing specific methodical and ethical challenges for guidance. These are dyads with child protective issues, caregivers' insecurities impeding the therapeutic alliance, and caregivers with unsolved relational issues or mental health problems. *Implication 1*: These dyads represent a client group with specific requirements and should be identified early in the guidance process, for example, through assessment of the parents' vulnerabilities and child protective issues.
2. Adapting the guidance to the requirements of these dyads renders the role of the therapist pivotal and demanding regarding the alliance, therapeutic interventions, selection of video material, and therapists' own emotion regulation. *Implication 2*: There is a need for conceptual development of the method for vulnerable dyads.
3. Marte Meo therapists experience profound conflicting or distressing feelings in the triangle between caregiver and infant that influence the guidance and put a strain on the therapist, especially where child protective issues are present. *Implication 3*: There is a need for development of supportive structures such as a rationale for Marte Meo in child protection services contexts, routines for cooperation with parents' mental health treatment, access to clinical supervision, as well as expansion of training curriculum to cover the specific requirements of overburdened parents, the therapeutic relationship, and transference/countertransference.

Statement of relevance to the field of infant and early childhood mental health

Our research on video guidance for parent–infant dyads shows factors that hinder or facilitate guidance processes for a vulnerable subgroup of dyads with increased risk for infant development. Our findings have implications for the practice field and conceptualization of video guidance and increase knowledge about interventions at the intersection of infant mental health work and child protection.

ments" structuring the interaction. Therapist and caregiver agree upon a working goal, for example, "better contact." The therapist films everyday interaction moments of the dyad, analyses the film, and identifies the dialogue element that needs developing, for example, "the caregiver registers the child's focus and contact initiatives." For the reviewing sessions with the caregiver, the therapist chooses clips that show developmentally supportive interaction, or an interactional opportunity for it, related to the dialogue element in question. The review makes use of microinteraction sequences and stills (Aarts, 2008; Hedenbro & Wirtberg, 2012).

Psychotherapy research indicates that the therapeutic alliance and therapist factors contribute substantially to therapy outcome (Castonguay & Hill, 2017; Norcross & Wampold, 2018; Schore, 2012). The intersubjective conceptualization of Marte Meo suggests that the therapist may be particularly important in promoting good outcome, especially when working with relationship disturbances. However, while considerable challenges in the form of emotional strain and marked pressure on the therapeutic alliance have been described for therapists using other parent–infant interventions (Brotherson et al., 2010; Diaz Bonino & Ball, 2013; Sadler et al., 2013; Schore, 2012), and therapist–caregiver interactions in VIG have been described as "messy and complex" (Chasle, 2011), therapist challenges in Marte Meo guidance are scarcely examined. Method descriptions and theoretical models focus on the application of the method and the therapeutic stance (Aarts, 2008; Hawellek, 2015; Hedenbro & Wirtberg, 2012). Therapists are expected to base the "dialogue" with the caregiver on the same dialogue elements they apply on the film, to be warm, attentive, give information in a neutral tone, and lead the focus on the film and the child's signals (Hedenbro & Wirtberg, 2012). Vik and Rohde (2014) stressed the importance of the therapist's sensitivity towards the caregiver. Kiamanesh et al. (2018) examined what therapists in the child protection services (CPS) experience as negative method factors in Marte Meo. But a closer description of the inner work of the therapists, their experiences and handling of challenges, is lacking.

Neander and Skott (2008) explored how parents and therapists experienced successful guidance processes and showed them to be cocreated by parents and therapists alike, underlining the importance of the therapeutic relationship. They highlight the need for empirical research on unsuccessful guidance processes. Such an exploration will illuminate several aspects of Marte Meo for parent–infant dyads: the therapists' role and requirements in challenging processes, and aspects of the method itself with regard to these dyads that may be problematic or need adapting. Taking into account the therapeutic challenges described for other interventions with parent–infant dyads, there is an absence of empirical investigation of the specific challenges in Marte Meo guidance with parent–infant dyads in the existing literature.

To the best of our knowledge, no previous empirical studies have explored therapists' experiences with challenging or unsuccessful processes in this specific method. The aim of the present study was to examine what skilled therapists experience during Marte Meo video guidance processes they describe as difficult, and how they respond to these difficulties. Our main research questions were: What do therapists experience as challenging when conducting Marte Meo video interaction guidance with parent–infant dyads, and how do they handle these challenges?

2 | METHOD

2.1 | Methodology

We conducted a qualitative interview study based on a phenomenological-hermeneutic methodology (Alvesson & Sköldberg, 2009; Hill et al., 2005) and chose reflexive thematic analysis as a pragmatic method that would allow us an inductive, data-driven analysis (Braun & Clarke, 2019). A semantic approach was adopted, identifying themes within the explicit meanings of the data. We aimed at a reflective, experience-near reporting of the data. The analysis was carried out as a team-based approach (Binder, Holgersen, & Moltu, 2012) that further strengthened the balance between closeness to the participants' experience, drawing in theories, and reflecting on our own position as researchers.

2.2 | Setting

The study was embedded in a research project about Marte Meo video interaction guidance for parent–infant dyads. It was a collaboration between the Infant Mental Health Team, Department for Child and Adolescent Mental Health, and the Research Unit, both at Southern Norway Hospital Trust, Kristiansand, and the Department of Clinical Psychology at the University of Bergen, Norway.

2.3 | Participants

To examine the experience and handling of difficult guidance processes with parent–infant dyads, we aimed at a purposive sample of Marte Meo professionals with experience in guidance processes. We recruited Marte Meo therapists and licensed supervisors. Therapists have

undergone a 2-year postgraduate part-time supervised training and certification. Licensed supervisors are therapists with additional extensive experience in the training and supervision of therapists and training supervisors, representing the highest level of training in Marte Meo (Marte Meo International, 2020). Sample size was based on the concept of information power (Malterud, Siersma, & Guassora, 2016). Eighteen participants were contacted through training supervisors or directly by the first author. All contacted therapists and licensed supervisors gave written informed consent to participate in the study.

2.4 | Data collection

We devised a semistructured interview guide to assist the exploration of the lived experience of therapists during challenging video guidance processes (see the Appendix). It was used for both therapists and supervisors, but additionally, the supervisors were asked about their experiences from training and supervision regarding therapist challenges. The questions were broad to allow varied and personal descriptions. Participants were encouraged to engage actively in the discussion, pursue topics they found relevant, and supply concrete examples from guidance processes and their personal reflections.

We interviewed the therapists in focus groups, but for practical reasons the supervisors were interviewed individually. The first author conducted three focus group interviews, lasting from 80 to 116 min ($M = 98$ min), and four individual interviews lasting from 60 to 100 min ($M = 79$ min) by between November 2016 and January 2018. Interviews were audio-recorded, the focus group interviews also video-recorded, and transcribed verbatim. One focus group interview with five participants (therapists) was excluded from the analysis due to reasons of research ethics and confidentiality (i.e., one participant in a focus group became a study author, thus that group was dropped from analysis).

We included 13 participants in the analysis. Nine were video guidance therapists, two of whom also were training supervisors. They had several years' experience with parent–infant dyads, a varied professional background, and affiliation, had been trained at different training sites, and came from different geographical regions of Norway. Four participants were licensed supervisors, three from Norway and one from Germany. Therapists and licensed supervisors had backgrounds of social work, pedagogics, and family therapy. Some worked in primary health services or family guidance, some in specialized health services, some directly, or through commissions for the CPS.

2.5 | Data analysis

Data analysis was technically assisted by NVivo 11 software (QSR-International, 2015). A reflexive thematic analysis was carried out in a seven steps collaborative process (Binder et al., 2012; Braun & Clarke, 2012) by the first, second, and last author: (1) All collaborators familiarized themselves with the data and noted down their first impressions and reflections about the experience related in each interview. (2) The first author reread each transcript line by line, identifying meaning units, and generating 145 initial codes. Meaning units were understood as features of the data that appear interesting or seem to convey meaning regarding the phenomenon. A code was attached to the meaning units and a fitting code was found for each one. Existing codes were used across transcripts only if they were considered a suitable description. (3) The first author reported the initial codes back to the group. Across transcripts, 42 meaning patterns or subthemes, and four main themes were identified in a collaborative process, using the first impressions, the initial codes, and referencing back to the transcripts. (4) Themes were summarized and reviewed as a process back and forth between the first author and the group, maintaining the four main themes, and formulating 17 most relevant subthemes. (5) The first author refined the themes and wrote an analysis of each one. (6) The themes were drawn together in writing, related to the research questions. (7) The research team formed a consensus on the formulation of the four main thematic categories.

2.6 | Researchers

The first author is a child psychiatrist and research fellow, and the second and last authors are associate professors in clinical psychology. The third author is a sociologist and senior researcher. The first and third authors are video interaction guidance therapists specialized in infant mental health. All authors have extensive clinical experience with psychotherapy and other mental health care treatment approaches. The second, third, and last authors have experience with qualitative research on a range of topics in mental health.

2.7 | Ethics

The study was registered and approved by the Norwegian Federal Center for Research Data. Written informed consent was obtained from all participants. They were

informed that they could withdraw from the study at any point. No participant retracted consent to the study after the interviews.

3 | RESULTS

We identified four main themes in the participants' experiences and handling of challenging guidance processes: (1) promoting relational growth in a coercive context, (2) building an alliance that feels safe for the parents, (3) looking at positive moments in difficult lives, and (4) handling intense feelings as a therapist.

3.1 | Promoting relational growth in a coercive context

Guidance with parents of young children often raised issues of child protection or had the CPS already involved in the family. The first theme, "promoting relational growth in a coercive context," describes the two main challenges that the therapists experienced: the dilemmatic nature of using a resource-oriented method in a context of child protection; and the difficulty in establishing therapeutic work with parents in this coercive situation.

When working with seriously challenged families of young children, therapists were aware of child protective issues, but they felt these issues to be at variance with the resource-oriented stance of the method. They felt that time was pressing and could become worried when they did not observe signs of progress a short way into the guidance and thus experience a conflicting double role where they had to balance a therapeutic perspective with concern for the child's welfare.

They also became privy to interaction within the family during the guidance process. Where they saw severe problems, especially when the guidance process did not lead to observable change, should they report this to the CPS? How could they focus on highlighting instances of positive interaction when they also witnessed seriously dysfunctional exchanges?

> Sometimes you capture things on the film you'd rather not see … bordering on, was this abuse I just witnessed, or wasn't it? … Are you supposed to move on and just focus on what is positive … and are you supposed to forget what was not okay at all? (Martin)

The therapists expressed that the exclusively positive perspective of the video feedback could feel inadequate in the light of the difficulties they observed with the caregiving. They could also worry about whether the alliance with the parents and the decidedly solution-focused stance of the method might keep them from realizing that the overall care for the child was not sufficient. Were they helping to maintain an insufficient situation and could the guidance even supply parents with strategies to conceal problems in the family? "That is a dilemma … because you are supposed to float on the wave of [parental] achievement, and yet you see such serious things that you just have to mention," as one therapist put it.

> Marian: I get so elated with these parents. [laughing] I dance out of [the guidance].
>
> Tessa: We would so much like them to succeed –
>
> Marian: [laughing:] And this even though we have witnessed so many negative things
>
> Tessa: Yes. It is a danger. It certainly is.

The coercive context influenced the praxis of video interaction guidance in several ways. When the CPS were involved, they were a third party in the guidance process, pressing for change, demanding reports and embodying the implicit threat of the child being placed outside the family. The therapeutic relation was therefore less secure for the parents. They often seemed afraid and showed no intrinsic motivation for change, apart from yielding to external pressure. Furthermore, filming as the central tool in Marte Meo could appear in a different light to the parents, more as a measure of external control than a means for empowerment. Some parents had previous experience of film exposing their inadequacies and being used against them. This affected their expectations of Marte Meo and the alliance with the therapist. Building trust was difficult in this situation, and parental mistrust in the alliance appeared realistic. Often, parents seemed defeated when they entered the guidance, which was not a good condition for relational growth. A central aim was therefore to use the alliance with the therapist and the resource-focused use of film to help them feel more secure.

Even though there could be cases where Marte Meo turned out to be insufficient, therapists held that the method was well suited for seriously compromised families. As one said, "I experience this as the strongest tool I have as a therapist. … If you cannot engage them … and help them change through Marte Meo, what then?" The dilemma of trying seemed thus unavoidable, and therapists had developed their own practices to handle

the challenges. Negotiating the mandate with the CPS was important, and therapists had previously refused assignments without a clear division of mandates. The CPS were asked to clarify their objective for the guidance. Therapists could then explain their resource-focused approach to the parents and draw a clear demarcation between video guidance and other services. They could also meet the parents in their negative feelings about the coercive context, as a basis to help them develop their own objective for the guidance process. Therapists also stressed the possibility, even obligation, to prematurely end a guidance process when child protective concerns became dominant, and several therapists described that they had done this.

> Sometimes we inform the CPS at some point because [the parents] don't take in the guidance. Or because we see that the situation of the child isn't good enough. The infant doesn't get recognized and validated and so on. Those cases are quite tough, since reporting is not the first thing you do—but there Marte Meo is not enough. (Jenna)

3.2 | Building an alliance that feels safe for the parents

The second theme, "building an alliance that feels safe for the parents," describes the challenges that therapists met in establishing a safe therapeutic alliance with parents for whom this could be a novel and challenging experience.

Therapists felt that the therapeutic relationship was especially fundamental in the guidance of more vulnerable parents. Security had to be built up through concrete, repeated experience. "I feel we don't laugh freely before we reach the third film," said another. Accordingly, filming preferably took place at the families' homes where parents felt more secure and in charge. Therapists established a friendly rapport with them about safe, every-day topics before and after filming and refrained from engaging overly much with the child. Centrally, the element that gave parents security was the reliably positive way that therapists presented the interaction in the video feedback: short, every-day moments where parent and child had a developmentally supportive exchange.

> We have an exclusively developmental focus. … What is unique is that we look at what people themselves represent of possibilities and potential for change in such a way that they can learn from themselves, they learn from what they already can do. (Tim)

For some parents, guidance on their own caregiving seemed to be perceived as critical, hurtful to their self-esteem or like admitting defeat. This also influenced their motivation and made it difficult to agree on working points for the video feedback. Surrendering to being filmed in the interaction seemed to feel threatening for other parents. Some negotiated about the control of the video material, whereas others expressed they were too fat, ugly, or not good enough in other ways to be filmed, which seemed linked to more fragile experiences of self-worth. To handle these challenges, therapists introduced filming as soon as possible. Besides letting the parents experience how video feedback was used reliably and with a positive focus, the aim was to detract the attention away from themselves onto concrete aspects of the child and concrete themes in the interaction.

> They come with shoulders up here [hand under chin]. And after the review of the film, their shoulders are down there [hand at shoulder height]. Because … when I ask, how was it for you to come here, what did you expect? They thought I was going to criticize them. They thought I was going to say all that they didn't manage. (Jill)

Focusing on the child made the reviews feel safer for the parents, and easier to concentrate more on themselves as caregivers and less on their personal issues. Where parents were too diffident to be filmed at first, therapists offered to exclusively film the child or blur the parents' image in the video feedback. Therapists showed the child's face and expressions, and contact moments between child and parents. This awakened the parents' interest and opened up their own motivation.

When parents felt the security that issues were dealt with in a resource-focused way, they could start to take up concerns of their own, which they might not have shared with anyone before. Therapists also noticed that once parents had seriously embarked on the guidance process, sequences and pictures from the video feedback could linger in their awareness for weeks and months and influence their caregiving.

> The deeper you dive down into it, the more the parents recognize what they maybe need help for. … First when that door opens up you get these … potent moments, where … they are receptive and want to share their own experiences. (Martin)

The therapists drew information from the interaction with the parents to help them handle their feelings during the video feedback. The central processes seemed to occur between the interaction on the screen and the interaction between parent and therapist, requiring both intuition and deliberation from the therapist.

> This triangle … generates a force field that is about things that are triggered by the screen but played out in the dialogue. And about looking at what is going on in the person you are giving guidance to … not just what is in the film, but to have this double gaze … to catch the signals from the person receiving guidance, and at the same time consider whether, "is this something we should use now?" (Tim)

Therapists described how parents needed to be acknowledged and at times even emotionally held and supported to promote development in the guidance. They experienced that the positive, attentive, regulating stance they had towards the parents correspondingly influenced the parents, both in the stance towards the child and in how the parents acted in the caregiving relationship. As one therapist summed it up, this was centrally about "the experience to… not use your eyes to localize weaknesses, critical issues, problems, but learn to read [the child] through the power of a loving gaze."

3.3 | Looking at positive moments in difficult lives

The third theme is called "looking at positive moments in difficult lives" to describe therapists' experience of how Marte Meo guidance could be challenging for parents when psychological vulnerabilities became activated in the interaction with the child or during video feedback. Therapists found that some parents had a heightened vulnerability for certain feelings or caregiving situations. They could become either intensely emotionally activated or emotionally very distant in the interaction with the child or when they saw it on film, often unable to put words to their experiences. "Very often they cannot handle their own discomfort. They are used to shut out painful, difficult feelings, and instead of sharing them and moving on, they close down inside themselves," one therapist related.

Some parents seemed very sensitive to feeling rejected and could read normal infant behavior as dismissing, whereas others became very activated by feeling an emotional connection with the child. Some parents could react strongly when they experienced the child as unregulated or demanding, while others were insecure about how to set healthy boundaries in caregiving situations. These vulnerabilities could be related to known previous trauma, or to relational problems such as with personality disorders, but they also occurred in parents without a defined mental health diagnosis.

Therapists took these vulnerabilities into account when they chose the film clips for the video feedback, looking for positive sequences that would engage but not overwhelm the parents. Centrally, therapists described a markedly deliberate way of showing the films. They focused on the child, tracing the interaction repeatedly, stimulated reflection about what the child was expressing, and gave room to the parents' feelings. They monitored the parents' signals closely under the feedback session, because facing strong emotions about the interaction could feel novel and scary. This crucial new experience of sharing and being emotionally supported by the therapists seemed a precondition for some parents to be able to be emotionally supportive towards their own child. Many parents at this point made a connection to their own caregiving experiences and reflected on how these influenced the relationship with the child. "To recognize that 'this is about myself, this is not about what my child does' can help the mother to change," said one therapist. Other parents seemed more overwhelmed by the influx of memories and emotions connected with their own childhood and needed help to regulate their feelings.

> Sometimes this gets very heavy for the parents. They look back and realize, "God, I never got this myself. I was never met like this when I was a child." … So you also have to handle the feelings the parents uncover, which can be tough for them. (Martin)

Therapists balanced carefully between validating emotions belonging to the parents' past and focusing on the present interaction with the child. A central aim was to strengthen the parents as caregivers in the present moment and lead their focus to the films of the actual caregiving relationship.

> Many have a great need to be comforted and to share … what they experience with the child. … So I respectfully receive [their communications], back to "and now we focus on your child, now it is you who is the mother, so look at this." … I often feel I am skipping over something I could have gone much further

> into—but you don't know how deep that pit is. (Ruth)

Some parents shared delight and pride about their child for the first time, while others became painfully aware of situations where they had not met their child's needs and shared their sadness and regrets about it. Therapists also experienced that some parents did not connect with the interaction and persistently avoided focusing on the child. Some expressed anger and frustration about not understanding what the therapist was aiming at. With others, therapists experienced shared moments but then felt them close up again. Centrally, those parents seemed to have a more self-centered focus and seldom wondered what was going on inside the child; they could describe their child in a distant, negative or even hostile way.

> They are emotionally not present. Towards their child. They are more self-centered. Egocentric. … And that becomes very noticeable once you begin to show the film. … all that gets transferred is the problem, onto the child, the child is the problem. The child is difficult, the child wants to hurt me. (Christy)

Here, therapists used closely filmed details of the interaction to lead the parents' attention onto the child. They magnified facial expressions and used stills, focusing on eye contact and on how the child reacted to the parents. They traced the rhythm of movement, prosody, and atmosphere.

> There is something about the tone of voice, about the rhythm of talking to each other, about the contact, eye contact. And there is something about the atmosphere in the room or in the interaction that is so crucial for whether one can take the perspective of the other person or understand the other's feelings. (Tim)

Through this focus, some parents could see their child in a new way. A decisive element in this seemed to be whether they would recognize that what they saw on the screen was genuine, and not dismiss it as false or random. Therapists would then enhance this moment through repeats and stills.

> That is the power of the film, the power of Marte Meo. If you have just one moment that lasts two seconds, you can extend it to last a whole lifetime. You just have to press pause and let the picture come to a halt, and then just remain there and focus on the child. And … the parents sort of grow bigger in their chair, and move forward, and look at their child in a new way, in a new light. Because they have never seen this before. Because the moment is over when it is over, … and then you are back in the old groove. (Martin)

3.4 | Handling intense feelings as a therapist

The final theme, "handling intense feelings as a therapist," describes the therapists' inner experiences when they navigated difficult guidance processes. Though asked about its challenges, all therapists also highlighted positive aspects about video guidance. They found working with film both more effective and satisfying than merely talking about the interaction and described the potency of pictures and how they felt they were working closely with the families. Yet this proximity entailed challenges. "You are impacted by it … You come quite close, you know. And the parents really are struggling. So when you work with a vulnerable family, it leaves an imprint upon you," as one therapist expressed it.

Parents used the secure therapeutic space to open up also about their personal history and problems. Moreover, the filming and reviewing of close-up pictures of contact and emotions, often taken at home, appeared to enhance the feeling of privacy for some parents. They could express the need for more direct emotional feedback from the therapist which could require careful balancing.

> How are you supposed to react when they express their own feelings that can be so private and intimate and vulnerable? … Many of these mothers may have been failed by their own mothers, which makes them especially sensitive towards a woman guiding them, so they want a reaction. And perhaps there is something in a mother's feeling or in a woman's feeling … that [makes] you recognize all those feelings. You transpose it to the professional. But how shall you professionally support another woman in her role as a mother, without sounding pathetic? (Ruth)

The feeling of success, when therapists could help a parent to change the interaction and saw how this positively impacted the child, was joyful and even elating, especially when it had entailed a difficult guidance process and much regulating of the parent. "I took a film in the end where she

managed to comfort him. And … it turned. …—he suddenly began to look at her …—that was really magical."

But therapists could also experience that they did not manage to engage the parents in dialogue, even though they worked hard to establish a therapeutic alliance. "It was difficult to reach her at all. I felt that case was really stressing me out," as one said. Therapists could feel that they had something to give that the parents were not able to receive.

> I would use myself as an example [and say:] "Yesterday I saw a mother and son on the bus, talking with each other. I could see that the mother cherished what he was saying. And looking at them at that moment, I felt like I was in that bubble together with them." "Don't know what you are talking about." [says the parent] "But that was what I tried to take you into," I say, "I was trying to take you inside [the bubble] with me." (Ellen)

When they did not succeed to draw the parents into this "bubble," therapists could react with increasing eagerness, tempo, and explanations. "If I get too eager, this is suddenly about something else than it should be" said one; and another: "If we realize we are halfway over the table, we have to consciously relax." But they also described feelings of frustration and even despair: "When I experience so strongly that there is no progress, I feel sad and anguished. However, I can place that feeling. It's about myself and my own mother." These strong feelings could be enhanced by the awareness that the parents' change was sorely needed for the children.

When filming, editing, and reviewing, therapists looked closely and attunedly at the children. It was into this perspective that they tried to invite the parents in the reviewing process. During filming, therapists were trained to look for sequences of developmentally supportive interaction and usually would not interrupt even exchanges bordering on the dysfunctional. Yet this could feel wrenching. "Painful … to witness so much hostility. … like two five-year olds, fighting. It was really hostile. … That was so painful. To be there, witness and not intercept," one therapist recalled. It was especially distressing for the therapists to witness hostility, and how this impacted the child.

> A boy (was) sitting with his mother who was going to feed him from a jar with baby food … and he pointed at the glass, it had many pretty colors, you know. Whereupon the mother draws away the jar and says "No-ho-ho!" [laughs sneeringly] "You won't get that, oh no!", whereupon he just looks away and remains sitting. There were many similar episodes. … Looking back I think he shouldn't have remained in that home … I feel it like a [with emphasis] urgh, painful lump in my stomach. He shouldn't have remained there. … A lovely little boy [sighs heavily] oh, that is painful. (Christy)

These experiences impacted the therapists. "Sometimes you wonder … how many children actually live like this. So it also gets to you as a person." one said. To handle this, they highlighted the importance of reflection and supervision. Being able to share their experiences with a colleague, receive external supervision on concrete guidance experiences as well as regularly attend seminars and refresh their theoretical knowledge were cited as helpful.

> I turn onto myself right away … how I didn't do a good job, I didn't manage … for it didn't go well, I think. But then you reflect together with a colleague. … And then you think, yes, this was about myself, but it was also about something together with them [the parents]. That it didn't go so well has to do with factors both in the person you give the guidance to, and in yourself. (Ellen)

4 | DISCUSSION

We identified and presented the four main themes from the analysis of how the therapists/supervisors experienced and handled challenging Marte Meo video guidance processes for parent–infant dyads, ranging from context and alliance to process and the therapists' inner experiences and conflicts.

The first theme, "Promoting growth in a coercive context," shows how the therapists experienced a dilemmatic collision of child protection perspectives and the salutogenic focus of Marte Meo, despite following method recommendations for clearly defined roles (Hedenbro & Wirtberg, 2012). Earlier empirical findings from the CPS (Kiamanesh et al., 2018) identified unaddressed issues of trust and coercion, and lack of structure, as weaknesses of the method, yet it was regarded as suitable for the CPS, and its salutogenic stance cited as positive for client motivation and change. Our findings show, however, that this stance made the therapists more insecure about the validity and implications of what they observed in the interaction, and when a continuation of the guidance became unethical. The difficulty of balancing perspectives has been described for caseworkers in the CPS, and a reconciliation of perspectives seems best achieved by more fluid, less

dichotomous conceptions (Oliver & Charles, 2016). Still, this pragmatic shifting of perspectives may be more difficult for Marte Meo therapists commissioned by the CPS, or confronted with child protective issues, because of the decided emphasis on empowerment, and the lack of method adaptations and procedures for Marte Meo in these contexts. Marte Meo has method elements, like brevity, using home visits, concrete focus on interaction, and enhancement of parental sensitivity, which have been efficacious in other interventions in high-risk families (Bernard et al., 2012). But its nonmanualized variant lacks a structured approach and does not have an explicit attachment focus. Therapist have found a combination with the Circle-of-Security model useful (Kiamanesh et al., 2018).

The second theme, "Building an alliance that feels safe for the parents," describes the challenges of establishing a secure therapeutic space for parents who struggle with mistrust, insecurity and negative relational experiences. Aversion to video taking has been reported as a factor hindering the alliance for some clients (Wang et al., 2006). In their meta-analysis, Diener and Monroe (2011) showed that insecurely attached clients often battle with "distrust, a more negative self-representation, a wariness to engage intimately with others, a pressing need to be reassured of the love of others" and therefore have "a more difficult time cultivating an emotional bond, agreeing … on goals for treatment and on tasks to achieve those goals." For parents where child protection issues apply, as well as their own inherent issues of mistrust and insecurity, the threshold to feeling secure in the therapeutic alliance will be even higher. To overcome distrust and wariness, the therapists in the present study use the video guidance in an exclusively positive way. Centrally, they draw the parents into the present moment of the interaction on the screen. When they are able to help them connect with the pictures, therapists report that parents open up and markedly engage with the filmed interaction. This can be linked to Stern's concept of the "present moment" (2004) which highlights that "present moments (and critical moments that effectuate change) must have both a duration in which something happens and, at the same time, take place during a subjective 'now'" (p. 366).

The third theme, "Looking at positive moments in difficult lives," describes challenges in the guidance process through the parents' own psychological vulnerabilities. These challenges are handled by the therapists in a markedly deliberate and reflective manner. This is manifested in the way they support the parents emotionally and how they employ the film, choosing video clips that engage but do not overwhelm the parents. Their handling by far expands existing method descriptions of the review situation as a "communication," and of film selection guided by what particular visual "information" is "useful" for the parents' development, even though therapist attunement and reading of the parents' reaction are stressed (Aarts, 2008; Hawellek, 2015; Hedenbro & Wirtberg, 2012). Beebe's model of a psychodynamic video-feedback intervention (2003), which stresses the therapists' emotional "holding" and timing of the feedback, has been found relevant in Marte Meo guidance of postnatally depressed mothers (Vik & Braten, 2009). Our findings expand this more generally for parents experienced as relationally vulnerable. Therapists centrally employed their intuition in the emotional support of the parents and selection of video clips, moving from a communications model into the more complex landscape of psychotherapy. Video selection may be linked to Bromberg's (2008) concept of "safe surprises," providing novel, "excitingly 'edgy'" perspectives that at the same time do not overwhelm clients who have a history of relational trauma (p. 333). In video guidance, the "surprises" entail new relational experiences with the infant *and* the therapist. With parents who are emotionally disconnected, therapists use video clips that trace facial expressions of the child as well as the rhythm and atmosphere in the interaction. This resonates with the "visual-facial, auditory-prosodic and tactile-gestural communications" mediating the development of attuned interaction and attachment (Schore, 2012) (p. 56) and the "vitality forms" that Stern (2010) has linked to "implicit relational knowing" (p. 111). We suggest that the therapists try to activate this right-brain implicit competence in the parents to facilitate an emotional connection that is not defensively warded off.

The final theme, "Handling intense feelings as a therapist," describes the strong and at times conflicting feelings that the proximity to the dyad elicits. Therapists often experience emotional engagement for the infants. Parental negativity and hostility can therefore feel wrenching and moreover raise ethical questions. We get glimpses of therapists' turmoil and inner work from other methods entailing close contact with parent–infant dyads (Rosenbaum, Bain, Esterhuizen, & Frost, 2012; Sadler et al., 2013a). Diaz Bonino and Ball (2013) place these kinds of processes in the context of transference/countertransference. Our data, particularly the intensity and immediacy of the feelings described, support this theorizing. We suggest that the use of video has a profound effect on the therapists' emotional engagement on behalf of the infants which seems enhanced by their own exposure to close-up views of them, tracing microinteraction, when filming, editing, and reviewing.

How can our findings help us to more generally understand challenging factors in Marte Meo for parent–infant dyads and the role of the therapist? Our data indicate that the guidance of a vulnerable subgroup of dyads is experienced as markedly different, where all components of the intervention can be fraught with challenges: caregiving

can raise child protective issues, and caregivers' insecurities can impede the alliance. Centrally, they often struggle with extensive problems related to unsolved relational issues and manifest mental health problems. For these kinds of "overburdened" dyads, several elements have been described as useful in the guidance (McDonough, 1995) that resemble the salutogenic stance of Marte Meo. Our findings add a new aspect to video guidance with these dyads, in that the role of the therapist seems to become markedly more pivotal and demanding. This concerns the therapeutic alliance, emotional support and regulation of the parents, selection of the video material adapted to their emotional capacity and connectedness, and transference/countertransference. Diener and Monroe (2011) found that the same parental attachment traits that pose a risk for the dyad also render the therapeutic alliance difficult. Our findings show how the parents' vulnerabilities are played out in the therapeutic relation and in the filmed interactions, demanding emotional work from the therapists. The guidance "dialogue" becomes centered on implicit relational processes on the screen and in the relationship, to a great extent navigated intuitively. Our findings highlight video guidance for these dyads as a psychotherapeutic process (Schore, 2012) that bears relational challenges characteristic for psychotherapeutic change processes, and specific challenges linked to the use of video. Consequently, therapists have requirements as to the framing and structure surrounding the guidance, as well as adequate training and supervision. The challenges we identified may also be relevant for other guidance interventions with vulnerable parent–infant dyads. This may especially be the case for interventions with a salutogenic stance that can collide with child protective issues, for home-visiting approaches with more flexible frames and a higher degree of proximity to the dyad, and for video guidance methods where therapists handle their own reactions to close up films of the infant as well as the pressure on the therapeutic relation.

To improve practice and counterbalance the strain on the therapists, vulnerable dyads should be identified early in the process, preferably preceding the guidance, by assessing the parents' psychological vulnerabilities and child protective issues. For parents with mental health issues, the need for treatment, and cooperation with treatment services should be established. There is a need for a rationale for Marte Meo in CPS contexts, including knowledge about when to report incidents or terminate the guidance. Therapists need structures of regular peer-based and external supervision. Their training curriculum should cover the specific requirements of overburdened parents, the therapeutic relationship, and transference/countertransference.

4.1 | Reflexivity and methodical considerations

Reflexive thematic analysis is conceptualized as a "creative, reflexive, subjective," process (Braun & Clarke, 2019). Because subjectivity is present at all stages, reflexivity about how this might inform and influence the acquisition, analysis, and organization of the data as well as their interpretation (Alvesson & Sköldberg, 2009; Tufford & Newman, 2010) is central. In our analysis, it involved being "honest and vigilant about … own perspective, preexisting thoughts and beliefs, and developing hypotheses" and to "recognize and set aside (but do not abandon) … a priori knowledge and assumptions, with the analytic goal of attending to the participants' accounts with an open mind" (Starks & Trinidad, 2007). The first author is an infant psychiatrist practicing video guidance. This could support data acquisition and analysis but held the danger of contaminating participants' experiences with own preconceptions, for example, by too early conceptualization instead of remaining close to the data. Our team-based approach (Binder et al., 2012) supported the experience-near analysis through a critical moderation of the process by the last author, and auditing by the second author who had experience with therapeutic processes but not video guidance or infant mental health. Conceptualizing, including conceptualized language, was consciously set aside until the discussion of the findings. The third author, who had extensive experience with video guidance in infant mental health, was involved in the research design and final discussion, but not in the data analysis.

We chose a qualitative approach to the phenomenon of challenges in Marte Meo video guidance, investigating through the lens of the therapists' subjective experience as analyzed by a subjective team. This has inherent strengths and limitations. Regarding sample size and information power (Malterud et al., 2016), the analysis showed that the interviews contained much and varied information, while there were many similar and recurrent nodes across the participants, indicating a sufficient sample size to investigate the phenomenon. Including informants from geographical regions, training sites, and professional backgrounds may be seen as broadening and strengthening the data. A further question was whether the participants were able to describe the breadth of their experiences in the interview situation. To this aim, the interview guide was formulated openly and used only as a scaffold, giving room for participants' own train of thought and topics. In addition, the interviewer and first author explicitly welcomed all types of experiences before and during the interviews. As 9 participants were interviewed in three respective focus groups, group dynamics may have

influenced the data acquisition. The subjective impression of the interviewer was that the participants freely engaged in the interviews and spontaneously interacted with each other, which may point to a secure and encouraging interview situation.

The findings of the thematic analysis contain so-called shadowed data about the parents (Morse, 2001), which represent the therapists' subjective understanding of the parents in the guidance processes. This expands the scope of the themes but may limit the validity of the data. An important methodical limitation was that we did not interview the parents themselves about challenging video guidance processes, which may be necessary to fully understand the nature of the challenges in using Marte Meo. Also, our exploration is limited to accounts of participants' experiences and does not include other data such as the video material itself.

4.2 | Implications for research and clinical practice

The present study is the first qualitative investigation of therapists' experiences and handling of challenges in Marte Meo video guidance for parent–infant dyads. Our findings show the need for further conceptual development that includes the emotional regulation in the therapeutic relationship and through the medium of video for vulnerably dyads. Further studies should explore how vulnerable parents themselves experience challenges in the guidance and therapeutic ruptures. Research on the video material itself by methods such as interpersonal process recall (Elliott, 1986), conversation analysis (Fogtmann Fosgerau, Schöps, Bak, & Davidsen, 2018), or parental embodied mentalization (Shai & Fonagy, 2014) could expand our knowledge about the method. As well, too little is known about vulnerable dyads with older children, where patterns of interaction have become more established and the child may have more manifest mental health problems. A comparison of the manualized variant, VIPI, and Marte Meo for high-risk dyads, and studies on guidance based on previous assessment of parental vulnerabilities could yield insight on guidance mechanisms and strategies for a positive outcome.

For clinical practice, the finding that a vulnerable subgroup of dyads presents specific challenges and requirements for video guidance should lead to the recognition of this client group, with implications for structural and method development. Structurally, a rationale for Marte Meo in CPS contexts, cooperation with parents' mental health treatment, therapist supervision, and expansion of training curriculum seem indicated. For the guidance itself, early systematic assessment of the parents' vulnerabilities and child protective issues could facilitate an adapted guidance process.

5 | CONCLUSION

The aim of the present study was to investigate what skilled therapists experience during challenging or failing Marte Meo video guidance processes and how they understand and handle these challenges. Our findings show that therapists experience specific therapeutic and ethical challenges when guiding parent–infant dyads with child protective issues, caregivers' insecurities impeding the therapeutic alliance, and caregivers with unsolved relational issues or mental health problems. The therapists' role becomes pivotal and demanding regarding the alliance, therapeutic interventions, and their own need for regulation, supervision, and structure. Early identification of these dyads could facilitate better adaptation of video guidance. Therapists need supporting structures, clinical supervision, and training, addressing these challenges. Our findings suggest the need for method development also on a conceptual level.

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ORCID

Indra Simhan https://orcid.org/0000-0002-4495-4477

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APPENDIX

Interview guide for Marte Meo therapists and licensed supervisors:

1. Can you state your name, profession and work affiliation, and how long you have been a Marte Meo therapist (or: licensed supervisor)?
2. How would you describe a guidance process that could be called "difficult"? Can you give some examples?
3. What, in your experience, does help in a difficult process?
4. What, in your experience, does not help?
5. Have you had processes where you experienced that the guidance did not have any effect?
6. How does a difficult process affect you as a therapist?
7. Would you like to share other experiences or reflections?
8. (For licensed supervisors only) In the training and supervision, what do therapists report as difficult? Which factors in processes do they experience as difficult?

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Like Taking a Magnifying Glass Into Everyday Life: Vulnerable Parents' Experiences With Video Guidance in an Infant Mental Health Clinic

Indra Simhan[1,2], Kari Vik[1], Marius Veseth[2] and Aslak Hjeltnes[2]*

[1]Department of Child and Adolescent Mental Health, Sorlandet Hospital, Kristiansand, Norway, [2]Faculty of Psychology, University of Bergen, Bergen, Norway

Background: Parents are a central focus in clinical infant mental health interventions because of the key importance of the caregiver-infant relationship, especially when dyads are burdened by psychosocial and parental mental health problems. However, knowledge is scarce about the lived experience of vulnerable parents who undergo video-based guidance.

Aim: The study explores how parents in an infant-psychiatric outpatient clinic who struggled to mentalize and remain emotionally connected to their infant experienced helpful and challenging elements in video guidance.

Method: We analyzed the interviews of a strategic sample of 12 parents after undergoing Marte Meo video guidance, using a team-based, reflexive thematic analysis (TA).

Results: We identified four main themes: (a) Handling initial feelings of fear and loss of control; (b) Filming as a disturbing or agentic experience; (c) Feeling validated or devalued in the therapeutic relationship; and (d) Bringing insights from video guidance into everyday life. Therapeutic and existential factors became apparent in the main themes of adjustment to the guidance, experiences with filming, the therapeutic relationship and integration of new experiences.

Conclusion: The parents' sense of agency, dignity, and shame may be important for their ability to integrate new ideas about themselves.

Implications: Video guidance for vulnerable parents in specialized clinical treatment should address relational challenges, parental mental health, and issues of recognition.

Keywords: qualitative research, parents psychology, parent-infant, parental mental health, video guidance, video feedback, marte meo

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****Correspondence:***
Indra Simhan
indra.simhan@sshf.no

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INTRODUCTION

What is it like to receive an intervention focusing on your parenting capacity and skills when you are burdened by mental health problems and struggling to understand and connect with your own infant? Which factors help you engage in the intervention, and which are challenging? Parents are a central focus in infant mental health interventions because of the centrality of

the parent-infant relationship for infant development and attachment (Word Health Organization, 2004). Parents burdened by psychosocial and mental health problems have received particular attention, as their multiple challenges put a strain on their resources and capacities as caregivers (Berg-Nielsen and Wichstrom, 2012; Parfitt et al., 2013). Focus has been most on the risk this poses for infants (Lyons-Ruth, 2008; Musser et al., 2018) and on the effect of interventions (Camoirano, 2017). There is less empirical knowledge about the lifeworld of parents who are overburdened or challenged by mental health problems and even less about their experiences of interventions that target parenting. Increased knowledge about the parents' experiences is relevant to elucidate important processes involved in parenting under duress as well as adapt interventions to their needs. In this article, we explore how clinically referred parents who struggle to mentalize or maintain an emotional connection with their infants experience the process of undergoing Marte Meo video guidance.

Video-guidance interventions use revised film clips of the actual dyad in the guidance of parents (Balldin et al., 2018). Marte Meo, a video guidance method widely used in Europe and Australia, is empowerment-based and resource-oriented, aiming at enhancing caregivers' intuitive parenting capacity. Only video clips showing developmentally supportive interaction are chosen for the feedback session with the caregivers (Aarts, 2008). Osterman et al. (2010) highlighted a knowledge gap between ready acceptance by counselors and clinicians in family guidance, child protective services (CPS) and infant mental health and the scarcity of scientific evidence and theoretical foundations of the method. This gap has partly been addressed by effect studies on parent-infant dyads with interactional problems (Høivik et al., 2015) and vulnerable first-time mothers (Kristensen et al., 2017). Bunder (2011) found that overburdened parents developed more positive structuring but especially more emotional connection through Marte Meo. Explorations of parental experiences of change have led to attempts to conceptualize the method in an attachment and mentalization framework (Vik and Hafting, 2009; Vik and Rohde, 2014; Gill et al., 2019).

However, since the existing studies are based in community settings, except for a pilot study including three parents from a psychiatric outpatient clinic (Vik and Hafting, 2006) and a three-case study from an infant psychiatric clinic (Gill et al., 2019), empirical knowledge about how the method works for clinical-range high-risk parents is marginal. Parents in specialized infant-psychiatric treatment are characterized by more serious or long-term mental health problems and related psychosocial stress, suffering from recurrent affective disorders, anxiety disorders, substance misuse, personality disorders, and others (Berg-Nielsen et al., 2002; Pajulo et al., 2011; Anke et al., 2019). Often, their intuitive parenting capacity is weakened (Papousek and de Chuquisengo, 2006) and they have difficulties establishing and regulating their emotional connection to the infant and discovering and mentalizing the infant's signals (Freeman, 2016; Binion and Zalewski, 2018). Research from communal settings shows effects for parents with depression and some personality disorders (Høivik et al., 2015) and high psychosocial risk (Bunder, 2011), which is supported by qualitative studies (Vik and Braten, 2009; Gill et al., 2019). There is a need for more empirical knowledge about how parents in specialized infant mental health services experience and respond to Marte Meo guidance.

The aim of the study was to explore the lived experience of parents from clinically referred dyads with difficulties mentalizing and maintaining emotional connection with their infants. We wanted to investigate the first-person perspective of how these parents experience the use of video guidance to describe and understand potential helpful and hindering factors when using the method for these dyads. We examined the following research questions: How did the parents experience the process of participating in Marte Meo video guidance? What did they experience as helpful and unhelpful aspects of this guidance?

MATERIALS AND METHODS

This project was designed as a hermeneutical-phenomenological investigation of the lived experience of parents receiving Marte Meo guidance in specialized mental health settings. We chose team-based, explorative, reflexive thematic analysis (TA) as the method of data analysis. In TA, meaning units, patterns, and key themes are generated from the qualitative data in an analytic and interpretative process. Results are thus not "found" in the data but develop in a dialogical process between the data and the researchers. The collaborative approach helped us to reflectively use our own preconceptions when conducting the research process.

Setting

The study was a collaboration between the Research Unit and the Infant Mental Health Team (IMHT), an outpatient service for parent-infant dyads, Department for Child and Adolescent Mental Health, Sorlandet Hospital, Norway, and the Department of Clinical Psychology at the University of Bergen, Norway. Clinicians from the IMHT assisted in the sampling process and administered Marte Meo guidance to the participants.

Data Collection Strategy

We used criterion sampling (Sandelowski, 2000) to recruit a strategic sample of parents of infants referred to the IMHT who had difficulties mentalizing or maintaining an emotional connection with their infant. Recruitment was assisted by the Parent Development Interview, revised version (PDI-R; Slade et al., 2004, Unpublished),[1] with the criterion being either (a) limited reflective functioning (RF) in the PDI-R, or (b) explicitly stated difficulties emotionally connecting with the infant and maintaining the connection under affective stress. The strategically recruited parents each received a course of Marte Meo video

[1]Slade, A., Aber, J.L., Bresgi, I., Berger, B., and Kaplan, M. (2004). "Parent Development Interview, Short Revised Version (PDI-R). Unpublished protocol." The City University of New York, NY.

guidance. After the guidance process, they were interviewed individually about their experiences by in-depth interview. As we understood the phenomenological-hermeneutic position of reflexive TA as inconsistent with the concept of data saturation (Braun and Clarke, 2019b), we employed the concept of information power (Malterud et al., 2016) and aimed at a sample size of 10–15 participants.

Parent Development Interview

Clinicians from the IMHT administered the PDI-R to 30 consenting parents. The PDI-R is a 45-item semi-structured narrative interview about parents' representations of their children, themselves as parents, and the parent-child relationship. A subset of 12 items can be rated for RF, defined as the manifestation of mentalization in speech or the capacity to recognize and understand internal experience in terms of underlying mental states (Slade, 2005). Interviews were digitally recorded and transcribed verbatim. The first author, a certified rater, read them for content and rated the subset of items on the 11-point RF-scale from limited to moderate to high RF (Fonagy et al., 1998); an overall score of less than five represented limited RF. Thirty percent of the PDI-R were double-coded by two certified, blinded external raters. Interrater reliability was good with an intra class correlation coefficient range from 0.75 to 1.0 (Koo and Li, 2016). Parents with an RF of four or less and parents with an RF above four who explicitly stated profound difficulties maintaining an emotional connection when interacting with their infant were recruited as participants.

Participants

A strategic sample of 15 parents was recruited. Two parents withdrew consent after the guidance, and one was not included because the infant was removed from care during the guidance process. We conducted in-depth interviews with 12 parents, 11 mothers and one father between 23 and 34 years of age ($M = 27$). All recruited dyads were referred based on the risk to the infant linked to parental functioning or mental health problems. Infant sex was equally divided between male and female, and infant age was between 2 and 30 months ($M = 12$ months) at the start of the guidance. All parents reported mental health problems, mostly of a long-term or recurrent nature, including personality disorders, post-traumatic stress disorder, uni- and bipolar affective episodes, obsessive-compulsive disorder, and substance misuse disorder. Most of them reported adverse or traumatic childhood experiences. In four families, the CPS were involved. Ten parents showed limited RF in the PDI-R, while two reported substantial difficulties in experiencing a stable emotional connection with their infant.

Video Guidance

Marte Meo video guidance (Aarts, 2008) was tailored to each individual dyad, with at least three filming and guidance sessions. Marte Meo therapists receive 2-year part-time, supervised training, and certification in the method. Four Marte Meo therapists from the IMHT with extensive experience with parent-infant dyads administered the guidance.

In-Depth Interviews

We devised a semi-structured interview guide to assist the in-depth interviews. Example questions were: "Is there something from the guidance you specifically remember?"; "How did you experience filming?"; "How did you experience the therapist? Was something he/she did helpful or not helpful?"; "Concerning your thoughts about the infant, has the guidance changed them in any way?" We used the guide to structure the interviews but encouraged participants to pursue topics they found relevant. All interviews ($n = 12$) were conducted by the first author between November 2016 and June 2019 and lasted between 23 and 89 min ($M = 61$ min). The interviews were digitally recorded and transcribed verbatim.

Methodology

We chose explorative, reflexive TA as a method allowing an inductive, data-driven analysis (Braun and Clarke, 2006, 2019a). We aimed at a reflexive, experience-near reporting of the data and carried out the analysis as a team-based approach, which further strengthened the balance between closeness to the participants' experience and reflecting on our own position as researchers (Binder et al., 2012).

Data Analysis

Reflexive TA is a stepwise process of data analysis and interpretation, moving from single meaning units, or codes, *via* shared meaning patterns to key categories, or themes. We used NVivo 11 qualitative data analysis software (QSR-International, 2015) for technical assistance in organizing meaning units and patterns. Reflexive TA was carried out in a collaborative process by the first, third, and last author: (1) All collaborators familiarized themselves with the data and noted their first impressions and reflections about the experience related to each interview. (2) The first author reread each interview, identifying meaning units and generating 52 initial codes. Meaning units were understood as features of the data that appeared interesting or seemed to convey meaning regarding the phenomenon. Existing codes were used across interviews only if they were considered a suitable description. (3) The first author reported the coded meaning units back to the group, and 19 meaning patterns and four main themes for the meaning units were formulated in a collaborative process. (4) The first author and the group summarized and reviewed themes in a back-and-forth process to define the most important and relevant themes. (5) The first author refined the themes and wrote an analysis of each theme. (6) The themes were drawn together in writing, related to the research questions. (7) The research team formed a consensus on the formulation of the four main thematic categories.

Researchers

The first author, a child psychiatrist, and the second author, a sociologist, are Marte Meo video guidance therapists specializing in infant mental health. The third and last authors are associate professors in clinical psychology. All authors have extensive clinical experience with psychotherapy and other mental

healthcare approaches, as well as experience with qualitative research on a range of topics in mental health.

Ethics

The study was approved by the Regional Council for Research Ethics, Southeast Norway. Clinicians at the IMHT gave oral and written information about the study to suitable parents and obtained written informed consent for participation and publication from all participants. The researchers were aware of the vulnerable position of both parents and infants involved in the research and were actively concerned with preserving the dignity of the participants in the interviews and subsequent research process.

RESULTS

We organized the parents' experiences of helpful and challenging factors in the video guidance process into four main themes: (a) Handling initial feelings of fear and loss of control; (b) Filming as a disturbing or agentic experience; (c) Feeling validated or devalued in the therapeutic relationship; and (d) Bringing insights from video guidance into everyday life.

Handling Initial Feelings of Fear and Loss of Control

The first theme illustrates the participants' emotional experiences at the start of the guidance. Most parents felt burdened by mental health issues and found it hard to cope as caregivers. They describe agency and choice, as well as their own psychological problems as factors that influenced how they initially felt. How free or coerced they felt and how much trust they placed in the intervention, made them feel less or more agentic. Many expressed the wish for more practical information, which would have helped them prepare for the guidance and counteracted feeling a loss of control when meeting the therapist who had all the knowledge. Some parents described themselves as agentic from the outset, albeit somewhat apprehensive. For most, however, this was a more conflictive issue. Disagreement with the need for referral was handled in different ways; it could create distance but also prove to be a positive challenge:

> "When [the clinician] read [the referral] out loud, I felt like, no, it is not like that, I am not like that. [Begins to cry] I felt really unwell, I thought 'Am I so awful?' … I was unaware of what was written in the referral. I came in, in a good mood and positive, and then … 'No way'. I was not going to accept that, and I felt like, I will agree to this because I do not want to be seen like this, I do not want them to think that I am like this. I want to show them they are wrong. That I can do much better than that."

Involvement of the CPS played a role but was not decisive; they could be seen as both controlling and serving the parents' needs. Parents who were motivated from the outset could distinguish between CPS involvement and the video guidance: "We felt [the Infant Mental Health Team] were there more to maybe help us, not jail us …. Help from [them] was wholly voluntary, because we ourselves had asked for it." However, it could be a painful process for parents to experience concern for their own infant and realize that they needed help:

> "We felt we were not good enough as parents right now, we need more help. … We really want what is best for [the infant]. It is tough – we reported ourselves to the CPS, that was heavy… we could have refrained from it, but then it would merely have been a matter of time before everything went wrong … because we know we are struggling."

In the midst of crisis, this parent nevertheless conveyed a sense of agency and an intrinsic confidence that help could be found. Several parents described an inclination to trust and gain new insights, and some even expressed curiosity about the guidance. For others, however, the intervention felt threatening or even overwhelming, involving a loss of control. They described a high degree of apprehension, a greater need to feel secure, and intense feelings of inadequacy. One parent felt constrained and paralyzed by her own inner pressure and fears, which she described as part of her psychological burden. She agreed to the guidance – both despite and because of her fears:

> "My whole approach to … being sick has been about my inability to make decisions. I do what I am told to. So, when my therapist at [psychiatric clinic] suggested this could be a good idea, I say yes. Because the alternative would be to say no, and then maybe they write in my medical journal that I refused, and confront me with it later, that I was offered this treatment, but you just say no. So, this is not about trust, this is about an enormous fear that they could use that against me later …"

She masked her fear and did not think her video guidance therapist realized how afraid she truly was; "I have a very well-functioning autopilot … Despite a very poor level of functioning [inside], I can function very well on the outside." She described an inner struggle between coming to terms with her psychological problems and feeling fear and despair of being defined by them. Several parents described that accepting help was a process requiring time. One parent relayed how she understood that she needed support to obtain better mental health and cope with parenthood. However, while she felt increasingly worn out, she could still not force the decision:

> "I realized that I could not sort this out by myself … it was important to get help, and for that, I needed to open up. The problem was, I should have tried to get help much sooner … I was so exhausted and so tired … I should have opened myself more, I know that – but at the same time, I needed to build up enough security to do it …"

Filming as a Disturbing and Empowering Experience

The second theme describes the parents' experience of being filmed and seeing themselves on film during the guidance. All parents described film, the central medium in video guidance, as challenging, even though they also found it empowering. While they noted that much of the focus was directed toward the infant, they became acutely aware of themselves during both filming and reviewing. They described feeling self-conscious, inauthentic, and apprehensive about losing control in the review situation. Often, they felt unnatural when filmed interacting with their infants. They tried to perform well, while wondering whether the video would capture something genuine. Filming created a gap, with the parents simultaneously engaged in the interaction, while at the same time thinking about being filmed. They also described an initial distance toward seeing themselves on film. Many parents said they at first did not recognize themselves in the video: "That is not me, that is a completely different person." One parent described how she truly felt she was looking at herself only at the very end of the guidance process. The reliable focus on successful interaction enhanced this distance. All parents noted this positive stance, and nearly all found it encouraging. However, many struggled with acknowledging that what they saw were genuine, valid interactions, that it was "real." Acceptance was more difficult when parents had strong feelings of self-doubt and criticism:

> "I cannot believe in the positive. I cannot believe that this is me, or I believe that this is just accidental, or that it was just because it was on film, or that I was just because I was trying to do my best. That I am not really as good normally, that it is more just performance. So, I only see the negative."

Many parents noted the attention that filming gave to minute interactions between the infants and themselves; "these little details … that you normally would not observe or particularly think about." This felt like a novel way of seeing. When small exchanges were magnified and highlighted, this focus also conferred weight to the parents. This could feel uplifting and empowering but entailed challenges: "You see that what you do … is important … [but] even if it is positive, you feel a lot of focus on all the things you do." Most felt themselves uncomfortably scrutinized; some felt as if they were under surveillance and experienced this as threatening. For parents who struggled with feeling very insecure and self-critical, being minutely observed seemed to impinge more upon their personal space and could feel embarrassing and intrusive:

> "Scary, actually … because there is so much focus on you and the child…. Because you are made very aware of everything you do. All the ways in which you move, the glances you direct, your body language … All those small things are noted a great deal. … It is almost more about myself than about the child. It feels scary because it is new and strange. It feels out of my control, anyway."

Nevertheless, almost all parents related positive development; many even felt empowered. In the course of the process, most of them were able to let go of the discomfort and worries about their own shortcomings, connect with what they saw on film, and increase their awareness of the interaction. One participant described this inner journey:

> "It was very strange. In a way, I felt this was not me. Well, I saw it was me, but … I experienced the interaction between me and [the infant] on film as very different from what I had thought it was. … I did not think it was genuine, you know, outside of the film. [But] I started feeling more confident about myself, that maybe I really am like that. [On film] I looked at him a lot, and smiled, and was in contact with him … And after the guidance, I have been very aware about being in contact. Eye-to-eye contact and that he looks at my face … And I feel I was being myself somehow. I did not feel I was merely acting either, so I was actually being myself."

Another parent who had struggled with profound feelings of insecurity and insufficiency as a mother described the transition to feeling more agentic and being able to handle her own self-doubt:

> "It was really awkward. To see myself on film … I thought, okay, this is going to be really terrible. I was sure I had done everything wrong … But in the middle of the film, when I saw so many positive things, I thought, I am just a mom, after all. I am just an ordinary mom who tries her best, so there is nothing to be afraid of. The film is just there to help me, nothing else. It is not going to be shown at the cinema, after all."

Feeling Validated or Devalued in the Therapeutic Relationship

The third theme describes facilitative and conflictive experiences with the therapist and the therapeutic relationship. Most parents expressed that the therapist was important in "giv[ing] the parents confidence that … we are here to help you, not put any more spokes in the wheels." It was also important that the therapist took time to establish contact with the infant and show interest in the parent as a person. Even though, the guidance was primarily focused on their relationship with the infant, most parents also wanted it to be about themselves as persons, about their feelings and experiences:

> "…That it was about myself as well. Because, no offense, but with the health visitor, everything was about the baby. The baby's physical health, and so on and so on. Yet it is just as important that the mother is doing well, mentally anyway. So, for once, I felt that *I* was being taken care of."

Most parents described this wish to be acknowledged and to be seen as a human being in their own right. Moreover,

it was important for them to feel accepted as competent caregivers who needed help with a defined problem and not to be seen as entirely defective. Parents also felt validated when the therapist respected their boundaries:

> "[It was helpful] that she actually talked to me and understood [our] past history. That she had time for that. That … she even understood if she was not welcome …That she did not just do her job. That she was more a person, not just somebody who did their job."

The therapist becoming visible as a human being was the other side of this picture, though the parents differed in the way they thought about this and how important this was for them. For most, experiencing common humanity with the therapist strengthened the therapeutic relationship. However, parents who struggled with their self-worth could compare themselves unfavorably and experience feelings of insecurity and inadequacy. It was reassuring but also daunting when the therapists showed unfailing competency. Therefore, it could feel good when they not only shared their own parenting experiences but even revealed their own mistakes: "You feel validated that it is normal to struggle the way you do and that even the person supposed to be a therapist also has problems and is not a super-human being," as one parent put it. Another parent, who struggled with feeling objectified and belittled by the guidance, described how the positive stance of the therapist felt alienating and frustrating to her:

> "She is so extremely positive … everything is, like, I feel she is looking at everything through rose-tinted glasses. She is either being very professional or just a very happy person, at peace with herself. Which I am not. […]"

The same parent felt an almost persistent emotional distance toward the films, while soon catching on to what she perceived as the behavioral content of the guidance; "when I figured out how it worked, it was like … two sessions would have been sufficient. The third one was merely, 'do this and this and that', and I've got it." When the therapist showed her videos of close interaction with the infant, her emotional distance did not diminish, while she felt applauded for something that was not worth mentioning. To her, this felt ridiculous and devaluating:

> "I feel that she talks to me like I was, well, small, or ignorant. Ignorant maybe. A lot of 'how do you feel about this?' and 'what do you think when you see that?' kind of stuff. So, I just like, that is so obvious. … and then, when I answer that which I think is totally obvious, but which I realize is what she wants me to say … she goes like, "Oh, wow". Like, if she is impressed by that she must think I am mentally retarded."

However, most other parents described the reflective stance as very helpful. When their attention and curiosity was guided toward the infants, it helped them to let go of their own thoughts and doubts about themselves and stimulated reflection over their infant and the interaction:

> "I saw so clearly how I was affected by her. I was very stressed and then I tried things that were obviously not right for her just then …But [the therapist] asks the kind of questions that make me think about what I did and the choices I made … 'is there something else you could have done [in this situation]?', and questions like that. And that makes me reflect more about it … [By myself], I only would have seen what I did wrong. But in [the therapist's] presence I get to hear all that I did that was very good."

The therapists' attuned support was also important in the reviewing situation: "When [the therapist] saw I was stressed, she said 'just do not think about it, just look at [the infant]', 'look at the way he looks at you.' Like that. That made me relax more". Several parents emphasized how the repeated experiences with the therapists' reliably positive and calm presence were instrumental to develop more confidence:

> "You become a bit quieter because you are aware that [the therapist] is present all the time … she repeats it … [the therapist] has a positive focus all the time, and she repeats that until you feel secure about it. You get to feel very secure about [the therapist] as a person also, because she is very calm and … does everything she can to make you trust that she will not do anything negative."

Bringing Insights From the Video Guidance Into Everyday Life

The fourth theme describes the parents' reflections on the guidance process and their experiences with putting it to use in their everyday lives. A central topic was the positive stance with its predominant focus on supportive interaction. Most parents had become distinctly aware of this because it collided with their negative expectations and felt new and even upsetting. They not only had negative ideas about themselves as parents that made it difficult to accept a positive stance but also felt that the problems in the interaction should have received more attention. Should the guidance not also inform them about what they did wrong? Could a positive review be trustworthy? Was it legitimate to let go of their own inner criticism? However, they remembered previous experiences with external criticism and how this had resonated with their own self-criticism. A focus on more problematic exchanges with the infants would have supported previous convictions of their own shortcomings and pulled them down:

> "[It is important] that the reviews are a positive experience … Because that makes me go out of the guidance and feel that I am doing a good job. That I can manage and that I can do a still better job. And that gave me enthusiasm, which again made me more open to see and understand…And to understand is so important…

> it makes you want to do it. That you don't go out of there thinking 'they just think all I did was bad.'"

Many parents described how they grappled with the experience of an external, reliably positive stance, represented by the therapist and the films, as opposed to their internal critical and self-doubting stance. The process of accepting and integrating could be intense and extend beyond the guidance session, requiring support from others: "I often need a lot of time afterward to digest everything … to accept it as positive … that can be difficult to handle if you do not have someone to talk to … To get confirmation from several people." The new perspective gave assurance through one's own visual and emotional experience, not through being told by somebody else. The pictures from the films were described as concrete proof. However, when the parents managed to connect with the positive perspective on the interaction, and themselves as parents, this also seemed to linger with them as a relational experience: "Even though you are at home in your own bathroom or bedroom or living room, there is this third person. So, you get this feeling of a presence [of another person]." Repeated experiences with the calming and benevolent presence of the therapist gave parents more confidence and reflectiveness:

> "I feel more secure in my role [as parent]. Well, not all the time, but I have become better at calming myself down and thinking more reasonable again, that I am good enough, and that I am doing what I can for [the infant], that I am aware of [the infant]."

Several parents also related that they could transfer these experiences into other relationships, with their other children but also with their partners, making it easier to deal with difficult emotions or conflicts. Many described an increased capacity to look at the small things in the interaction and experience change in the mundane tasks of everyday life. The guidance had enhanced their significance as parents and they, in turn, saw more significance in small exchanges. "It is like taking a magnifying glass into everyday life and to use it, to see many more details." Even a parent who said that she had not truly learned anything new that the guidance had strengthened her sense of the meaning of the minutiae of the interaction: "You are [usually] not aware of that because it is such an everyday thing. We do it a 100 times a day. But it is special." The parents described a connection between their awareness of the little things, their capacity to reflect more about the infants' signals, and their enhanced capacity for self-compassion:

> "[By] how she looks at me, and her facial expressions, I realize that she communicates with me just like I with her. So, I must stop being self-critical … I must stop and try to understand [her] better … instead of … berating myself that I cannot give her what she wants. And that can be a little thing; maybe she just needed to lie close to me."

Another parent also related the discovery that ordinary, everyday interactions could be highly important in contact with the infant:

> "It makes me more aware and more able to understand what she actually needs … And that it does not have to be so much fun and action. It can be very quiet-like, just sitting on the floor together. That this can actually be enough."

DISCUSSION

We identified four main categories in high-risk parents' experiences of challenging and helpful aspects of Marte Meo video guidance.

The first theme, "handling initial feelings of fear and loss of control," shows how many participants entered the guidance with high levels of anticipation and inner conflict. Parental fears have been scarcely addressed in the existing literature on Marte Meo guidance and not for clinical samples. In community samples, they are described as normal stress before the intervention (Clarke et al., 2011) or as a manifestation of power differentials (Kiamanesh et al., 2018). In our clinical sample from infant mental health, apprehension seems more connected with parents' struggles to come to terms with how their psychological burden affected them as caregivers. They mainly described this as a solitary process unrelated to the therapist or even the referring agency. This perspective has not previously been described in the literature on Marte Meo guidance.

The second theme, "filming as a disturbing and empowering experience," illuminates the parents' experiences with video as a medium in therapy. Filming and viewing activated fears of being scrutinized and found wanting, especially in insecure and self-critical parents who may have been more prone to feel shame in the guidance situation. However, the process also created a gap between what parents thought about themselves and what they saw on the screen, gradually allowing them to integrate new viewpoints of themselves. Earlier research stressed the "outside perspective" of Marte Meo as facilitating the reflection and integration of new schemas of being with (Vik and Hafting, 2009; Vik and Rohde, 2014) or as a "surprise to the unconscious" (Steele et al., 2015) mediating change in the face of powerful emotions including shame. Our findings may be understood as first-person descriptions of these processes.

The third theme, "feeling validated or devalued in the therapeutic relationship," illustrates how parents experienced issues of being valued and recognized for having personal worth as important in the therapeutic process. In this, they described the therapeutic stance, and being acknowledged as sharing a common humanity with the therapist, as especially important. While recognition in the therapeutic relationship has been emphasized (Vik and Hafting, 2009), issues of value and dignity have not been reported to be an important factor in previous Marte Meo research. They transcend mere method-related factors toward a broader therapeutic

perspective (Gelso, 2002) and the need for recognition as an existential condition. Recognition can be seen as part of the parents' struggle to remain a person in a potentially alienating and reifying process (Falkum et al., 2011). It may also be viewed as related to issues of shame, as a need to balance the narcissistic wound of being found wanting as a parent. This connects to findings from the second theme and could be related to studies of narcissistic personality traits in parents hindering the effect of video guidance (Høivik et al., 2015).

The final theme, "bringing insights from the video guidance into everyday life," shows how repeated exposure to positive film clips in conjunction with the repeated relational experiences with the therapists decreased the impact of self-conscious emotions and increased the parents' capacity to regulate themselves, reflect more, and feel more self-compassion in their daily lives. Our findings suggest this process to be a close interplay of the filming and viewing and of experiencing the regulating presence of the therapist. This expands earlier theorizing that had stressed the viewing (Vik and Hafting, 2009) and the therapeutic relationship (Vik and Rohde, 2014; Hawellek, 2015) but had not conceptualized the interaction between these elements.

Our overall findings indicate several important clinical and ethical challenges of Marte Meo guidance for high-risk parents in specialized clinical treatment. Centrally, the parents' psychological and psychosocial burden permeates their experience of the guidance. While more psychosocially resourceful parents in earlier studies looked upon Marte Meo as a type of training or learning program (Osterman et al., 2010; Clarke et al., 2011), the vulnerable parents in our sample described the process as centrally also about themselves. Coming to terms with the existential position of struggling with mental health and as caregivers and needing guidance was an important yet mostly lonely initial process for them. The need to be recognized and validated can be seen as related to this experience, while it can also be understood as the navigation of self-conscious emotions including shame (Zaslav, 1998). The experience of especially one parent, who, while emotionally disconnected, felt devalued by the reflective stance, may point to the possibility that Marte Meo may be less useful to parents handling shame more by devaluing others than devaluing themselves. Earlier research on the usefulness of the method for depressed parents and parents with dependent and paranoid but not narcissistic personality traits (Høivik et al., 2015) would support this hypothesis. Our findings also provide a novel first-person description of the integration of new schemas of being with (Stern, 1994, 2004). The integration takes place in the conjunction of inner distancing created by video use and the experience of film as concrete proof. This description may denote that video opens up an inner space, where concrete positive pictures of relatedness can replace earlier, concrete negative pictures of possibly pre-mentalistic origin (Freeman, 2016). Crucially, this process is described as embedded in the regulating presence of the therapist, which lingers after the guidance.

Reflexivity

Reflexivity involves how the researchers' own background, preconceptions, and subjectivity might inform and influence the acquisition, analysis, organization, weighing, and interpretation of the data (Alvesson and Sköldberg, 2009; Binder et al., 2012; Braun and Clarke, 2019a). Aiming at an experience-near analysis of the parents' experiences demanded reflexivity on the side of the research team. The first author is an infant psychiatrist with a background in video interaction guidance, and her interest in the parents' lifeworld developed out of clinical work. This had both the potential to support the acquisition of relevant data, but also to color participants' experiences by imposing preconceptions derived from her own experiences with parent-infant dyads. The analysis process was therefore critically moderated by the last author and audited by the third author, who had experience with therapeutic processes but not infant mental health nor video interaction guidance. Conceptualizing, including conceptualized language, was consciously set aside until the discussion of the findings. Since the second author was one of four Marte Meo therapists giving the interventions, she took part in the development of the study design and the final discussion of the results but not in the data analysis.

Limitations

There are several methodological limitations in the present study. Our participants, while all recruited from a specialist clinic and striving to mentalize and connect emotionally, were heterogeneous regarding their mental health problems and psychosocial resources. Transferring our results to other parent or patient populations should be viewed with care. We used a narrative interview, the PDI-R, to strategically recruit the parents, and it has methodological limitations. It can, for example, be argued to mainly address mentalization in speech, neglecting its embodied manifestations. Our qualitative approach investigated the parents' subjective experience of Marte Meo video guidance. It cannot answer questions regarding causal relationships between the described phenomena. We interviewed a strategic sample of 12 participants, which again raises the question of the generalizability of the findings to other contexts and populations. More idiographic approaches may have been better suited to capture the complex lived experiences of the individual parents during video guidance. Among our participants, women were overrepresented, with the risk of a skewed description of parenting experiences.

Implications for Research and Clinical Practice

The findings in this study have implications for research and clinical practice. First, more knowledge is needed about Marte Meo for clinical high-risk samples, which should also inform and change clinical practice with these dyads. Second, research on clinical samples should cover studies on the effect of the method as well as on examining parents with different mental disorders, including personality traits related to self-conscious emotions (avoidant, narcissistic) and personality disorders.

Additionally, more research on fathers as a parent group would be important. Third, future research should also investigate embodied aspects of mentalization. Moreover, future research should also cover dyads with older children of high-risk parents with more deeply engrained patterns of interacting and more developed verbal communication.

For clinical work, our findings indicate that it may be important to recognize these parents as a distinct group who experience specific and complex challenges and individual needs. For them, video guidance is closely interwoven with their psychosocial health and vulnerabilities, a psychotherapy of the parent-infant relationship more than a training program. This means that therapists need to be aware and able to handle this, with consequences for practice and training. Furthermore, this implies a closer initial assessment of the parents, and addressing issues of struggling, acknowledgement, and self-conscious emotions during guidance. Cooperation with the parents' own psychotherapist should be considered. Finally, a further development of the method could incorporate more explicitly mentalization-based techniques.

CONCLUSION

The aim of the study was a hermeneutical-phenomenological exploration of the lived experience of parents who struggle to mentalize and remain emotionally connected with their infant with helpful and challenging elements in video guidance in an infant psychiatric setting. We identified four main themes in the parents' experiences: (a) handling initial feelings of fear and loss of control; (b) filming as a disturbing and empowering experience; (c) feeling validated or devalued in the therapeutic relationship; and (d) bringing insights from video guidance into everyday life. Our findings show that parents' experiences of agency, dignity, and shame are important for their ability to benefit from guidance. The integration of new ideas about themselves as parents is achieved in close interplay of video and relational experiences. Therefore, video guidance for parents in specialized clinical treatment needs to address relational challenges, parental mental health, and issues of recognition in the therapeutic process.

DATA AVAILABILITY STATEMENT

The datasets generated for this study are available (in Norwegian) on reasonable request to the corresponding author.

ETHICS STATEMENT

The studies involving human participants were reviewed and approved by the Regional Council for Research Ethics, Southeast Norway, registration number 50546. The patients/participants provided their written informed consent to participate in this study.

AUTHOR CONTRIBUTIONS

IS, KV, and AH contributed to the conception and design of the study. IS carried out the data collection and wrote the first draft. IS, MV, and AH contributed to the data analysis. KV contributed to the discussion. All authors contributed to the article and approved the submitted version.

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Learning to mentalize: Exploring vulnerable parents' experiences of change during video guidance in an infant mental health clinic

Indra Simhan[1,2*], Kari Vik[1], Marius Veseth[2] and Aslak Hjeltnes[2]

Abstract

Background: Interventions that promote infant mental health face challenges when applied for parents who struggle with psychosocial and psychological burdens. Video-based guidance using the Marte Meo method is used in specialized clinical settings with high-risk families to improve parent-child interaction, parental sensitivity and mentalizing. However, knowledge about the lifeworlds of these parents and their experiences of the therapeutic process during video guidance is limited.

Aim: This qualitative study explores how parents in an infant mental health outpatient clinic who had difficulties mentalizing and maintaining an emotional connection with their infants experienced the change process during Marte Meo video guidance.

Methods: We identified a strategic sample of parents with difficulties mentalizing and maintaining an emotional connection with their infants through the Parent Development Interview. Twelve parents received video guidance and were afterwards interviewed in-depth. The research interviews were qualitatively analysed via a team-based reflexive thematic analysis.

Result: We identified four themes: a) feeling inadequate or disconnected as a parent; b) discovering the infant as a relating and intentional person; c) becoming more agentic and interconnected; and d) still feeling challenged by personal mental health issues.

Conclusion: Parents described positive changes in their interactions, in mentalizing their infants, the relationship and themselves as parents, in their experiences of self-efficacy and on a representational level. They also described increased confidence and improved coping despite ongoing personal mental health challenges. The findings suggest that video guidance using the Marte Meo method can be a critical intervention for vulnerable parents but should be coordinated with parents' primary treatments when complex parental mental health issues are involved.

Keywords: Parents, Infant, Parental mental health, COPMI, Video guidance, Video feedback, Marte Meo, Thematic analysis, Parent development interview

* Correspondence: indra.simhan@sshf.no
[1]Department of Child and Adolescent Mental Health, Sorlandet Hospital, PO Box 416, N-4604 Kristiansand, Norway
[2]Faculty of Psychology, University of Bergen, Bergen, Norway

Background

What is it like to engage in video guidance focusing on your their parenting skills when you are struggling to understand and relate to your own infant and are burdened by mental health problems? How do parents with mentalization difficulties experience their own change processes, and what can we learn about video guidance from these parents' experiences? In this study, we present an investigation of video guidance in an infant mental health outpatient clinic for parents with difficulties mentalizing their infants and maintaining an emotional connection with them.

A parent's capacity to mentalize the infant's experiences, that is, to see the infant as an intentional being, to understand overt behaviours in terms of the infant's underlying mental states, and to regulate the infant's emotions, is associated with parental sensitivity and secure attachment [1]. Enhancing parents' mentalizing and promoting sensitive, attuned caregiving is therefore a central aim of parent-infant interventions [2]. Among interventions, video guidance approaches that use film clips of actual interactions to guide parents are a versatile group of methods for both home visits and clinical settings [3]. The positive effects of video guidance for parent-child dyads have been comprehensively documented and to some extent conceptualized [4, 5]. Marte Meo video guidance [6] and its manualized variant, video guidance of parent-infant interaction (VIPI) [7], use videos of everyday situations between parents and infants. For the review sessions with caregivers, therapists choose clips showing developmentally supportive interactions or an interactional opportunity for them and makes use of micro-interaction sequences and stills. Marte Meo thus has a solution-focused stance, omitting material that shows a negative or ineffectual interaction [6, 8]. Research on Marte Meo has hitherto been mainly based on community samples. Studies of mothers with postnatal depressive symptoms have shown how Marte Meo enhanced their vitality and invited them to self-reflection and other-centeredness in the presence of sensitive and attuned therapists. These studies have conceptually linked Marte Meo to Stern's theories of early communication and mentalization, especially mentalized affectivity [9, 10]. Quantitative studies have identified positive effects of Marte Meo on parental sensitivity, interaction, and infant development also within more vulnerable dyads [7, 11, 12]. However, there is a lack of research on Marte Meo in specialized clinical settings, where parents are characterized by more severe psychosocial stress and mental health problems, frequently suffering from affective disorders, substance abuse, personality disorders and other disorders [13–15]. This lack of scholarship also concerns parents' lifeworlds, or lived experience. Often, their intuitive parenting capacity is weakened, and they have difficulties establishing and regulating their emotional connections to their infants and discovering and mentalizing the infants' signals [16, 17]. In community samples, Marte Meo has been shown to be effective for parents with depression, with certain personality disorders [7], and with high psychosocial risks [12]. A three-case study with parents in a specialized infant clinic has suggested that the therapeutic contexts in which the videos are shown could support a positive circle of mutuality, reflexivity and self-confidence, centrally enhancing parental sensitivity [10]. More empirical knowledge is needed about how parents with challenges in key capacities of parenting experience and respond to Marte Meo video guidance during specialized infant mental health services. This knowledge would contribute to elucidating the processes involved in parenting under duress and to adapting the Marte Meo method to the requirements of this parent group. The present study is part of a larger body of data from Marte Meo in specialized settings. An analysis of vulnerable parents' experiences of both helpful and hindering aspects of video guidance is available in (Simhan I, Vik K, Veseth M, Hjeltnes A: Like taking a magnifying glass into everyday life: vulnerable parents' experiences with video guidance in an infant mental health clinic, submitted for publication.). It highlights the challenges and opportunities of using video guidance as a method for parents who tend to feel highly insecure, self-critical, threatened or devalued. None of the themes presented in this study were reported in our previous publication.

The first aim of the present study was to explore the lived experience of changes during video guidance for a strategic sample of clinically referred parents who had difficulties mentalizing and maintaining emotional connections with their infants. Its second aim was to develop a conceptual understanding of Marte Meo video guidance and its clinical uses for these clients. We asked the following research question: How do parents who find it difficult to mentalize or maintain an emotional connection with their infants experience the change process or a lack of changes during Marte Meo video guidance?

Methods

To explore the lived experience of parents receiving Marte Meo video guidance in specialized mental health settings, we used open-ended in-depth interviews [18] that were subjected to an explorative, team-based reflexive thematic analysis (TA) [19, 20].

Setting

The study was a collaboration between the Research Unit and the Infant Mental Health Team (IMHT), an outpatient service for parent-infant dyads, the

Department for Child and Adolescent Mental Health at the Southern Norway Hospital Trust, Kristiansand, and the Department of Clinical Psychology at the University of Bergen, Norway. Clinicians from the IMHT assisted in the recruitment process and administered video guidance using the Marte Meo method to the participants.

Recruitment of participants

To recruit a strategic sample of parents of infants who had been referred to the IMHT and experienced difficulties mentalizing or maintaining emotional connections with their infants, we employed criterion sampling [21], assisted by the Parent Development Interview, revised version (PDI-R). The PDI-R is a 45-item semi-structured narrative interview about parents' representations of their children, themselves as parents, and the parent-child relationships (Slade A, Aber JL, Bresgi I, Berger B, Kaplan M. Parent Development Interview, Short Revised Version (PDI-R)). Unpublished protocol. 2004). A subset of twelve items can be rated in terms of reflective functioning (RF), an operationalized measure of mentalization manifesting in speech, or the capacity to recognize and understand internal experiences in terms of underlying mental states [22]. The sampling criterion was either a) limited RF in the PDI-R or b) explicitly stated difficulties emotionally connecting with the infant and maintaining the connection during affective stress. Based on the concept of information power [23] and considering the aim, framework and specificity of experience and the expected quality of dialogue, we targeted a sample of 10 to 15 participants.

The PDI-R was administered to 30 consenting parents where video guidance was clinically indicated for the dyads. The interviews were digitally recorded, transcribed verbatim, and then read by the first author, a certified rater, who rated the subset of items on the 11-point RF-scale from limited to high RF [24]. An overall score of 4 or less represented limited RF. Thirty percent of the PDI-R was double-coded by two certified, blinded external raters, with an intraclass correlation of 0,89 (95%-confidence interval 0.58 to 0.97) [25]. Quantitative data from the strategic sampling process were not used in the qualitative analysis.

Strategic sample

We recruited a strategic sample of 15 parents who met criterion a) or b). Parents received Marte Meo video guidance and were afterwards interviewed in-depth about their experiences. One parent was excluded because her infant was removed from her care during the guidance, and two parents declined to participate in the research interview for personal reasons. We conducted in-depth interviews with 12 parents, including 11 mothers and one father, from 23 to 34 years of age (M = 27). All recruited dyads were referred to specialized treatment based on the risk to their infant linked to parental functioning or mental health issues. The infants were 6 males and 6 females, and infant ages ranged from 2 to 27 months (M = 9 months) at the start of the guidance. Ten parents met criterion a), limited mentalization capacity; and two met criterion b), experiencing a lack of emotional connection. Eight parents reported adverse or traumatic childhood experiences. All parents reported mental health issues, mostly of long-term or recurrent natures, including posttraumatic stress disorders, personality disorders, uni- and bipolar affective episodes, obsessive-compulsive disorders, and substance misuse disorders.

Intervention/video guidance

Marte Meo video guidance courses [6] were tailored to each individual dyad. One of four Marte Meo therapists from the IMHT with extensive experience with parent-infant dyads administered each dyad's guidance. Filming sessions generally took place during home visits. All parents received 3–7 guidance sessions (M = 4 sessions).

In-depth interviews

We devised a semi-structured interview guide to assist the interviewing, asking about participants' experiences with the course of video guidance, the therapeutic relationship, particularly helpful or hindering aspects of the guidance, and changes that might have taken place regarding their thoughts about their infants and parent-infant relationships. Some example questions were the following: 'Is there something from the guidance that you specifically remember?', 'How did you experience filming?', 'How did you experience the therapist? Was something specific he/she did helpful or not helpful?', and 'Concerning your thoughts about your infant, has the guidance changed these in any way?' We used the guide to structure the interviews but encouraged participants to pursue the topics that they found relevant. All interviews ($n = 12$) were conducted by the first author from November 2016 to June 2019, lasting between 23 and 89 min (M = 61 min). The interviews took place 2–6 months after the end of the guidance (M = 3 months). They were digitally recorded and transcribed verbatim.

Methodology

We chose an explorative, reflexive thematic analysis (TA) as the method for an inductive, data-driven analysis [20, 26]. We aimed at a reflexive, experience-near reporting of the data and carried out the analysis through a team-based approach [19], which further strengthened the balance between closeness to the participants' experiences and reflections of our own positions as researchers. Conceptualizing, including

conceptual language, was consciously set aside during data analysis.

Data analysis

We used NVivo 11 qualitative data analysis software [27] for technical assistance. Reflexive TA was carried out in seven steps by the first, third and last author in a collaborative process. 1) All collaborators familiarized themselves with the data and noted their first impressions and reflections about the experiences related to each interview. 2) The first author reread each interview, identifying meaning units and generating 40 initial codes. Meaning units were understood as features of the data that appeared interesting or seemed to convey meaning regarding the phenomenon. The existing codes were used across interviews only if they were considered to provide suitable descriptions. 3) The first author reported the coded meaning units back to the group, and 34 meaning patterns or subthemes and 4 main themes were formulated in a collaborative process, using the first impressions, the initial codes, and referencing back to the transcripts. 4) Themes were summarized and reviewed as a back-and-forth process between the first author and the group, maintaining the 4 main themes and formulating 21 most relevant sub-themes. 5) The first author refined the themes and wrote an analysis of each one. 6) The themes were assembled in a written form related to the research questions. 7) The research team formed a consensus on the formulation of the main thematic categories.

Researchers

The first author, a child psychiatrist, and the second author, a sociologist, are Marte Meo video guidance therapists specializing in infant mental health. The third and fourth authors are associate professors in clinical psychology. All the authors have extensive clinical experience with psychotherapy and mental healthcare, as well as experience with qualitative research on a range of topics in mental health.

Ethics

The study was approved by the Norwegian Regional Council for Research Ethics. The clinicians at the IMHT gave oral and written information about the study to the suitable parents and obtained all participants' written informed consent for their participation and the study's publication. Participants could withdraw from the study without consequences for their treatment. The researchers were aware of the vulnerable positions of both the parents and infants involved in the research [28, 29] and were actively concerned with preserving the dignity of the participants in the interviews and the subsequent research process.

Result

We organized the findings into four main thematic categories, moving from parents' experiences before receiving guidance to their initiations and the subsequent unfolding and transference of change processes to their everyday lives after the guidance, as follows: A) feeling inadequate or disconnected as a parent, B) discovering the infant as a relating and intentional person, C) becoming more agentic and interconnected and D) still feeling challenged by personal mental health issues. For confidentiality, all data are anonymized and all infants and parents are labelled as female.

Feeling inadequate or disconnected as a parent

This first category describes the participants' situation at the beginning of the guidance process. All participants were struggling with being parents, and feelings of loneliness and isolation were common to most of them. Many felt very insecure and inadequate as caregivers, and some felt emotionally disconnected. Many participants were parents for the first time and found the transition to parenting to be unsettling.

> It was a bit scary … When I came home from the hospital, at first, I almost felt I was waiting for someone to - that I somehow had just borrowed the baby. That someone would come and take her away again. That I was a bit like a baby-sitter. I didn't realize at first that she is actually here; this is my baby.

Parents who expected a high degree of perfection from themselves could feel overwhelmed in this new and uncharted territory and afraid to engage in caregiving activities. Even when they knew that their own standards and needs for control were impossible to meet, they still could not let them go: "I wanted to be perfect in a way, although I understand that nothing is perfect. One cannot be perfect, and I knew it then, and I know it now". Some parents felt uncomfortable interacting with their infants. Holding or talking to their child did not feel natural and easy, and it could also be hard when the other parent seemed more competent and connected. This could enhance pre-existing doubts about being a good enough parent or being fit for parenthood at all, which, again, obstructed them from connecting with their child. Many parents described themselves as being prone to self-criticism. "I thought very negatively about myself in that role [as a parent], so I constantly found fault with myself." Some experienced ambivalence about their perceived shortcomings: "There was actually a small voice inside me saying that what I did was right. But then somehow the negative thoughts entered and took over".

Some parents described themselves as being removed from their feelings, as if their emotions were paralyzed.

One parent exemplified this when relating how she missed noticing when her infant took her first steps:

> *[direct speech is addressed at infant, who is not present during the interview:]*
> " … I didn't even look up when you tried to make contact. It was as if I couldn't manage then. I couldn't manage to relate to your wanting to make contact." So, I get a bad conscience - I get a bad conscience afterwards. That she took her first steps, and I wasn't even looking.

Some parents experienced the absence of an emotional connection with the infant. They felt a lack of delight in the interaction that would have helped them create a sense of their belonging to the infant, or of the infant belonging to them: "I found it actually good to be away from the baby. I didn't feel anything, and I could easily have stayed away for several days, the way I felt then." This enhanced their experience of not coping, which again heightened a sense of emotional distance that could turn into more antagonistic feelings.

> I did have very negative feelings about my baby before I came here. I did think in a way that she – destroyed my life, that she just - I thought about that - I did sort of look at her and think, "you actually destroyed my life."

Another parent felt a connection in certain moments but found it difficult to sustain this. For her, pregnancy and birth had mainly felt like an extension of her newly built relationship with her partner, which was central for her own stability. Her infant's presence intruded upon this relationship: "Now I am just ready for, 'now it's done, we've had this [the baby] together. Now I and [the baby's father] will be alone and travel and so on.' But then I realized, 'sh*t, that's not possible anymore.'" She described her child as obstructing her personal freedom and spontaneity, two essential parts of who she felt she was. For her, the main problem towards her infant was her lack of what she imagined to be "a mother's feelings", which would thwart her need to feel free. She compared herself with her best friend:

> … she is just sort of, so absorbed. Like, from when [the friend's baby] was born … She couldn't even sleep because she … It was like she was in love. She just lay there and looked at her baby all night while it was sleeping. I just thought, "Jesus". When [my infant] was born, I was, like, "Ok, can someone take the baby away now so I can sleep. I don't feel like - I don't feel like anything at all."

For this mother, it was very difficult to find a viable mode of being a parent amidst her ideas of autonomy and self-abandonment. For most parents, their negative thoughts about themselves hindered them in their spontaneous interactions with their infants.

All parents found it especially challenging to handle an infant's distress. They felt stressed and unable to understand what the infant was expressing and just wished that any distress might pass as soon as possible. They could also fear not being able to handle a tense situation: "I was afraid to go outside with her. A bit also, like, afraid of her. That she would not want to lie in her pram, or that she would suddenly wake up when I walked her in the forest". To most, their infants' crying signalled that they were not good enough and not coping effectively. Remaining emotionally present was demanding when the distress felt unbearable, or when they struggled to separate their infants' feelings from their own. However, admitting to themselves that they needed help could take time:

> When I first got the offer [for treatment], the baby was maybe four months old … and I thought, like, "hormones", and "that's how it is in the beginning", but it never got any better. … I thought, "when I stop breastfeeding, everything will get much better", but it didn't. It just stayed the same, really. And when it somehow never got better … I thought, "No. Now I have to get help … I can't live like this for, I don't know, many years."

Discovering the infant as a relating and intentional person

The second category describes the initiation of changes in how the parents perceived their infants, their interactions and themselves. The change process began when they were shown minute details of their exchanges with their infants and discovered their infants' contact-seeking behaviours. This touched them emotionally and made them more aware of their infant as a person. This, in turn, changed their experiences of connection, meaning and complexity in the interaction and of themselves as more secure and agentic parents.

Most parents described that it was their infant's gaze that first captured their attention and engendered the change process. Discovering that their infant looked at them and followed them with her gaze was an unexpected experience that opened them up to the child. Initially, this discovery was mainly connected with themselves and how it made them feel more adequate, important or cherished as human beings and caregivers. Their infants' contact initiatives and attempts to continue these connections arrested the parents and made

them aware of how their infants sought them, waited for their attention and expressed delight in them.

> I think it was when I saw it on video that the baby was very interested in what I did and what I said. That she smiled at me. That made me feel very good. I felt that she loved me, too, and not just [the other parent]. That I, too, was able to build up this connection. I guess this was what affected me … no matter what I did, she was interested. And, well - that I saw that gaze. The eye contact that the baby gave me.

Parents described this discovery as a repeated experience that gradually assured them of their importance to their infant and of being good enough parents: "She comes to me spontaneously, lies down in my lap or seeks physical contact …. That is very gratifying. And again and again reassures me that what I do is good enough." Many parents related how they experienced the infant's unwavering desire for contact as a feeling that they were intensely valued and cherished: "I was afraid that I couldn't manage … But then I really saw that she adored me anyway." One parent described how the repeated, reliable contact-seeking of her infant made her realize that she truly was of personal importance to her child, whereas before she had assumed it did not matter to her infant whether it was her or somebody else who was present. The infant's gaze always returned to her, sought her, and rested upon her, which gradually made her trust that there was a special connection. Many parents described these gaze contacts and how their infants' readiness to smile elicited joy in them. They felt more secure and confident in an infant's presence and more competent as parents. This element in the change process then led to their being more interested in their infants.

> … I [see] how much my baby looks up to me. She is following me all the time and wants my attention. And there is something in the gazes and expressions that you maybe don't catch so easily while it's happening. But when you see it from a little distance, you realize that, okay, maybe I actually have to begin to try to understand her a little better.

When parents increased their efforts to understand, their infants' actions became more meaningful, which in turn made it easier for parents to figure out what was taking place in a particular interaction. They began to see more complexity in their exchanges with their infants and how their minute interactions influenced one another and were interconnected. This in turn made them view their infants more as complete persons and recognize their agency. Their infants' behaviours were now seen as genuine communication. Parents experienced they could understand both their infants and themselves better and realized how much their own efforts at reading their infants' signals meant.

> I also saw how she appreciated - that she understood that I was trying to understand … I had never thought that … such a little baby could communicate so much without words. That was a shock for me.

Parents' initial change processes unfolded from an increased awareness of their infants to a new perspective of their interactions and a changed experience of parenting. One parent described how the review sessions helped her to see that her infant was dependent upon her and loved her, and that this changed her own stance towards caring. Another parent related how her parental feelings were activated when she first became aware of her infant's gaze initiatives: "that was a real eureka moment … just as if I could 'see' motherly love, you know?" Parents who had felt insecure and awkward about handling their babies gained more confidence when they realized that complex, prolonged exchanges were occurring between themselves and their infants and found it easier to submerge themselves in these interactions. This was experienced as a gradual, natural development.

Becoming more agentic and interconnected

The third theme presents the further development of the change process. Parents described how they sustainably experienced themselves as more agentic and connected with their infants through video guidance. All parents said that the discoveries they made in the reviews also changed their perspectives on their daily interactions. Having first become more aware of the interactions made it easier to recognize the same exchanges in everyday life with a child and make them last longer.

> It's not so easy to be aware in everyday life … things go on autopilot all the time. But it has made me a little more aware that she is actually doing something, or looking at me in a certain way, so she wants to have contact. This makes it easier for me to recognize it, and then I can sit down alongside her and make something out of the situation instead of just thinking "Oh, hi" and then moving on to something else.

An important discovery for parents during reviews was to see how their actions and an infant's actions were interconnected. Realizing this increased their own experiences of agency. Parents described how they slowed their pace and involved themselves more actively with their infants, even in stressful situations, because they now felt they had the ability to influence what was going

on. They became more aware of how their own stress influenced their infants. "When I am stressed […] she becomes fussy and whiny. [Guidance] helped me to understand that this is interconnected. She is not being fussy for fun. I'm the one running around and being stressed out; no wonder it affects her." This was a significant realization. First, their infants' distress became more understandable. From experiencing their infants' stress as uncomfortable, agitating or even antagonistic, parents began to see stress as a meaningful expression of needs and as a communicative act. In addition, the parents now also found it more meaningful to try to contain themselves in moments of stress. "I can now more easily calm myself down again and think, rationally, that I am good enough and I do what I can for the baby; I am aware of her." These repeated experiences of being able to take greater charge when they remained aware and contained their own feelings of stress led to gradual changes of their parenting towards being more active and responsible.

> If she is somehow angry or stressed, I think all the time, "okay, now at least I have to stay calm" so that she feels that I am relaxed and secure, and now we will find out what to do with this.

Parents developed more confidence, especially in demanding and tense situations. They described profound changes in being together with their infants and soothing them. Parents also experienced distress differently from a temporal perspective; things could be difficult in the present moment, but they would change again soon: "I try to just be patient and let her express herself, and try to figure it out, because it's going to be alright […] it will end." Furthermore, they also felt more stimulated to reflect upon the infants and the interactions because they found both to be more meaningful. They described a positive, self-enhancing circle of increased interest, increased understanding and increased experience of agency.

> … Through Marte Meo, I have understood that I must try to read my baby. What is it that she is expressing? – and it doesn't matter if that takes some time. The most important thing is that I try to understand … instead of panicking, "o, no, how terrible".

Many parents described how they became more able to see an infant's perspective and understand an infant's signals. They discovered that a child expressed a range of feelings and communicated with them. Parents also recognized the developmental contexts of their infants: "It's easier for me to understand why the baby is doing the things she does … related to her development. So, it doesn't stress or irritate me so much in our daily life anymore". When parents became aware of their infant as a meaningful person, they also saw more patterns and structure in the infant's interactions; their infant became more predictable. Several parents related how these changes also led to seeing themselves as agentic, competent and connected parents. They described how the guidance gave them more security, which made them experience the bonds with their infants as being stronger but also more relaxed and realistic.

> I am very attached to the baby, but in a more relaxed and balanced mode of thinking somehow - varying from day to day, actually. How much you feel you can manage … because one can have bad or good days.

Many parents found themselves more flexible and tolerant in everyday interactions with their infants. They had become less self-conscious in the interactions and often intuitively navigated the exchanges; "I'm different with her now […] more confident and sure about what I am doing". Parents were able to give themselves more time to determine what their child expressed and felt more empowered to make decisions that they felt were right, even though these decisions might increase a child's distress for a short time, such as putting an overtired baby to bed or prohibiting an unwanted activity. They were able to focus confidently on the resources they had rather than emphasise what they might lack. Thus, living with an infant became more complex, manageable and enjoyable.

> I experience more pleasure and feel that pleasure, even though things can be tough sometimes. So, in a way, it has taught me to appreciate that I have the baby anyway and that I can understand her better. That there actually is a pleasure in that too … So, there is a change in that I feel a lot of pleasure. I love her very much.

Many parents described how they had developed a strong emotional connection and responsibility towards their children. They also narrated how their relationship with their infants became more personal and how they found their own individual roles as parents, which again strengthened their bonds and provided security. One parent described how she gradually dared to hope for change and trusted in her own adequacy. While she initially depended upon external confirmation, she developed an internal supportive voice that enabled her to remain connected with her infant where before she would have disconnected and used other activities to self-regulate.

> [They] were good somehow, those moments when the thoughts - I could sit down on the sofa and cuddle. And play a bit, and then ask myself: "Could this be all that is needed?" That was actually a very good experience. Because there were no other thoughts. I forced myself in a way to focus just on the baby. "Don't think, don't think about the washing-up. Or checking the phone or stuff like that". To look at her: "What is it that she wants?"

When the reviews showed how interactions changed, parents were enabled to believe in their transformations. One parent related her surprise about how relaxed and calm she now handled a situation of distress, and how this convinced her that she had integrated her discoveries from the previous review sessions. Many parents described how they had become more intuitive in their responses to their children.

> In a way, it got easier when I saw how the baby reacted … gradually, just naturally, actually. Maybe now and then I would think I'd try, like, to say what we are about to do. Like "now we shall change the nappy". Yet mainly I felt this just gradually came by itself. That when she was crying or something, I said something like, "oh, poor thing, does your tummy hurt?" Or, yes. I couldn't do that before, so I just felt it developed. And now this just happens automatically.

These changes also affected other areas of everyday life. One parent narrated how she had gone from being generally pessimistic and expecting the worst to tackling challenges in an optimistic way: "Because I feel I have to be like that for her, or that it's the best for both of us, I am automatically also like that in other situations in everyday life." Another parent was able to be more open with her friends and family about her mental health issues and worries as a parent. She also stopped comparing herself to her partner, which led to better companionship around parenting issues and more openness in the relationship.

Still feeling challenged by personal mental health issues

The fourth and final category describes the continuing emotional difficulties many parents experienced, despite also experiencing sustained and often profound changes. These difficulties were related to the parents' psychological problems that still influenced their expectations or their perceptions, especially as parents. The psychological problems were felt also to be about parents themselves and not merely about external disorders: "I have said that I think this was never a postnatal depression. This is because I am as I am."

Some parents still experienced the bond with an infant as weak or unstable. One described how she moved between feeling competent and optimistic and being ambivalent about her child and unsure of herself as a parent. The difficult feelings arose especially when her infant's needs collided with her own needs or expectations, and when she could not handle distress. She would then collapse into feeling intensely frustrated, unloved and futile. Her unstable feelings conveyed to her that she lacked something essential needed for parenting.

> It happens actually often at night that I am putting her to bed and ask for her forgiveness, and say "Sorry for being the worst mother in the world." While she just [seems untroubled]. Yes, well – often actually with tears in my eyes. That, "Poor thing, you didn't choose this. You could have had it much better, but this is how it went."

Another parent still felt removed from both herself and her infant. While she now reflected more about her infant and herself and interacted with her child differently, she did not experience more feelings or a personal connection.

> I do see she smiles. I see she has expectations, I see she seeks contact, I see that she gets happy … – I see all these things. It's just that they - they don't move anything inside me. It's like watching whatever child on TV.

She described herself as being split into a sick part and a rational part, and she was afraid that she had used the guidance primarily as a technical tool for satisfying her infant's needs so that she would be less overwhelmed by the infant's demands. This increased her self-contempt and despair.

However, even though most of the other parents saw their persisting tendencies towards insecurity and self-doubt as a part of who they were as persons, they now felt more secure and competent as parents, and said that the experiences from the guidance still lingered and nourished their self-esteem. Their form still varied on certain days. What had changed, however, was their way of understanding and handling these variances.

> I have become more secure about myself and I understand the baby better … Back then, I mostly became irritated when she cried a lot, and I couldn't understand that this actually is the way she communicates … But one should bear in mind how it is when one is tired or needs attention … because I also have days when I am not super stable. When

> I also need that little extra something. … It helps that I also manage to see it from this perspective.

Many parents related that it was now less important whether they still had problematic or unresolved mental health issues. Even though the interactions could feel rocky at times, now parents mostly felt that they could cope with their infants: "I am not fully cured, that has to be said. But … now I have learnt to accept recognition for the job I am doing as a parent … no matter if I am pulling my hair in frustration now and then." One parent described how she still struggled and doubted herself, but now she felt agentic:

> I know many people are better than me in many things, so I have to be strong enough to ask … "Can you teach me that?" I want to become good, too … I am very open towards new things. Not everything has to be an obstacle. It can be a challenge, and so I take up the challenge. And I do my best, because then I have tried. If I fail, well, so I failed, but I tried. I did something about it. I am not left with the feeling that "why didn't I do something about that?" That I always try as best as I can.

Most parents adjusted their outlooks towards more realistic and hopeful perspectives on parenting and on their own abilities. Their own insecurities were no longer experienced as hindrance to being a parent, but rather as parts of who they were in their everyday lives.

Discussion

In our analysis of how parents who had difficulties mentalizing and remaining emotionally connected with their infants described their own experiences of change during and after Marte Meo video guidance, we identified four main categories. In the following, we discuss the results in light of established perspectives, with the aim of further developing the existing conceptual understandings of Marte Meo and its clinical uses with these clients.

The first category, "Feeling inadequate or disconnected as a parent", shows how the predominance of preoccupied and self-critical states may have hindered parents' normal development of caregiving through repeated successful interactions with their infants [30, 31]. An inhibition to touch, handle and vocalize with an infant points to difficulties in a parent's intuitive parenting capacity [32, 33]. Parents' tendencies to not cohesively regard infants as relational and intentional beings and to read infant cues as negative references about their own caregiving, which represent a low degree of mentalizing, may have maintained negative transactional feedback loops [34]. This is in line with evidence that parents with mental health problems experience more early feelings of estrangement from, anxiety towards and anger with their infants [35, 36], constituting risk factors for infant development [37] and contributing to manifest relationship disturbances [38]. Therapists working with insecure parents have described how they shift parents' awareness from themselves onto their infants and into the present, focusing especially on contact moments [39]. The visual focus of guidance on successful, minute interactions and contact moments to highlight existing resources in both parents and infants to support intuitive caregiving competence [34] may be especially suited for this parent group.

The second category, "Discovering the infant as a relating and intentional person", depicts the incipient change process that is sparked by a parent's surprise upon discovering an infant's relatedness. However, parents' initial reading of this discovery was still centred on what this relatedness meant in terms of their own lovability, adequacy, and importance. Gill's study of a specialized setting mentions a similar self-centred reading of the child's gaze [10]. The surprise, or "shock", on seeing videos of their interactions has been hypothesized to be facilitating access to parents' unconscious material relating to their own attachment and stimulating a new organization and reflection [4, 40]. The findings from our parent group indicates that this surprise first jolted their preoccupations with self-conscious emotions [41] and supported changes towards better acceptance of positive relational experiences that were directed at themselves. This process seemed to precede and engender their increased engagement, joy, and experience of mutual connectedness and competence, which in turn formed the basis for their mentalizing stance.

The third category, "Becoming more agentic and interconnected", shows the integration of new relational experiences in everyday life with an infant. Increased self-regulation and tolerance in the face of infant distress and description of distress as now having a temporal structure suggest a change at the representational level of negative emotions, becoming symbolized, second-degree representations [42]. Infant distress was now also experienced as a communicative cue, eliciting an intuitive caregiving response [43], affect regulation and marked mirroring [44]. These positive reinforcing transactional circles [34] enhanced parents' representations of themselves as competent caregivers [31]. Parents reported key facets of increased mentalizing in their interactions with their infants, such as their sustained curiosity about the infants, their awareness of their infants' and their own mental states being complexly interconnected; their focus on affect-regulating the infants, their considering developmental perspectives in the interactions [45]; and their descriptions of increased self-regulation and mentalization in functional areas other than caregiving.

The final category, "Still feeling challenged by personal mental health issues," emphasizes how change is often an ongoing process embedded in a parent's psychosocial situation. Most parents integrated more flexible ideas of themselves as caregivers, with strengthened experiences of connection and self-confidence, even amidst challenges. This suggests a fluid shifting between representations, between past and present, and between self and infant [31]. Parents were better able to navigate conflicts, which can be understood to result from increased relational security [46]. Their view of everyday life with their infants was more relaxed and balanced and thus more normalized, as ambivalence and insecurity are common fleeting states in parenting [31]. Their confidence expanded to not only other situations and relationships but also how they handled persisting mental health problems, which most parents still experienced with varying frequency. However, for some parents, these problems remained very burdensome, indicating more deeply engrained mental health challenges that may necessitate a better coordination of interaction guidance with a parent's primary therapeutic process.

Overall, these findings indicate that Marte Meo guidance supported crucial changes amongst this strategic sample of parents. The change process seemed to be sparked by parents feeling sufficiently encouraged to emotionally connect with the actual interactions, as presented in the video clips. Feeling loved and validated by their infants' contact-seeking behaviour seemed to supply this encouragement, especially when this behaviour came as a surprise, with the ability to jolt pre-existing ideas or schemata. Visual encounters with infants' benign nature may have helped parents to discriminate between their actual infants and their internal representations of earlier, less benign relational experiences [46, 47] to facilitate relational openings towards their children. This "discovery" of their actual infants led to more positive emotions, experiences of reciprocal connectedness, and interest in their children, supporting further developments in two areas; namely, in mentalizing and in experiencing themselves as agentic and influential. Regarding VIG, a video guidance method with similarities to Marte Meo [48], conceptual papers have discussed the discrepancies between parents' old, negative beliefs about themselves and the evidence of positive interactions presented in video feedback, which have been posited to create a cognitive dissonance that promotes metacognitive capacity, or mentalization, as well as increased self-efficacy and empowerment [49, 50]. In an analysis of Marte Meo method elements, the combination of unreality or distance created by video and the experience of film as concrete proof has been identified as a relevant facilitating factor (Simhan I, Vik K, Veseth M, Hjeltnes A: Like taking a magnifying glass into everyday life: vulnerable parents' experiences with video guidance in an infant mental health clinic, submitted for publication.). The experiences of surprise presented in this paper seemed to capture aspects of the change process that pertain more to overcoming avoidance, or the fear, of relationally connecting, as a first step towards an increased mentalizing capacity. This opening towards more positive relational experiences and increased connections with the visually presented interaction were central elements that supported the increases in reflective functioning and sensitivity. After guidance, most parents were able to more flexibly shift between positive and negative states and to represent their negative emotions and distress on a symbolic level. Our findings imply that the guidance stimulated change, both on an interactional and representational level and in parents' reflective functioning. The presence of the attuned therapists who regulated the parents and invited them to reflection is assumed to be an important factor that facilitated these relational changes and increased mentalization capacities [9, 49]. Parents also described how the therapists' presence lingered with them even after guidance sessions and promoted an integration of their new experiences (Simhan I, Vik K, Veseth M, Hjeltnes A: Like taking a magnifying glass into everyday life: vulnerable parents' experiences with video guidance in an infant mental health clinic, submitted for publication.).

Most parents experienced increased agency, flexibility and confidence as parents and in other areas of their lives, including their own mental health challenges. This seems to reflect a pivotal increase in a parent's experience of self-efficacy [51], not only in the domain of parenting but also on a general level. Parents' self-efficacy is defined as "confidence about their ability to successfully raise children" and is linked to several positive parenting functions. General self-efficacy more broadly involves positive self-perceptions of one's agency, competency and influence over events [52, 53]. Enhanced self-efficacy in this sample of parents promoted relatedness, affect regulation, mentalization and intuitive parenting competency to extend more generally to coping with mental health issues. These findings relate well to knowledge from the recovery movement in mental health, which has repeatedly demonstrated how people are able to find ways of leading meaningful lives in the face of a wide range of different mental illnesses [54]. Davidson et al. have defined recovery as "a process of restoring a meaningful sense of belonging to one's community and positive sense of identity apart from one's condition while rebuilding a life despite or within the limitations imposed by that condition" [55]. This strengthens the suggestion of earlier conceptualizations that have placed Marte Meo amongst resource-oriented methods [8] and aligns with research that has demonstrated

symptom reduction in depressed parents from a community sample [7].

Reflexivity and methodical considerations

Reflexivity involves systematic efforts to articulate how researchers' own preconceptions and subjectivity might inform and influence how data are acquired, analysed, organized and interpreted [19, 20, 56]. Aiming at an experience-near analysis of parents' experiences demanded reflexivity from the research team. The first author, an infant psychiatrist with a background in video interaction guidance, derived her interest in the parents' lifeworld from her clinical work. This had the potential to impose preconceptions derived from her own experiences with parent-infant dyads. Therefore, conceptualizing, including conceptual language, was consciously set aside during data analysis. Moreover, the analysis process was critically moderated by the fourth author and audited by the third author. Both had experience with therapeutic processes but not with infant mental health or video guidance. The second author was one of four Marte Meo therapists providing the interventions. She took part in the development of the study design, the discussion of the results, and the conceptualization but not in the data analysis.

Limitations

The present study has several methodological limitations. Our participants, while all recruited from a specialist clinic and striving to mentalize and connect emotionally with their infants, were heterogeneous regarding their self-reported mental health issues. Our findings do not allow for discrimination between different mental conditions. Moreover, transferring our results to other parent or patient populations should be done with care. It could be argued that the narrative interview we employed in the sampling process mainly addresses mentalization in speech, neglecting its embodied manifestations [57]. Our qualitative approach investigated the parents' subjective experiences of Marte Meo video guidance. It cannot determine causal relations between the described phenomena. The interviews varied in length, which may have led to more dismissing parents having less prominent voices in the data. Among our participants, women were overrepresented, with the risk of a skewed description of parenting experiences.

Implications for research and clinical practice

The findings in this study have several important implications for research and clinical practice. As they suggest that video guidance using the Marte Meo method can stimulate a profound change in dyads that have been referred to specialized treatment, research should investigate the application of the method for defined parental mental health issues, such as personality disorders, recurrent depression, substance misuse or posttraumatic disorders. These investigations should include changes in mentalization capacity and self-efficacy. An interesting topic would be a combination of parental video guidance and parents' primary therapeutic treatment. Additionally, more research on fathers as a parent group would be useful. Moreover, future research should cover parents of older children with more deeply engrained patterns of interacting and a more developed capacity for verbal communication to identify whether their change processes differ from those of parents of infants.

For clinical work, our findings suggest that Marte Meo can be useful in the specialized treatment of dyads where parents have complex psychosocial or mental health issues and difficulties mentalizing their infants. This study's parents' experiences indicate that there are concrete requirements for video guidance. Therapists should be aware that, initially, parents may be very preoccupied with self-conscious emotions. To initiate change, the review sessions should focus on showing an infant's gaze and contact initiatives. Especially for insecure parents, these moments should be shown repeatedly. Once parents become engaged, film clips showing mutuality and interconnectedness in interactions with an infant can stimulate their further awareness and reflection. As the parents' own challenges and parenting seem closely interconnected, and as the experience of agency and confidence seem to be central focal points, a combination of guidance with the parents' primary treatment could be considered. Our findings imply that these change processes involve change at the levels of both interaction and representation. Guidance can strengthen vulnerable parents' connectedness, mentalization and self-regulation, as well as their self-efficacy, both as parents and in other areas of life.

Conclusion

The exploration of vulnerable parents' experiences of change during Marte Meo video guidance elicited several aspects of the therapeutic process. At the outset, many parents felt disconnected, could not engage their intuitive parenting capacities, and interpreted their infants' cues as negative feedback. The change process was engendered when they discovered their infants' relational interest, which at first centrally confirmed and strengthened their self-worth and ability to relate. This led to a cascade of increased engagement and joy and an experience of mutual connectedness and competence, which in turn formed the basis for a mentalizing stance and reflective functioning. Changes occurred at the interactional and representational levels and through increases in parents' self-efficacy, flexibility and confidence, not only as caregivers but also in other

relationships and towards their persisting mental health issues. The findings suggest that video guidance can be a critical intervention for parents who struggle to mentalize and maintain an emotional connection with their infants, but it should be coordinated with primary treatment when complex parental mental health issues are involved.

Abbreviations

PDI: Parent development interview; IMHT: Infant mental health team; RF: Reflective functioning; TA: Thematic analysis; VIG: Video interaction guidance; VIPI: Video-guidance of parent-infant interaction

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Authors' contributions

IS, KV, and AH contributed to the design of the study. IS carried out the data collection. IS, MV and AH performed the collaborative data analysis; IS carried out the initial coding and wrote the first draft. KV contributed to the discussion. All authors contributed to the manuscript revision and read and approved the submitted version.

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Availability of data and materials

The qualitative datasets generated and/or analysed during the current study are not publicly available due to reasons of confidentiality but are available from the corresponding author on reasonable request (Norwegian only).

Declarations

Ethics approval and consent to participate

The study was approved by the Norwegian Regional Council for Research Ethics (No. 2014/474). Participants received oral and written information about the study and gave written informed consent.

Consent for publication

Not applicable.

Competing interests

The authors declare that they have no competing interests.

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Publisher's Note

Appendices

A Interview guide study 1

B Interview guide study 2

C Consent form study 1

D Consent form study 2

A Interview guide study 1

Hvordan erfarne terapeuter håndterer og reflekterer om «vanskelige» forløp i videobasert veiledning (Marte Meo) av sped- og småbarnsforeldre.

1) Kan du si ditt navn, yrke og arbeidsplass, og hvor lenge du har vært Marte Meo terapeut?
2) Hvordan ville du beskrive et veiledningsforløp som kan kalles for «vanskelig». Kom gjerne med eksempler.
3) Hva har du erfart hjelper i vanskelige forløp?
4) Har du hatt forløp der du opplevde at veiledningen ikke hadde noen effekt i det hele tatt?
5) Hva har du erfart hjelper ikke?
6) Hva gjør et vanskelig forløp med deg som terapeut?
7) Har du andre erfaringer eller refleksjoner som du vil dele?

B Interview guide study 2

Sped- og småbarnsforeldres tanker omkring barna, foreldreskap og samspillsveiledning. Intervjuguide

1) Jeg vil gjerne høre dine tanker og erfaringer omkring Marte Meo-veiledningen. Jeg er oppriktig interessert i dine ærlige svar. Du trenger ikke å tenke på hva jeg mener eller ønsker å høre. Det første jeg vil gjerne spørre deg om er dine spontane tanker i forhold til den veiledningen du har fått.
2) Hvordan opplevde du selve filmingen?
3) Hvordan var det for deg å få tilbakemeldingene?
4) Var tilbakemeldingene og erfaringene du gjorde nyttig for deg i hverdagen med barnet ditt? Hvis ja, på hvilken måte?
5) Hvordan opplevde du terapeuten? Var noe av det terapeuten gjorde hjelpsom for deg? Var noe av det terapeuten gjorde ikke hjelpsom?
6) Hvis du tenker på tankene dine omkring til ditt barn: tenker du at veiledningen har endret noe på dem?
7) Hvis du tenker på forholdet ditt til ditt barn: tenker du at veiledningen har endret noe på forholdet?
8) Er det noe som er viktig som jeg ikke har spurt om?

C Consent form study 1, approved by Norwegian Center for Data Security (NSD)

Forespørsel om deltakelse i forskningsprosjektet
Hvordan erfarne terapeuter håndterer og reflekterer om «vanskelige» forløp i videobasert veiledning (Marte Meo) av sped- og småbarnsforeldre.

Bakgrunn og formål

Jeg heter Indra Simhan og jobber som barnepsykiater og overlege i sped- og småbarnsteamet og forskningsenheten ved Avdeling for Barn og Unges Psykiske Helse (ABUP). Studien inngår i min PhD-studie om Marte Meo veiledning for foreldre med mentaliseringsvansker. PhD-studien er knyttet til Avdeling for Barn og Unges Psykiske Helse (ABUP) ved Sørlandet Sykehus i Kristiansand, og Psykologisk Fakultet, Universitet i Bergen (UiB). Studien blir veiledet av sosiolog PhD Kari Vik, ABUP, og psykolog PhD Helge Holgersen, UiB. Studien er del av et overordnet prosjekt som heter "The Baby in Mind" fra ABUP og Avdeling for Avhengighetsbehandling (ARA) ved Sørlandet sykehus, Universitetet i Agder (UiA) og UiB, som undersøker Marte Meo veiledning i et klinisk perspektiv og med forskjellige risikogrupper. Målsetningen er å videreutvikle klinisk bruk og konseptuell forståelse av Marte Meo.

Metode:

Fokusgruppe intervjus med et strategisk utvalg av Marte Meo terapeuter. Kvalitativ analyse av intervjuene etter en fenomenologisk-hermeneutisk modell.

Målsetningen med studien er

1) identifisere problemområder ved metoden for sped- og småbarnsforeldre som kan trenge en videreutvikling av metoden.

2) identifisere terapeutiske strategier og metodelementer i Marte Meo som hjelper å håndtere vanskelige terapeutiske prosesser med foreldre av sped- og småbarn.

3) Bidra til konseptuell utvikling av Marte Meo

Du blir spurt om deltagelse i studien fordi du er en erfaren Marte Meo terapeut og dine erfaringer og tanker er viktig å få med. Kontakten til deg ble formidlet gjennom Rolf Rohde, Marte Meo Licensed Supervisor ved ABUP Kristiansand, Mette Prytz i Terapeutisk Nettverk, Sandnes kommune, og Julianne Villanger, Oslo.

Hensikten med utvalget er å kunne intervjue Marte Meo terapeuter med flere års erfaring av å veilede foreldre. Forespørselen ble sent til Marte Meo supervisorer/veileder med oversikt over Marte Meo terapeuter i flere kommuner, slik at det samles erfaringer fra flere Marte Meo miljøer. Supervisorene/veilederne henvendte seg til egnede terapeuter som bli spurt om deltakelse i studien.

Hva innebærer deltakelse i studien?
Deltagelse i studien består i deltagelse i et fokusgruppeintervju. De vil være tre til fire terapeuter i en fokusgruppe. Intervjuet ledes ut fra en intervjuguide utviklet av erfarne Marte Meo terapeuter. Spørsmålene omhandler erfaringer fra Marte Meo veiledning med sped- og småbarnsforeldre. Både terapeutens opplevelse, håndtering av veiledningen og refleksjoner er av interesse. Intervjuguiden er ment som en ledetråd, med mulighet for å gå inn på andre spørsmål og tanker som måtte vise seg under intervjuet. Intervjuet varer i maksimal 2 timer og tas opp på film og lydopptak.

Hva skjer med informasjonen om deg?
Alle personopplysninger vil bli behandlet konfidensielt. Personopplysninger vil kun omhandle navn og prosfesjonelle detaljer (arbeidsområde, hvor mange års erfaring, utdanning). Kun jeg som gjennomfører intervjuene vil ha tilgang til personopplysningene. Intervjudata blir anonymisert. Både opplysningene og koblingsnøkkel for anonymisering lagres i lukket arkivskap i forskningsenheten på ABUP. Koblingsnøkkel lagres atskilt fra øvrig data. Opptakene lagres digitalt på en trygg server i forskningsenheten. I analysen og senere publikasjon vil ikke informantene kunne gjenkjennes.
Studien skal etter planen avsluttes i 2021. Datamaterialet blir oppbevart i fem år etter prosjektslutt på en trygg server ved forskningsenheten for det anonymiseres. Det er kun jeg som ansvarlig som vil ha tilgang til materialet.

Frivillig deltakelse
Det er frivillig å delta i studien, og du kan når som helst trekke ditt samtykke uten å oppgi noen grunn. Dersom du trekker deg, vil alle opplysninger om deg bli anonymisert.

Dersom du har spørsmål til studien, ta kontakt med Indra Simhan, ABUP Kristiansand, telefon 38177426, mobilnummer 45091574.

Studien er meldt til Personvernombudet for forskning, NSD - Norsk senter for forskningsdata AS.

Samtykke til deltakelse i studien
Jeg har mottatt informasjon om studien, og er villig til å delta

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(Signert av prosjektdeltaker, dato)

D Consent form studies 2 and 3, approved by Regional Committee for Medical and Health Research Ethics (REK Sør-Øst)

FORESPØRSEL OM DELTAKELSE I FORSKNINGSPROSJEKT

Sped- og småbarnsforeldres tanker omkring barna, foreldreskap og samspillsveiledning.

Vil du delta i en studie om sped- og småbarnsforeldres tanker rundt foreldreskap og barna, og hvordan samspillsveiledning oppleves?

Mitt navn er Indra Simhan. Jeg er legespesialist i barne- og ungdomspsykiatri, terapeut i Marte Meo-veiledningsmetoden og jobber som overlege i Sped- og småbarnsteamet ved ABUP, Sørlandet sykehus. På bakgrunn av dette gjør jeg nå en forskningsstudie som del av mitt doktorgradsarbeid.

Jeg vil med dette informere deg om studien. Din behandler i Sped- og småbarnsteamet gir deg denne skriftlige informasjonen. Dersom du ønsker det kan jeg delta i en samtale med deg for å gi ytterligere informasjon. Da sier du i så fall fra til behandleren din som ordner det.

Målet med studien

Studien skal hjelpe oss til å vite mer om hva som er nyttig i veiledning av familier med sped- og småbarn henvist til ABUP. Å veilede foreldre i samspillet med barnet er en viktig del av arbeidet i Sped- og småbarnsteamet. Studien tar utgangspunkt i en veiledningsform som heter Marte Meo, en videobasert metode for utviklingsstøtte. Marte Meo brukes overfor foreldre som ønsker å forstå mer om barnets behov, som opplever utfordringer i samspill med barnet eller som er bekymret for at deres egen psykiske helse kan påvirke samspillet.

Når man opplever samspillet som utfordrende, kan også tankene rundt det bli mer vanskelige. Vi ønsker å vite mer om hvordan Marte Meo veiledning oppleves i forbindelse med disse utfordringene, og om tankene før veiledningen får en betydning under veiledningen. Dette vil sette oss bedre i stand til å hjelpe og veilede foreldre som står i vanskelige situasjoner.

Hva innebærer deltagelse?

Studien består av to deler.

Alle foresatte deltar i del 1, som innebærer et foreldreskapsintervju. I intervjuet spør vi om tanker, følelser og utfordringer knyttet til foreldreskap, barnet og samspill. Intervjuet gjennomføres av behandleren din. Intervjuet analyseres og avhengig av refleksjoner og tanker som kommer frem vurderes det om du får tilbud om å delta i del 2 av studien.

Hvis du blir med i del 2, får du tilbud om Marte Meo veiledning, som gis av sertifiserte terapeuter i teamet. Etter avsluttet veiledning blir du intervjuet om dine erfaringer og opplevelse av hvordan metoden har vært for deg. Veiledningen omfatter minst tre ganger en kort filming og etterfølgende veiledningssamtale. Tema i veiledningen vil være tilpasset deg og ditt barns behov.

Hvis du deltar i studien og ikke blir utvalgt til del 2, så vil du få oppfølging og behandling på vanlig vis.

Mulige fordeler og ulemper ved å delta
Som forelder til et lite barn som er pasient på ABUP kan du kjenne deg sårbar i denne situasjonen. Samtidig kan det oppleves positivt å bidra til kunnskap som hjelper i behandling av familier med sped- og småbarn. Jeg håper at du kan oppleve at du og erfaringene dine er viktige.

I del 1 av studien, så er selve intervjuet en del av det ordinære behandlingstilbudet som alle foresatt får. Intervjuet varer i ca. 1 ½ time. Tidspunkt for intervjuet legges til rette etter hva som passer for deg. Det vil bli brukt en lydopptaker eller filmopptak.

Hvis du blir valgt ut til del 2 av studien, får du tilbud om Marte Meo-veiledning. Dette innebærer minst tre ganger filming av samspill hjemme hos deg eller på ABUP om du ønsker dette. Selve filmingen tar ikke mer enn noen få minutter. Så får du veiledning på filmene på ABUP. Veiledningen blir tatt opp på film. Noen foreldre opplever det som ubehagelig å bli selv filmet. Vi kan ta hensyn til det ved å hovedsakelig ha fokus på barnet eller veilederen, slik at du selv kommer minst mulig på film. De fleste foreldre opplever også at det er mindre ubehagelig å bli filmet enn de på forhånd trodde. Etter at veiledningen er avsluttet, vil du bli bedt om et intervju til, som varer ca en time. Tidspunkt for dette legges til rette etter hva som passer for deg. Det kan tas hjemme hos deg eller på ABUP. Det vil bli brukt en lydopptaker.

Frivillig deltakelse:
Studien er frivillig å delta i. Du kan når som helst trekke deg som informant uten videre begrunnelse og uten at det vil påvirke det behandlingstilbudet du får fra ABUP, også hvis du først har gitt tillatelse. Dersom du ønsker å delta undertegner du samtykkeerklæringen på siste side. Dersom du har spørsmål til studien eller ønsker å trekke deg, kan du kontakte Indra Simhan, 38177400/45091574.

Datamaterialet/mer informasjon
Datamaterialet avidentifiseres slik at det ikke kan knyttes til konkrete personer i studien og oppbevares konfidensielt på Forskningsavdelingen på Sykehuset. Det blir slettet etter studieslutt.

Rett til innsyn

Hvis du sier ja til å delta i studien, har du rett til å få innsyn i hvilke opplysninger som er registrert om deg. Du har videre rett til å få korrigert eventuelle feil i de opplysningene som er registrert. Dersom du trekker deg fra studien, har du rett til å kreve innsamlet materiale slettet.

Økonomi
Det er ingen økonomiske ytelser eller interesser knyttet til studien.

Utfallet av studien:
Deltakerne har rett til informasjon om utfallet til studien. Kontakt i så fall Indra Simhan, Telefon 38076200. Epost: indra.simhan@sshf.no

SAMTYKKE TIL DELTAKELSE I STUDIEN

Jeg er villig til å delta i studien. Jeg bekrefter å ha fått informasjon om studien.

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(Signatur av prosjektdeltaker, dato)

Jeg bekrefter å ha gitt informasjon om studien

……
(Signatur av behandler, dato)

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