Practitioner experiences of delivering Video Interaction Guidance with caregivers and infants: Toward Culturally Competent Care

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ABSTRACT

Recent reports and research have highlighted systemic racism and cultural insensitivities within maternal and perinatal services, causing harm to those using services and impacting access and engagement within care. Video Interaction Guidance (VIG) has gained an early evidence base and is rising to prominence within perinatal services. This is a relationship-based intervention that incorporates feedback of recorded clips of positive and attuned interactions between caregiver and child. Addressing cultural competence within VIG practice is pertinent to delivering effective, ethical care, that benefits all families.

The qualitative study explores VIG practitioners' experiences of working with caregivers and infants and how they deliver culturally competent care. A reflexive thematic analysis of interviews with practitioners ($N = 9$) working within perinatal and parent-infant services yielded two themes (each with three subthemes): *the VIG diamond*, and *missing families and untold stories*.

The findings suggested that VIG practitioners' practice can promote cultural competence, whilst aspects that hinder cultural considerations within their work also affect who is able to receive and benefit from the intervention. Implications for future research, practice and training, and policy are discussed.

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LIST OF FREQUENTLY USED ABBREVIATIONS

UK: United Kingdom

NHS: National Health Service

PHE: Public Health England

NICE: National Institute for Health and Care Excellence

DOH: Department of Health and Social Care

VIG: Video Interaction Guidance

RTA: Reflexive Thematic Analysis

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1. INTRODUCTION

1.1. Overview

This section will outline prior research into the importance of caregiver and infant relationships, with a focus on infant development, caregiver mental health and the role of cultural factors in shaping experiences within the perinatal period. The section begins by introducing the key constructs used within the study to contextualise them within previous research and the current research. A summary of the research evidence of the importance of caregiver-infant relationships, and the context underpinning psychological interventions offered within the perinatal period will then be outlined, alongside the theoretical underpinnings for the research. Following this, a literature review will provide context for the current study. The research aims and questions will then be outlined.

1.2. Constructs and Terminology

The constructs outlined below introduce the reader to the terminology adopted within the study regarding the topic, related to the perinatal period, and culture and cultural competence. The definitions identified are not intended to be comprehensive. However, they provide a rationale for the choice of language used within the study, appraise the constructs, and to familiarise the reader with the philosophical position adopted by the researcher. Since the researcher’s personal position in relation to these constructs can shape how they are experienced, the researchers position to the current study is explored in section 2.8 and 4.7.

1.2.1. <u>The Perinatal Period</u>

The notion of the perinatal period is contested, and differing definitions have been used in research and practice. Prior researchers have considered this time period to incorporate pregnancy up until 12 months post-childbirth (e.g. Garcia & Yim, 2017; Smythe et al., 2022). However, Health Education England (2023) have considered that the perinatal period denotes to pregnancy and up to 24 months following birth. Furthermore, the NHS Long Term Plan set out that specialist perinatal mental health services will be offered at the beginning of pregnancy to 24 months following birth (NHS, 2019b). This is in accordance with the goals set up by the All Party Parliamentary Group for Conception to Age 2 (2015) for women and children, during the 1001 critical days of an infant's life. Considering this period to include infants up until 24 months is in line with multiple organisations who have emphasised the importance of the period between conception and the first few years of life (Marmot, 2020; PHE, 2016; Unicef, 2019; WHO, 2020). The definition adopted in the current study considered the period to include pregnancy and up until 24 months post child-birth. This supports producing findings that have practical implications and relevance for clinical care.

1.2.2. Gender, Sexuality, And Parenting

Cisnormativity refers to the assumption that everyone's gender identity is consistent with the gender they were assigned at birth, i.e. that everyone is cisgender (James-Abra et al., 2015). Heteronormativity refers to the assumption that heterosexuality is the 'norm' and the singularly appropriate sexual orientation (Chase & Ressler, 2009). These assumptions are imbedded throughout perinatal services, and research and theoretical constructs (Kirubarajan et al., 2022; Pezaro et al., 2023) that will be drawn upon in this study. Gendered-neutral language, such as parent or caregiver will be adopted alongside the terminology associated with the hetero-cis–normative assumptions of 'womanhood' (Green & Riddington, 2020). This is to recognise and avoid upholding the marginalisation of those who identify as LGBTQI+, whilst also representing what was reported in previous studies.

1.2.3. Perinatal Mental Health

Some researchers have postulated mental health difficulties during the perinatal period may be distinct from those developed outside this time period (Putnam et al., 2017), perhaps as aetiology and course of difficulties can closely tie with experiences associated with pregnancy and birth (O'Hara & Wisner, 2014; Smythe et al., 2022). Perinatal mental health difficulties generally refer to diagnosed mental health disorders or symptoms of mental health difficulties that occur during the perinatal period, most commonly anxiety and depression (Howard & Khalifeh, 2020; O'Hara & Wisner, 2014). This definition will be adopted as it is in accordance with clinical services (NHS, 2019b). This is further discussed in section 1.3.1.

1.2.4. Culture

Culture has been considered a somewhat fluid, social-political, time and context dependent construct (Senior & Fleming, 2006); and as meanings are interpreted differently and shaped over time, it can be difficult to find a consensus. Torales and González-Urbieta (2020) defined culture as a learnt "set of norms, beliefs, values and customs that are shared by a group of individuals" (p. 180). Geographical location of birth, country of residence, ethnicity, 'race', religion or spirituality, sexuality, gender and class all may influence what is considered to be someone's culture (Fernando, 2010; Lago, 2011).

Cultural experiences can shape the development of a world-view, which frames how social features or experiences within society are constructed, understood and judged according to a hierarchy of perceived value (Patel et al., 2000). The hierarchical operation of power and the influence of structural discrimination on people's experiences needs to be considered in the experience of culture and cultural differences (McClaren, 1994). Identifying and recognising inequalities of power can thus challenge the normalising of what is perceived as the 'dominant' cultural norms and the problematising of that which is deemed not to fit within that narrative.

1.2.5. 'Race' and Ethnicity

The two constructs of 'race' and ethnicity are often mistakenly interchanged, and thus it is important to clarify what these constructs refer to. 'Race' is a socially constructed set of categories with no biological basis, that often refers to human physical characteristics, such as skin tone or visible features (Fernando, 2010). Racial categories were initially enacted by White European scientists and scholars to uphold and exert systems of socio-political and economic power (Ryde, 2019). Thus, the concept of 'race' is directly linked to racism. Fernando (2010) considered ethnicity to have a more fluid definition, "taken to mean…a mixture of cultural background and racial designation, the significance of each being variable" (p. 14), the emphasis of the latter related to the levels of racism in that society. Ethnicity has been used in derogatory ways to 'other' people, by using these terms to define what is in deemed to be 'the norm' and what is considered 'different' from this (Fernando, 1991). However, considering different ethnicity categories on a wider level may be beneficial in some circumstances, such as for statistics for monitoring of inequality

(Fernando, 2010). Although if used in this way, personal experiences cannot be directly inferred from these categories.

1.2.6. Whiteness

Whiteness is directly linked to the construction of ‘race’ and a racialised hierarchy, as it creates the conditions that others, marginalises, subjugates and discriminates against those deemed to be the ‘Non-White’ other (DiAngelo, 2018). An awareness of the historical legacy and current operation of whiteness, and how Western institutions contribute to whiteness, and maintain structural inequalities that disproportionately and harmfully affects people who are racialised, is necessary for anti-racist practice (Nylund, 2006). The operation of whiteness, regarding the consideration of cultural factors in psychological research, ideas and practice will be considered in the backdrop throughout this study.

1.2.7. Intersectionality

Intersectionality is a term coined by Kimberlé Crenshaw (1989) to bring to light the lack of legal recognition of the experience of discrimination from the combined impact of racism and sexism among Black women. It has since been used to describe the layers of discrimination and inequality associated with different aspects of identity that can lead to complex and cumulative experiences of disadvantage, social inequality, and systemic and structural injustices (Crenshaw, 1989).

Burnham (2012) introduced a framework that incorporated the consideration of social position and power across multiple held identities (Gender, Geography, Race, Religion, Age, Ability, Appearance, Class, Culture, Ethnicity, Education, Employment, Sexuality, Sexual orientation, Spirituality). Whilst it is important not to flatten human identity into discrete categories, the approach can suggest how positions of power and disadvantage may be simultaneously interacting to inform someone’s lived experience, which includes aspects related to culture.

1.2.8. Culturally Competent Practice

Culturally competent practice has been posited to refer to both understanding how practitioners’ own set of cultural values and belief systems influence assumptions, as well as having the knowledge and skillset to understand their clients’ culture (Torales

& González-Urbieta, 2020). It involves the appreciation of and attentiveness to both similarities and differences between the practitioner and service user, from the perspective of the client (Newland et al., 2015). This is notably different from how 'cultural competence' has been used to describe the process of accumulating cultural knowledge through education or training, that has been associated with stereotyping (e.g. Dogra et al., 2007). It does not refer to a static achieved state, as all encounters within a therapeutic interaction can be deemed cross-cultural (Comas-Díaz, 1988). It is similar to other notions such as cultural humility, which has been defined as "a process of self-reflection on one's cultural identity and biases in order to build respectful and trusting relationships" (Yeager & Bauer-Wu, 2013, p. 1). Huey et al. (2014) noted that 'cultural competence' lacks a consistent definition across psychotherapy research, and grouped how culturally competent practice is researched according to three distinct but related ways of attending to clients' cultural needs: according to practitioner specific skills (e.g., Sue et al., 1982), by systematically adapting interventions (e.g., Lau, 2006), and attending to intervention processes (e.g., Lopez, 1997).

Cultural competence and culturally competent practice will be used to refer to the way in which practitioners can recognise their own cultural experiences and biases, in addition to knowledge and understanding of the cultural needs of the caregiver and family worked with (Pedersen, 2002). This may include knowledge of cultural contexts, values and power systems (Hays, 2001). The researcher acknowledges that this is an ever-evolving process of both acquiring the knowledge and skills to work with people. Given the multifaceted, unique and complex nature of human experiences it is both unrealistic to expect, and not the intention to, require all knowledge about all experiences i.e., competence is never 'achieved' through an artificial exercise of knowledge application. Rather, it refers to continuous growth and development of practitioners' skills, knowledge and understanding that enables curious, fluid and flexible discovery and reflection alongside the client. This is the lens through which culturally competent practice will be considered in this research.

1.2.9 Terminology

As mentioned, the term parent or caregiver will be adopted to refer to an adult who has responsibility for caring for the infant or child. Where a gendered term for caregiver is utilised by prior researchers or participants, this will be adopted to accurately represent what is being conveyed. The term ‘racialised’ will be used to denote to the act of constructing a ‘race’. Although ‘race’ and/or racial categorising will not be considered in detail in this study (and addressing the impact of racism within healthcare is in of itself a vital task that requires specific focus), this research will consider the influence of the process of racialisation and experience of racism within the perinatal context. Ethnicity category will be referred to when known, and the term ‘minoritised’ will be used to recognise that what is considered to be a minority ethnic group is dependent on perspective (Patel et al., 2000); often positioning people belonging to ethnic groups common to the Global North as the dominant. Culture is used to refer to the multifaceted intersections of identity and experiences as defined previously (rather than incorrectly applying it as a means to group or categorise). Cultural competence and culturally competent practice is used to refer to the process of practitioners tapping into their own personal cultural experiences and their awareness, knowledge and skills to consider clients’ cultural experiences within their work.

1.3. The Perinatal Period and Transitioning to Parenthood

This section will outline the literature examining the importance of this time period for the caregiver and infant development. The context of support services in the UK, and the experienced inequalities in access and treatment within NHS services will be discussed. Research suggests that core aspects of infant development in the perinatal period form the fundament on which future skills are achieved. Brain development and neuronal growth is most active in-utero and the first to third years of life, which are important for building the foundations for later cognitive, emotional, and social skills (Ilyka et al., 2021). Brain architecture is shaped through repeated iterative interactions between infants and their caregivers (Balbernie, 2001; National Scientific Council on the Developing Child, 2012). Consistent exposure to high stress, that in extreme instances is associated with abuse or neglect of infant emotional or physical needs, has been proposed to bolster the activation of the infants’ stress response system (a neuronal network responsible for regulating stress) (Nelson et al., 2020; Teicher, 2002). Experience of prolonged stress in infancy has been linked to weaker immune systems (Elwenspoek et al., 2017), difficulties with memory and learning, difficulties managing mood or emotions in childhood (Bucci et al., 2016), as well as physical and mental health difficulties in adulthood (Nelson et al., 2020). The brain development literature has been criticised for being overly biologically deterministic and politicised (Macvarish et al., 2014; Peckover, 2019). Whilst infant development is highly dependent on the caregiver-infant interactional environment, failing to recognise the role of wider societal issues, such as inequality and poverty leads to individualist, blaming narratives (Macvarish et al., 2014; Peckover, 2019).

1.3.1. Perinatal Mental Health

Approximately 20% of women develop mental health difficulties during pregnancy or within the first year of their infant's life (Fisher et al., 2012; National Maternity Review, 2016; Royal College of Obstetricians and Gynaecologists, 2017). However, prevalence and incidence data have inconsistent findings, perhaps due to the wide-ranging nature of the difficulties and underreporting of needs that can develop during this time (Hansson et al., 2013). Data on partners has mostly focussed on fathers, and suggest that around 10% experience perinatal depression (Cameron et al., 2016; Paulson & Bazemore, 2010) and around 10% experience perinatal anxiety (Leach et al., 2016). Paternal depression has been found to correlate with partner depression (Cameron et al., 2016) and can influence both mothers' mental health and child outcomes (Munk-Olsen et al., 2007; Sweeney & MacBeth, 2016). Research suggests that poor perinatal mental health, such as anxiety and depression can inadvertently affect a caregivers' capacity to provide warm, responsive and sensitive care that fosters healthy development (Mitchell et al., 2019; Nakić Radoš, 2021; O'Higgins et al., 2013). Despite appearing to be a risky time for the development of mental health difficulties, the association between caregiver mental health difficulties and infant outcomes do not exist in isolation. Contextual factors associated with structural inequalities such as racism, poverty, belonging to a minoritised gender, experiencing gendered violence, poor housing, education or social support can contribute to mental health difficulties and can make it very difficult to provide the physical and emotional care needed during infancy (Howard & Khalifeh, 2020; PHE, 2017). Thus, a holistic approach may be needed to support caregivers who are struggling with mental health difficulties, to help facilitate an environment that is meeting their own and the infant's needs.

1.3.2. UK Statutory Services For Caregivers Within The Perinatal Period

Midwifery and health visiting services, together with medical care available to the general population (e.g. NHS 111, General Practitioners), offer statutory support during pregnancy and in the first few years of life (DoH, 2009). Practitioners with direct contact with families during the perinatal period (e.g. health visitors, midwives and social workers) are in a key position to identify those struggling with their mental health and refer on to appropriate services (e.g. NHS specialist community perinatal mental health teams or talking therapies, for anxiety and depression services; DoH, 2015; PHE, 2020a). Perinatal mental health services specifically offer mental health support for caregivers, the caregiver-infant relationship, and also support with planning for pregnancy for women with mental health problems (NHS, 2019b; PHE, 2020a).

Perinatal mental health services are a relatively new service development in the NHS. The development of perinatal mental health services across England started in the Five Year Forward View for Mental Health (Mental Health Taskforce, 2016). An investment of £365 million pounds was put into the system to create specialist community and inpatient mental health services for infants and caregivers between 2016 to 2020, and aimed to support 5% of the birth population (Gov.UK, 2016). This was further developed in the 'NHS Long Term Plan' (NHS, 2019a), which proposed to expand perinatal mental health services and enable 10% of the birthing population (an additional 66,000 women) with 'moderate to severe mental health difficulties' to access specialist support up to 24 months after their birth. It also set out to increase provision of 'specialist' parent-infant support, for partners to receive support in the community, and provide greater accessibility of 'evidence-base' psychological therapies (NHS, 2019a). Whilst plans are in place to improve the perinatal and maternity service offer, the current experiences of discrimination, leading to inequalities and difficulties accessing services during the perinatal period need further exploration, in order to adequately improve services.

1.3.3. Racism, Discrimination and Inequalities in UK Statutory Perinatal Services

Contextual factors shape how caregivers, infants and families experience services, such as the NHS during the perinatal period. Institutionalised racism has been reported in NHS care; for example risk of dying from childbirth is over four times greater in women from Black ethnic groups and nearly two times greater in women from Asian ethnic groups (Knight et al., 2021). An investigation of the racial injustice and human rights of women receiving UK maternity care revealed that women felt unsafe, ignored or not believed by medical staff "at least in part a consequence of racism" (Birthrights, 2022, p. 11). Other reports suggest that healthcare professional's negative attitudes, poor knowledge, and biased and stereotypical assumption, plague Black women's (Awe et al., 2022) and Muslim women's (Gohir, 2022) experiences of UK maternity services. Families have similarly reported feelings of being misunderstood, mistrusting of professionals, and hesitant to access support due to cultural insensitivity and language barriers in early years services (HM Government, 2021). In addition, minoritised women are underrepresented within perinatal mental health services, and report perceiving them as unsafe spaces and/or culturally inappropriate (Kapadia et al., 2022; Watson et al., 2019). Interviews with midwives about their care towards childbearing trans and non-binary people showed microaggressions, transphobic attitudes and assumptions (associated with cisnormative and heteronormative beliefs) are likely common experiences (Pezaro et al., 2023). These experiences of marginalisation and discrimination are examples of how caregivers and infants experience unequal care during the perinatal period.

Another factor to consider is that pregnancy and the early years were difficult for families during the Covid-19 pandemic. Lockdowns, isolation, and Covid-19 infection during pregnancy increased stress, perinatal mental health difficulties, and affected relationships with families and their infants and access to services (Kotlar et al., 2021; Saunders & Hogg, 2020). Whilst trying times for everyone, families from minoritised ethnic groups and lower incomes were more likely to be adversely impacted by the Covid-19 pandemic. For example, the 'Babies in Lockdown' survey reported that "fewer Asian/British Asian and Black/Black British respondents felt they had the information they needed during pregnancy or after birth compared to White respondents" (Saunders & Hogg, 2020, p. 14). Parents with a household income under £16k were found to report the highest anxiety levels due to Covid-19 and the lockdowns compared to their peers who had a higher income (Saunders & Hogg, 2020). Thus the Covid-19 pandemic further exacerbated the UK's entrenched disparities in the outcomes for children in the early years period (Saunders & Hogg, 2020). The NHS has a crucial role in supporting the health and development of children, during pregnancy and infancy, and more needs to be done to protect, help and support families accessing care.

1.4. Psychological Interventions to Support Caregivers and Infants

This next section sets the context for the current evidence base of psychological interventions within the perinatal period. UK healthcare guidelines (NICE, 2012) promote a preventative approach, and intervening as early as possible, to support the system around the child to create an environment that fosters healthy development. Relatively unique to the structure of NHS services, interventions offered in the perinatal period are *tiered* depending on identified need, due to the recognition of the huge benefits of intervening early to both mental and physical health, as well as positively impacting economic costs (DoH, 2009; PHE, 2020b). Thus, psychological interventions to support the parent-child relationship mirror this tiered system (Butterworth et al., 2019). This can range from: intervening at a socio-cultural systems level such as through universal, preventative interventions targeting stigma (Bronfenbrenner, 1979); to supporting services in their delivery of trauma-informed, containing, reciprocal (e.g. Solihull approach; Douglas, 2010) and culturally responsive care (Nelson & Mann, 2011). A more intensive offer, such as psychotherapy can then be provided to those struggling with their mental health and with their relationship with their baby; in some cases specific interventions focussed on supporting the caregiver-infant relationship may better facilitate relational improvements than adult mental health interventions (Butterworth et al., 2019).

Caregiver-infant interventions are a relatively new addition to the field of evidence-based psychological support. Programmes that focus on supporting caregiver sensitivity and oriented within attachment theory (see 1.5. for definitions and information about constructs) were highlighted as particularly effective on both improving the caregiver-child relationship and infant cognitive development (Broberg, 2000; Jeong et al., 2021; Rayce et al., 2017). They also have been found to improve social, developmental and health outcomes in infants and can benefit caregiver skills (Jeong et al., 2021; Mountain et al., 2017). Some caregiver-infant interventions that aim to target caregiver sensitivity utilise recorded interactions of caregiver and child within the intervention. For example, through incorporating video clips into their intervention (such as Circle of Security; Mercer, 2015), or utilising feedback of recorded clips of caregiver-child interactions as a therapeutic tool, such as Watch, Wait and Wonder (Tucker, 2006), Video Feedback Intervention to Promote Positive Parenting (VIPP; Juffer et al., 2018) and Video Interaction Guidance (VIG) (Kennedy et al., 2017).

Video-feedback approaches have acquired a good early evidence base. In their literature review, Bakermans-Kranenburg et al. (2003) found that interventions that focused on behaviour and used video to feedback on caregiver-child interactions were more effective at improving caregiver sensitivity, but less effective at improving attachment security, than those not using video (Bakermans-Kranenburg et al., 2003). A later review examining the effectiveness of parenting intervention studies, utilising Randomised Control Trial (RCT) design, in improving attachment security did not replicate this finding; although video feedback was considered to be a useful tool commonly used in interventions to effectively foster attachment security compared to controls (Wright et al., 2017). However, as the authors noted, prior studies were missing from the review as they did not utilise RCT methodology. Perhaps considering a greater range of the evidence-base can clarify the conflicting findings.

A meta-analysis also looked into the use of video-feedback methodology for parents and children aged 0-8, and found that video-feedback improved positive parenting attitudes, stress, skills and behaviours, and general child development (Fukkink, 2008). Of course, due to the multifaceted nature of the interventions, such as disparity in theoretical underpinnings, methods and measurements of outcomes, the video aspect cannot be isolated as the key contributor to these changes. A review found video-feedback interventions (aimed at children aged 0-5) lead to improvements to parent sensitivity in comparison to no intervention or a control group, however improvements to attachment security were mixed and there were no improvements to child behaviour outcomes or parental stress or anxiety (O’Hara et al., 2019). Whilst further research is needed to clarify the inconsistencies in parent and child outcomes in prior studies, the findings suggest that interventions using video-feedback method are effective in supporting the development of caregiver sensitivity and may benefit attachment. The video-feedback intervention, VIG will be briefly introduced in the next section.

1.4.1. Video Interaction Guidance

VIG is a behaviourally-based video-feedback intervention underpinned by attachment theory and caregiver sensitivity, to bolster caregiver-child communication and relationships (Kennedy et al., 2011, 2017; see section 2.5 for more information on the approach). Video feedback interventions such as VIG are recognised by UK public bodies as an efficacious, evidence-based intervention; NICE (2012, 2015) guidelines recommend implementing video feedback approaches with caregivers in the postnatal and early years (under 5 years) period, to support with difficulties in caregiver sensitivity and/or infant attachment, or for children who are at high risk of going into care, are in care, or are adopted.

A systematic review of 22 studies examining the effectiveness of VIG, found that all studies reported positive child outcomes (e.g. emotional availability, corporation, responsiveness and behavioural changes) and improvements in those that measured caregiver-child relationships (e.g. bonding, attunement and attachment; Dodsworth et al., 2021). In terms of caregiver specific outcomes, consistent improvements were found in parental sensitivity, shifts in parenting beliefs, motivation and reflective skills. However parental stress did not significantly improve across all studies (Dodsworth et al., 2021). Two studies have examined whether VIG can effectively reduce intrusiveness (caregiver behaviours that are controlling and directive over child behaviours; Diemer et al., 2021) and found no significant improvements post-intervention (Hoffenkamp et al., 2015; Lam-Cassettari et al., 2014). This outcome may be associated with the finding that cultural context may influence whether parent intrusiveness leads to positive or negative child emotional outcomes (Diemer et al., 2021). Hoffenkamp et al. (2015) suggested that perhaps the negative parenting behaviours that are associated with emotional or behavioural difficulties for children (e.g. anomalous or harsh physical discipline; Madigan et al., 2006; Skibniewski-Woods, 2017; Wiggers & Paas, 2022) may be less likely to change in VIG as they are not the focus of the intervention. Further research is required to elucidate the influence of VIG on various caregiving behaviours.

1.5. Theoretical Framework

The next section outlines the chosen theoretical framework that underpins the research findings outlined in the previous sections, and will shape the development of the research.

1.5.1. Attachment theory

Bowlby (1969) developed attachment theory to define what he coined as a universal relationship-based system between infants and a consistent caregiver, namely the mother, which develops from around 6 months to 2 years (Prior & Glaser, 2006). The protective factors of attachment were thought to be biologically underpinned to ensure infant survival, seeking to elicit proximity from the caregiver, for food, shelter or emotional support and comfort in times of stress (Bowlby, 1988; Levine & Heller, 2010). Bowlby (1997) proposed that an 'internal working model' is developed based on early attachment experiences, and is used to articulate and interpret all future relationships, feelings of trust in others, social skills and self-worth. Thus, the development of a secure attachment relationship could explain the protective nature of the caregiver-infant relationship in both current and long-term infant development.

The short- and long-term benefits of attaining a secure attachment, compared to an insecure attachment, has been supported by a wealth of research (e.g. Cassidy & Shaver, 2018; Groh et al., 2017; Howe, 2011). Studies have suggested that attachment security is associated with increased brain development (Leblanc et al., 2017), physiological, psychological and social outcomes and mental health in children (Feeney, 2000; Goldner & Scharf, 2013; Howe, 2011; McLaughlin et al., 2012; Ranson & Urichuk, 2008). Conversely, insecure attachment has been found to have a negative influence on children's neurological, physical, psychological and emotional development and function (Newman et al., 2015; Ranson & Urichuk, 2008). Attachment difficulties in adulthood have also been associated with difficulties within relationships, within parenting, and with mental health or physical health (Calvo & Bianco, 2015; Candel & Turliuc, 2019; Howe, 2011; Pietromonaco & Beck, 2019). Although, attachment style can change over time (Fraley, 2019) and thus it is important not to adopt a determinist approach.

Whilst it is beyond the scope of this research to delve into all underpinning mechanisms and processes set out in attachment theory, several constructs have been proposed to be important predictors of attachment security during the perinatal period and future long-term development (Butterworth et al., 2019; Planalp et al., 2019). These include cognitive constructs such as mind-mindedness (caregivers' understanding that infants have separate minds and intentions of their own; Meins et al., 2012) and mentalisation and reflective function (caregiver's ability to interpret infant psychological and emotional mental states; Fonagy et al., 1991), and caregiver sensitivity (Ainsworth et al., 1978). The latter of which will be further explored below.

1.5.2. Caregiver Sensitivity

According to attachment theory, infant attachment security is influenced via parenting skills and behaviours. These were initially outlined by Ainsworth et al. (1978) who developed a method of assessing the attachment relationship and categorising the style of attachment. From her study observing mother-infant interactions in Baltimore, USA and Uganda, Ainsworth et al. (1978) suggested that maternal-infant interaction quality and sensitivity may predict attachment security. This led to the construct of caregiver sensitivity, widely postulated to represent caregiver's skill to understand infant behaviour and respond congruently (Ainsworth et al., 1978). Much of the research has linked this construct to the development of healthy attachment and social development (Sroufe, 1997; Wright & Edginton, 2016). However, statistical modelling studies have also found that caregiver sensitivity does not account for all variation in attachment style (Verhage et al., 2016). Thus, other facets of caregivers' behaviours or experiences may be influential in the development of attachment.

Additionally, observational assessments of caregiver sensitivity (Mesman & Emmen, 2013) may not adequately capture all aspects of the phenomenon. Caregiver sensitivity has been thought of by some as an umbrella construct that encapsulates other facets of the caregiver-infant relationship considered to be important, such as contingency, reciprocity and responsiveness (Dunst & Kassow, 2008). Similarly, the concept of *attunement* has been used in parallel with the construct of sensitivity to explain similar ways in which caregivers are responsive to their infant's cues, and their ability to interpret them, and respond appropriately (Bornstein, 2012;

Butterworth et al., 2019). Perhaps diversity in the constructs used across attachment literature may lead to difficulty in objectively measuring and observing facets of caregiver-infant interactions, and may explain the missing variance in the caregiver-infant relationship that is associated with secure attachment. Another reason may be to do with the limitations of its application cross-culturally.

1.5.3. Cultural Variation in Attachment Theory and Caregiver Sensitivity

There is a current debate in the attachment literature about cultural variation within sensitive caregiver behaviours, which calls into question the universality of the theory. The construct of sensitivity is based on the model of childcare emerging from cultural assumptions held amongst Western scientists (Keller & Kärtner, 2013; Keller, 2018). For example values prioritised in current attachment literature relate to a hierarchy of relationships and style of interacting through verbal, vocal, face-to-face, distal communication found in Western, middle-class families (Stern, 1974). It has been suggested that caregiver-infant communication in contexts such as 'traditional rural farming households' can have greater dependence on the body and physical proximity (Keller et al., 2009; Schmidt et al., 2023). Although, the observational research has also found there are overlaps in how caregivers and infants respond to each other in different cultural contexts (Keller et al., 2009). Whilst the authors considered this to be due to the specific task that was employed in the study, the finding suggests that it cannot be inferred that discrete categories and interactions depend on cultural group, and it is likely that there is variation within and across cultural contexts (Lewis, 1972). It is important to note that literature mostly focusses on the mother's role, suggesting this relationship underpins successful infant development (Keller & Chaudhary, 2017). However, caregiver-infant relationships can also exist within larger networks, and with key caregivers also including grandparents, uncles, aunts, and siblings for example (Lancy, 2014; Schmidt et al., 2023). Thus, the emphasis on the events within a mother-infant interaction is not always relevant. Taken together, what has been operationalised as 'caregiver sensitivity' may not be a universally applicable construct.

Research has explored whether the construct of attachment and sensitivity holds outside of the original cultural milieu in which it was developed. Maternal sensitivity has been associated with attachment in a study using urban and rural samples in

Mexico (Gojman et al., 2012), urban samples of middle class mother-infant dyads from Colombia (Posada et al., 2002), middle class families in Japan (Miyake et al., 1985), and mother-infant dyads from South Korea (Jin et al., 2012). Whilst this suggests cross-cultural acceptability of these constructs, it is important to note that these findings may be influenced by an exposure to western values amongst urban and middle-class families. A study examining caregiver sensitivity within the Dogon community in Mali found the link to attachment style was not significant, suggesting that the constructs did not transfer well (True et al., 2001). More recent evidence has suggested that caregiver sensitivity was found in rural communities in Peru, Indonesia, Kenya and Yemen, but varied from the majority of the urban samples examined (Mesman, 2021). Urban samples from Brazil, Indonesia, and Iran tended to have similarities to what is observed in the West (Mesman, 2021). These findings suggests that some sensitive caregiving behaviours may be universal due to the evolutionary pressures of keeping an infant alive; however behaviours classified as 'sensitive caregiving' may differ depending on cultural values and experiences (Cheung & Elliott, 2016; Grossmann & Grossmann, 2021; Mesman et al., 2018). Given these limitations, an alternative model would be useful to conceptualise these competing positions.

1.5.4. The Cultural Approach To Parenting

Bornstein's (2012) 'cultural approach to parenting' model is intended to explain some of the similarities and difference observed in the cross-cultural attachment literature. It also provides a framework that can be implemented to understand how to work with caregivers and infants across cultures. Aspects of caregiving that have been observed to have the same form (parenting cognition and/or behaviour) and function (meaning or intended outcome) could be considered to be universal (Bornstein, 2012). For example, physical caregiving of infants to protect them from danger or threats in the environment (Lansford, 2022) and caregiver vocalisations to increase infant vocalisation (Bornstein et al., 2015). However, caregiving behaviours with different form and function have also been observed across cultures, suggesting aspects of parenting may depend on the values or goals prioritised within a cultural context (Bornstein, 2012). For example, orienting towards an infant (form) to develop interdependence within mother–infant relationships (function) and the orientation of an infant towards a third party object (form) to develop exploration, independent from mother (function) (Bornstein et al., 2012). This suggests that caregiving can also be shaped within the norms and values of a cultural context. Without appreciating this, it can lead to mistakenly approving certain behaviours and/or misunderstanding others. Caregiving behaviours may also have the same form but lead to a different function, as indicated from research that found caregiver intrusiveness or control has different influences on child emotional outcomes across cultures (Diemer et al., 2021; Dwairy & Achoui, 2010). In addition caregiving behaviours can have a different form but the same function, as suggested by research finding different behavioural signifiers of 'maternal warmth' across cultures (Cheah et al., 2015). Considering the nuances within caregiving behaviours can bring an awareness about what cultural aspects of sensitive caregiving are influencing the caregiver-infant relationship and attachment. Not only is this vital for reducing bias in the development of theory and research, but also in clinical practice, to support caregivers and infants to develop the relationship that is appropriate within their cultural context.

1.6. Scoping Review

Much of the literature that has examined the caregiver-infant relationship within the perinatal period, and established interventions to improve the strength of this relationship, draws upon attachment theory and its related constructs. Despite the awareness of some potential differences in aspects of the caregiver-infant relationship across cultures (Bornstein, 2012; Bornstein & Esposito, 2020; Keller, 2018; Mesman et al., 2018), as far as the researcher is aware, it appears to be unclear in prior literature how this translates into the delivery of culturally component evidence-based interventions.

Thus, a scoping review was carried out to identify how previous studies have investigated cultural competency within parenting or parent-child interventions. A scoping review was deemed appropriate as it maps out the extent of relevant literature to ascertain current gaps in a research topic of interest (Arksey & O'Malley, 2005). Accordingly, Arksey and O'Malley's (2005) six stages scoping review framework (pinpointing the research question, finding relevant studies, extracting the data, synthesising the results) was employed when conducting the review. Critical review of the included studies was informed by previously published critical appraisal frameworks (Health Care Practice Research and Development Unit evaluation tool for qualitative studies; Long & Godfrey, 2004; the PRISMA checklist; Page et al., 2021). To identify relevant studies, key terms pertaining to parenting and parent-child interventions, and cultural factors were inputted into the databases PsychINFO, Academic Search Ultimate, Scopus and CINHAL in December 2022. This included ("perinatal period" or "parent child" or "mother child" or "father child" or "caregiver child") AND (intervention or therapy or treatment or program*) AND cultur*. The full search strategy within each database is outlined in Appendix A. Reference lists for identified articles were scanned for eligible studies.

A broad initial search was adopted to set out avenues for further exploration regarding cultural factors and influences in the field of parenting and parent-child intervention literature. Due to the large volume of studies generated, the search terms related to culture were restricted to what is set out in Appendix A to address specific and relevant findings.

Restrictions

- Accessible in English
- Limit to Title, Abstract and Keywords
- Published from 1999-2023

Exclusion Criteria

- No parenting or parent-child focus
- Cultural factors (see section 1.2. for definition of culture) related to an intervention not included
- Specific diagnosis of interest guiding the context of the intervention (e.g., obesity, ADHD, ASD, drug use)

Database searching generated 757 results, which were collated and organised using Zotero (version 6.0.18). Studies examining cultural aspects of parenting or parent-child interventions were collated into the following themes.

- Practitioner perspectives or practitioner-led cultural adaptations
- Caregiver perspectives on culturally adapted interventions

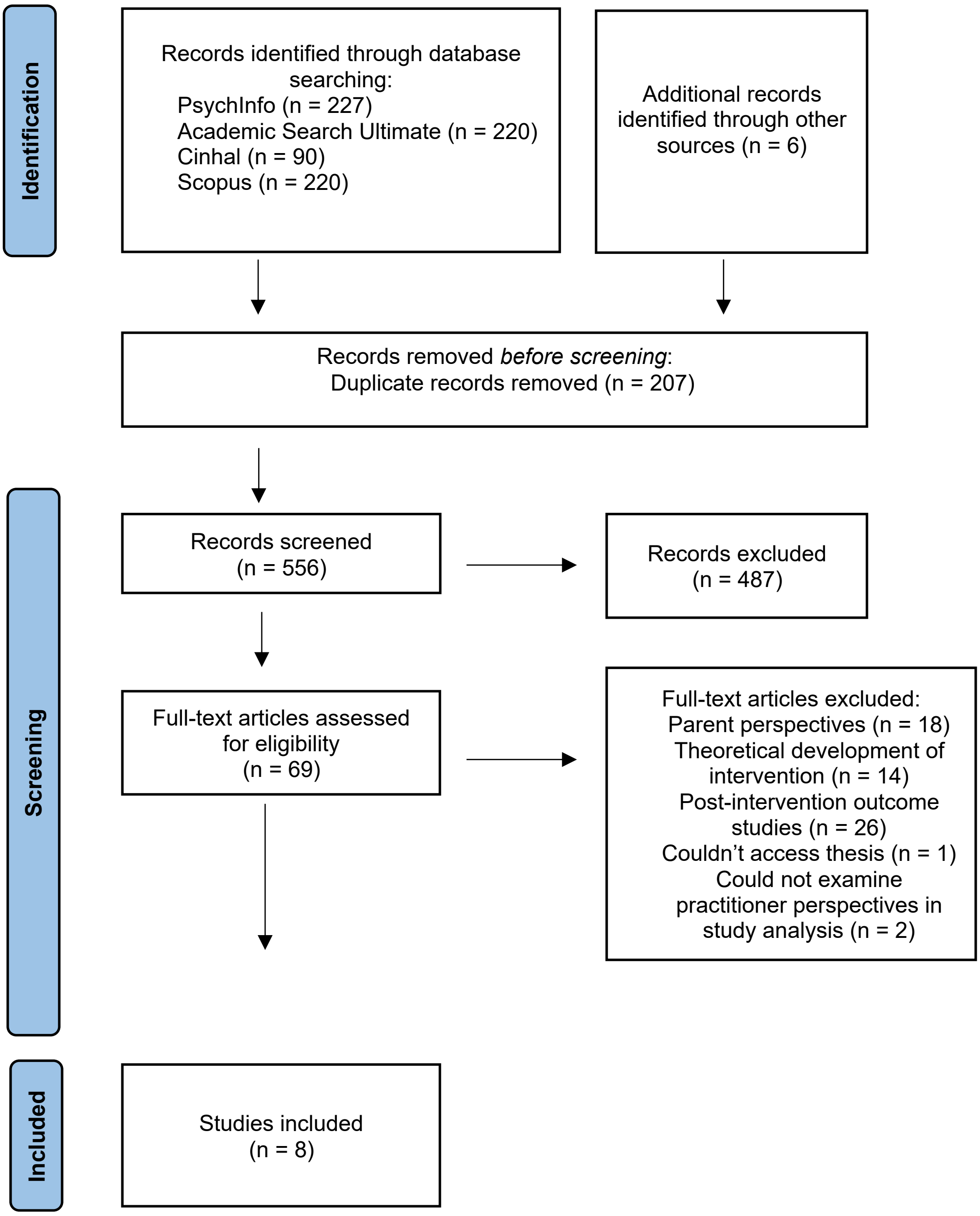
- Theoretical development of a culturally adapted intervention
- Outcomes-based studies following attendance to a culturally adapted intervention

This indicates that practitioners' perspectives of delivering culturally competent parenting or parent-child interventions have been previously examined within prior literature. This places primary responsibility on the practitioners to ensure delivery of the intervention is appropriate for the client and was considered relevant for understanding how practitioners consider culture within the delivery of parenting or parent-child interventions. Thus, exploring how study's that examine practitioners' perspectives of delivering culturally competent parenting or parent-child interventions have been implemented, and what the findings were, became the guiding question of the literature search.

Titles and abstracts were reviewed according to the inclusion and exclusion criteria, as shown in Figure 1. Eight studies met criteria to be included for full review.

Figure 1.

Study selection flow diagram (Page et al., 2021)



1.6.1. <u>Synthesised Themes</u>

1.6.1.1. *Cultural considerations in caregiver-infant interventions*: two studies did not explicitly examine cultural competence, but reflected upon processes involved to consider culture within a parent-infant intervention. Fitton (2008) implemented a single case study research design, and reflected upon the cultural differences between themselves and an 18-year-old mother, in a mostly descriptive account of their therapeutic work and relationship, informed by psychoanalytic theory. Culture was conceptualised as an individualised and personal story, from principles of narrative practice (Laird, 1998), particularly shaped by aspects such as ethnicity and appearance. Reflections upon cultural difference were elicited after reviewing video clips as part of Interaction Guidance (McDonough, 1992) with the mother and infant. A reflexive stance, and awareness of potential exploitative power dynamics, was suggested to negate imposing biased interpretations or personal belief systems onto the client's own cultural experience. Whilst reflections provided rich data of a practitioner's consideration of cultural competence within the context of parent-infant therapeutic interactions, the study was of poor quality: it lacked clear research questions, did not document ethics processes or contain researcher reflexivity, or have transparency around the data collection and analysis processes. Thus, checks against these biases could not be carried out and transferability of findings are limited.

Preston et al. (2019) carried out a qualitative study with focus groups and individual interviews of 11 practitioners delivering Baby Mat, attachment-informed, therapeutic support sessions for caregivers and infants. Practitioner perspectives on cultural competence were asked about among general reflections of the culturally sensitive caregiver-infant intervention (developed within Alexandra Township, South Africa). Thematic analysis suggested that cultural knowledge and sensitivity supported the establishment of the therapeutic relationship, leading to intervention success. Responses suggested this was enabled by co-facilitating sessions with a psychological practitioner and lay counsellor, as it brought together 'Western' psychological knowledge with cultural knowledge of needs within the perinatal period. This appeared to be key in meeting potential differences of caregiver form and function that may lead to incorrect assumptions about the caregiver-infant relationship. The authors considered that knowledge of the cultural information within language use was particularly important. However this notion did not appear to be derived from participant responses and thus this conclusion ought to be treated with caution. Whilst culture was not considered as the main aim, the study suggests that examining practitioner perspectives can offer useful insights into how culturally competent interventions within the perinatal period can be provided.

1.6.1.2. *Ad-hoc adaptations to manualised parenting interventions:* several studies explicitly addressed practitioner's perspectives upon, or decisions regarding, cultural adaptations for structured/manualised parenting or parent-child interventions. Most looked at practice-based adaptations during implementation of the intervention. Luis Sanchez et al.'s (2022) mixed methods study examined how Parent-Child Interaction Therapy practitioners employed practice-based adaptations to serve their clients' clinical or cultural needs in the US, with a focus on Spanish-speaking families. Quantitative data of 314 practitioners suggested that practitioners were significantly more likely to adapt the intervention by adding components, rather than by reducing or disengaging from aspects of the intervention manual. However, speaking English and another language (which was mostly Spanish) significantly predicted practitioners' reduction of content. Although causality cannot be inferred from cross-sectional data, this suggests that access to another language may enable practitioners to adjust aspects of the intervention to better suit the needs of the client. There may also be practitioner language barriers influencing these findings. Practitioner perspectives on adaptations were supplemented in 23 interviews, 9 practitioners spoke Spanish in addition to English. Thematic analysis of qualitative data suggested very few adaptations were made upon the basis of culture; participants referred to some language-based changes and use of culture-specific metaphors. Other aspects of language-based adaptations such as simplifying word use, reducing content or adapting materials to cater for literacy levels were mentioned in the final theme of 'adaptations with Spanish-speaking families'. These changes were not considered to be for 'cultural relevance', and there was a lack of clarity around what language-based changes would be considered for cultural reasons. Additionally, fitting findings to a cultural adaptation model ('The Adaptations to Evidence-Based Practices Scale'; Lau et al., 2017), which considers adaptations as binary (adding to or reducing from manualised content), may have led missing nuances in data collection, analysis or interpretation of adaptations. The authors concluded that practitioners need to have personal experience of the cultural factors relevant to the client group to improve cultural adaptations.

Roulette et al. (2017) specifically examined practitioner-led cultural-based adaptations of a manualised parent-training group for adolescents in the US Pacific Northwest, SFP (Strengthening Families Programme 10-14). The authors considered the importance of examining the implementation of ‘evidence-base’ interventions, to provide valuable information about ad-hoc adaptations to meet the experiences and values or belief systems of the local population served (Cooper et al., 2016; Hill et al., 2007; Moore et al., 2013). Practitioners delivering SFP with families that they defined as being from native American or Latin American descent, were purposefully sampled to examine the use of the intervention within a different culture from which the intervention was originally validated. Grounded theory analysis of interviews of 16 trained practitioners suggested that all facilitators make adaptations for the families they work with. Adaptations made for cultural reasons included: differing the time boundaries; altering language use; symbols or materials; allowing for additional family members to join; and attending to culturally specific issues (e.g. with cultural identification across generations). The definition of cultural adaptation was based on participant responses. The authors appeared to construct othering narratives by interchanging terms such as ethnic minority and ethnic diversity. This may suggest that those with a minoritised status are considered as ‘different’ or ‘diverse’ from a norm, and implies a lack of cultural competency. The authors reflect on the dilemma of achieving speed and flexibility when examining practitioner-led perspectives to study culturally competent parenting interventions, as it limits findings to practitioners own opinions and experiences. This can introduce bias, which they considered could be mitigated with a more systematic method of how to include or consider culture when adapting a programme.

Self-Brown et al. (2011) similarly examined practitioner-reported cultural adaptation, to SafeCare, a home-based parent-child and family intervention that focuses on reducing risk of child abuse and neglect in the US. Thematic analysis of 11 practitioners suggested implementing adaptations to meet the client’s cultural needs. Flexibility in session structure to accommodate for cultural events, location, who is included in the intervention and the timeframe allocated to parts of the intervention, were all considered as important and potentially unique to each family. Participants reported that they adapted intervention materials to be culturally sensitive, and accommodate for language differences or low literacy levels. They also considered ways to improve initial engagement with families. Participants suggested that matching families’ spoken language or ‘race/ethnicity’ [sic] to practitioners’ might improve engagement, although was not necessary if an understanding of cultural experiences or beliefs led adaptations. Awareness of past negative experiences with services and epistemic mistrust was considered necessary to support trust building, and to provide context for how parenting practices are understood. Knowledge sharing across participants' experiences of working cross-culturally was deemed to be useful, whilst imposing systematic adaptations according to a particular cultural grouping of a family was considered to be harmful and stereotyping. Transparency of full interview questions provided some context to how culture was framed within the study, although there was no explicit definition of culture or how 'diverse families' were understood. Authors also reflected on the potential for sampling bias, as several participants dropped out before interview.

López-Zerón et al. (2021) examined eight practitioners' and supervisors' perspectives on practitioner adaptations made to Parenting Through Change for Reunification (PTC-R), a manualised group training intervention for parents who have experienced child removal due to maltreatment or neglect in the US. Constructivist thematic analysis suggested that participants considered the importance of cultural relevance during the engagement period, and reported that providing information around the situational context of child protection services to families helped to build trust. Participants also said that they would simplify and revise intervention materials, language-use or activities for parents' context or cultural relevance. Participants considered the cultural context of punishment practices, and how to respond when these do not meet the intervention's values and philosophy around 'limit setting'. The Ecological Validity Model (Bernal et al., 2009), was used to determine which intervention characteristics were changed to meet cultural and contextual relevance. Authors appear to blur boundaries between what was considered a family's cultural context and clinical context, perhaps due to a lack of definition of culture. However, this may also reflect the realities of a family's complex and intersecting identities. Both authors also carried out the analysis, and appear experienced in the intervention under investigation. This may have introduced bias through practitioner social desirability, in the data collection or analysis of the results. Efforts to establish reliability and validity, such as through discussing codes with a third author, checking of participant responses, and 'journaling' may have reduced the influence of researchers' contextual position over findings.

Osman et al.'s (2022) mixed methods study, incorporating practitioners perspectives, examined the implementation of a culturally adapted parenting programme, Ladnaan. This combined a 10-session attachment-based parent training with societal information sessions for Somali-born parents in Sweden. Quantitative methods measured parent satisfaction and clinical outcomes and was therefore not included. Perceived cultural sensitivity of the adapted intervention, alongside other markers of implementation success, were qualitatively examined through observations and focus groups with group facilitators, their supervisors, and support staff facilitators. Cultural sensitivity was considered according to whether the cultural experiences of the 'target' client group were included within the intervention's development, implementation and evaluation (Resnicow et al., 1999). Content analysis of qualitative data suggested that involving "respected" and "well-known Somalis" (Osman et al., 2022, p. 11) in the intervention was most important for the development of cultural competence, in-part due to the trust this engendered with families and the shared experiences that the facilitators were able to draw on. Perceived value of being able to offer culturally relevant examples alongside a Swedish co-facilitator was appreciated. Participants also reported that culturally relevant materials (such as poems, proverbs, metaphors, role-plays) enabled shared understandings. Participants also reflected on aspects of the intervention that supported attendance. The lead author of this study had a role in data collection and was involved in developing the intervention. Although the data was analysed and interpreted by another team, social desirability may have influenced participant responses. The study also shed a light on ethical implications of involving peer leaders; it was not clear whether the peer group leaders were specifically employed by social services for the intervention, but feedback suggested that they did not receive the adequate support and time in paid working hours to fulfil the role. This demonstrates the risks of exploitation of efforts when relying on those with lived experience to develop and offer therapeutic interventions.

1.6.1.3. *Cultural consultation of a manualised parenting intervention:* One study enlisted experienced practitioners and asked for their perspectives on proposed adaptations. Beasley et al. (2017) utilised practitioner perspectives to provide feedback on the cultural adaptations developed for a group-based, early years parenting prevention programme for Hispanic mothers and young children in the US.

A coding template approach (King, 2012) alongside content analysis was used to analyse focus group interviews with 19 group facilitators and supervisors who had experience delivering various home-based parent training programs to first-generation Hispanic families in Oklahoma**.** Purposive sampling of Hispanic, Spanish-speaking practitioners was carried out, and study materials were provided in Spanish and English. Culture was considered according to the provision of “culturally congruent services” (Beasley et al., 2017, p. 300) that are changed to meet the specific cultural needs of the local population that it is serving (Whaley & Davis, 2007). Participants considered the intervention was culturally appropriate; particularly regarding content, pacing, language-use, and the goal of reducing social isolation (due to identifying this issue was commonly faced). Practitioners made suggestions for how to improve ‘cultural congruence’, such as using simplified language, using pictures that more accurately reflected the families due to attend the group, and using more traditional songs. Authors considered engagement in the intervention was a key marker of cultural congruence, and practitioners offered practical, culturally appropriate suggestions for developing rapport, trust, sense of safety, methods of recruitment, and ideas for ways to support attendance throughout the intervention. The authors recognised this method of culturally adaption may lead to homogenising families’ cultural experiences. These findings have limited ecological validity without putting the intervention to practice or receiving feedback from service users. However, the study has shown that consultation to experienced practitioners can be of value when developing a culturally appropriate intervention.

1.6.2. Summary of Findings

The existing literature both proposes encouraging conclusions, as well as exposes some limitations. It does not provide a wealth of data on examining cultural competency within parent-infant interventions. Nevertheless, qualitative data provided rich examples of how practitioners’ perspectives could shed a light on improving cultural competence within caregiver-infant interventions. Similar themes across the different interventions suggest areas that may be useful to attend to, such as how cultural knowledge is gained, accommodating for language or cultural sensitivity during of the intervention, and engaging families within a context of epistemic mistrust, marginalisation and experience of professionals lacking understanding. Some of the studies rely on practitioners having personal cultural experience appropriate to meet the needs of the culture of the clients, although one study specifically mentioned that this was not necessary to provide culturally appropriate care. This places a burden on specific practitioners to be open to fulfilling this role, is potentially de-skilling of the ability to work across a diverse spectrum of cultures, and homogenises people's experiences. The limited evidence base of intervention in the perinatal period led to an intentionally widened search in the scoping review, to be inclusive of older children with the aim of understanding anything generalisable to the perinatal population.

1.7. Rationale and Aims

The paucity of research evidence into the effectiveness of psychological interventions that addresses the quality of caregiver-infant relationships in the perinatal period also speaks to the lack of literature examining the implications of offering them cross-culturally. Researchers have examined and documented similarities and differences within caregiver-infant interactions (Bornstein & Esposito, 2020) and debated the appropriateness of considering constructs associated with attachment theory and caregiver sensitivity across cultures (Keller, 2018; Mesman et al., 2018). Yet there is a lack of research that has explored how these observations and debates may feed into attachment-based interventions intended to support the caregiver-infant relationship. As mentioned earlier, it has been postulated that there may be both appropriate and inappropriate ways in which caregiver behaviours could be assessed and interpreted across cultures (Bornstein, 2012). This is also relevant to the provision of support for these parenting skills. Some evidence has suggested that targeting sensitive caregiving in interventions has the potential to support families from different cultural groups (Ekmekci et al., 2015). Additionally, a small scale study suggested effectiveness and acceptability of VIG in families from minoritised ethnic backgrounds (Chakkalackal et al., 2021). However, the methods in which culturally competent practice is implemented, and ways caregivers' experiences and preferences are considered during the intervention, were not specifically examined.

As outlined by Newland et al. (2015):

> “It is incumbent upon us all to ensure that our practice is competent in every way to meet the expectations and the rights of a diverse population to quality health services. With this obligation comes the ethical imperative to address the social context within which people live, including confronting the discriminatory theories and practices embedded in our services, and our professions.” (pp. 178-179).

Appreciating and including cultural context is thus vital for NHS practices and services delivered to the UK’s multicultural population. Families currently experience discrimination and lack of access to perinatal and mental health services, in part due to cultural barriers, practical difficulties, stigma and cultural insensitivities (Watson et al., 2019). In addition to the findings from the literature review, this suggests cultural competence needs to be explored in interventions that support caregivers and infants. It is important to ensure an intervention that is rising to prominence, such as VIG, does not further subjugate or discriminate against families; a lack of understanding in turn perpetuates racism and healthcare inequality (Stern et al., 2021). Good practice in UK maternity services have been reported to involve “culturally-sensitive care”, “person-centred’ and “good communication” (Birthrights, 2022). Given that VIG involves teaching a skill that is formed from the basis of positive examples of what the caregiver is already doing, it may offer the flexibility to accommodate behavioural practices, needs, experiences, and wishes related to each family worked with. Examining how practitioners implement VIG can shed a light onto how these are included in VIG delivery and practice.

Thus, the current study is important to begin to close the current gap in the literature. The aim of the current study is to examine how practitioners implement VIG with caregivers and infants across cultures, and their perspectives on culturally competent delivery of VIG. Exploring the implementation of VIG by examining how it can support families “to reduce psychological distress and to enhance and promote psychological wellbeing” is directly linked to the purpose of clinical psychology (DCP, 2001, p. 2). The results of the current study can inform clinical psychologists’ and allied professionals’ practice, improve the support for caregivers, and inform practitioner training. In particular, this research can help to reduce inequalities for racialised and marginalised caregivers in perinatal services.

1.8. Research Questions

- What are the experiences of VIG practitioners working with caregivers and infants across cultures?
- How do practitioners approach VIG in the context of their own and clients' cultural background, and what is the perceived relevance of considering cultural factors?

2. METHOD

2.1. Overview

This section will begin with an outline of the philosophical assumptions underpinning the research. Study design, ethical considerations, procedure and analysis strategy undertaken will be explicitly documented for transparency and to facilitate replication. VIG's theoretical and procedural background will be briefly outlined prior to documenting the procedure to provide context about the intervention to the reader. The processes involved in researcher reflexivity will be detailed to identify the researcher's engagement with the study and the reciprocal influence between researcher and study.

2.2. Philosophical Assumptions

Research methodology is contingent on assumptions about the nature of reality (ontology) and how knowledge can be accessed (epistemology) (Pilgrim, 2019). The researcher cannot be separated from the matter that is being studied; elucidation in how the research development process and methodology chosen has been influenced by and is consistent with the adopted position is thus required (Barker et al., 2015).

2.2.1. Ontology

The literature referred to in the introduction has suggested that there are varied definitions of culture, diverse meanings behind 'cultural competence', and aspects contributing to personal cultural experience (e.g. 'race' or religion) which are socially constructed. Whilst this could lend itself to positioning the research within social constructionism for example, adopting a singular relativist position can conflate epistemology and ontology as a single entity, i.e. an epistemic fallacy (Bhaskar, 2008). Willig (2016) proposed that realism and relativism co-exist within a critical realist stance, appreciating there are concrete, material consequences of constructed meanings and phenomena. For example, the assumption of the existence of culture, cultural insensitivity, and the material impact of substandard care within NHS services. This avoids over emphasising the role of language ‘constructing’ an experience, which may invalidate clients’ lived experiences of accessing perinatal health care. Accordingly, the research is within ontological realism. Multiple realities based on subjected constructions, including between participant and researcher, may exist outside knowledge or awareness (Khalil, 2014; Willig, 2016). Thus, the researcher cannot access true reality, however it is accepted that it exists within participants’ experiences, and how culture is considered within VIG practice.

2.2.2. Epistemology

A critical realist position adopts relativist epistemology, recognising that knowledge is accessed through the historical, socio-political, and subjective contextual lenses within which people experience the world (Willig, 2016). Not only do participants construct meaning from their experiences, but the researcher constructs an understanding about what is being shared (Willig, 2016). This recognises the researcher’s influential role in data collection and analysis (Braun & Clarke, 2006). As such, researcher reflexivity is required to support and account for particular assumptions upheld and conclusions drawn (Pilgrim, 2019).

The participant’s reported experience of how they consider their own and families’ culture within their VIG practice is thus taken as a representation of their perceived reality that has concrete consequences, and accommodates for how they perceive phenomena that are arguably socially constructed and subjective (e.g. what is culture and cultural values). Thus, adopting a critical realist position enables the exploration of participants’ unique and personal experiences; that can produce applicable findings and generate change in a material reality. It also enables healthcare interventions to be examined within the synergistic context they operate within (Sturgiss & Clark, 2020).

Critical realism lends itself to adopting a qualitative approach, and research questions assume participants’ experiential, mental or emotional responses to phenomena are present independently of the researcher (Willig, 2016). Epistemological relativism claims that knowledge is accessed via constructed and linguistically discursive processes of enquiry, and the idea that researcher reflexivity is required to reduce subjective biases and maintain humility (Willig, 2016). This position is particularly appropriate given the current study's cross-cultural line of enquiry, and the inherent contextual and cultural aspects that underlie participants' responses and the researcher's analysis.

2.3. Experimental Design

Qualitative methodology was adopted as it garners rich, in-depth data on participants' perspectives and their experiences (Willig, 2013). It also has fewer restrictions on how novel information can be gained about the participants' experience, compared with quantitative methods (Woodfield & Cartwright, 2020). Thus the qualitative approach was deemed appropriate given the paucity of previous literature on cultural considerations in VIG, and within parent-infant therapeutic interventions. Analysis of qualitative data of interviews with practitioners has offered useful insights regarding the cultural acceptability of parenting interventions, and treatment of depression for women within the perinatal period (e.g. Iturralde et al., 2021; Luis Sanchez et al., 2022; Roulette et al., 2017). Thus, interviews with VIG practitioners were deemed appropriate to consider how VIG delivery interacts with aspects of families' culture. Whilst this does not replace views and experiences from clients themselves, interviews with practitioners were chosen to provide an important first exploratory step in considering how VIG may accommodate for cultural factors when delivered with families.

One-to-one interviews were chosen over focus groups, as the former are thought to garner more in-depth exploratory data on individual, personal practice (Frith & Gleeson, 2012). Semi-structured interviews were adopted to provide focus and structure around the central topic, whilst also allowing space to follow trajectories within discussions held (Magaldi & Berler, 2020).

Whilst the concept of data saturation (when no additional insights can be generated from the data; Guest et al., 2006), is more flexible in qualitative approaches compared to quantitative, it has been suggested that 12 participants is a good marker, and saturation can be achieved in as few as nine participants (Guest et al., 2006; Hennink & Kaiser, 2022). However predetermined sample sizes have been considered a superficial and arbitrary criteria, and ‘data saturation’ or participant number can be gauged by additional markers, such as study characteristics, goals, complexity of concept examined, and instruments used (Hennink & Kaiser, 2022; Vasileiou et al., 2018). This study is exploratory and seeks to capture initial themes and concrete issues, lending itself to a smaller sample (Hennink et al., 2017). Thus approximately 9-12 participants were considered sufficient for data collection.

2.4. Ethics

2.4.1. Ethical Approval

Ethical issues were considered according to the British Psychological Society’s (BPS, 2021) Code of Ethics and Conduct, and University of East London’s (UEL) code of practice for research ethics and data management policies. The study received ethical approval from UEL’s school of psychology ethical committee (See Appendix B) before recruitment began. An amendment was made to the original ethics application to permit contacting consenting participants after the interview, to review the transcript and analytic model (See Appendix C). This was approved before it was carried out.

2.4.2. Informed Consent

Participants were emailed an electronic version of the information sheet (See Appendix D) after expressing interest in the study and meeting study criteria. The information sheet outlined what participating in the study would involve, what happened to the interview transcript and personal or sensitive data, and participants’ right to withdraw from the study. Before the interview was conducted, participants were presented with the information sheet again and signed the consent form (see Appendix E). This was accessed on Qualtrics XM Platform™. The consent form was reviewed with the participant before the interview. Participants were given opportunities to ask questions via email when setting up the interview date, and immediately before and after the interview was conducted. Participants were also reminded at the beginning and end of the interview of their right to withdraw from the study at any point. Participants were reminded at the end of the interview that they could request for their data to be removed from the research up to three weeks after interview.

2.4.3. Confidentiality and Anonymity

All identifying information was removed during transcription and a participant number was used in the transcript and write-up to maintain anonymity. Minimal demographic information was collected, and care was taken to ensure that, as far as possible, participants cannot be identified. For example, demographic information that is reported was not tied to participants. Documents containing personal or sensitive information (e.g., participant contact information and consent forms) were stored in separate folders to the demographic information and the transcripts to protect anonymity and confidentiality. Participants had the opportunity in the consent form to identify whether they wanted to review their transcript for clarification, remove anything from the analysis, not be quoted on, or provide feedback on the analytical model. Participants were reminded of their selected preference in the debrief.

2.4.4. Data Protection

Processes to protect data were upheld according to the data management plan. This was devised during initial study development and approved by UEL's research data management team (see Appendix F). All data was stored on UEL OneDrive for business, a secure and encrypted online storage platform provided by the university. Recordings of the interviews were temporarily stored on the interviewer's personal UEL Microsoft Stream Library (where recordings are stored automatically) whilst undergoing transcription and accuracy checks. Basic contact information was stored on the secure and encrypted Qualtrics XM Platform™ whilst data collection was ongoing. After data collection was completed, stored data on Qualtrics was deleted, after being transferred to OneDrive. Anonymised and synonymised data shared with examiners upon request will be facilitated using OneDrive secure links.

2.4.5. Remuneration

Participants could choose to be entered into a prize draw to receive £50 Love2Shop vouchers. Reimbursement for all participants was not deemed necessary as this research will contribute to the development of VIG practice, and contribute to continuing professional development.

2.4.6. Debrief

The information sheet provided details about what could be expected from the interview conversation, and it was not anticipated that the interview would lead to significant distress. However, there was a chance that participants unexpectedly experienced distress during or following the interview. To mitigate the chance of distress, participants were debriefed immediately after interview questions ceased; their experience of the interview process and post-interview wellbeing was enquired about. A written debrief sheet was sent immediately after the online video call interview ended (See Appendix G). In the written debrief, participants were provided the contact details of the researcher and researcher supervisor and were signposted to further support services. No participant fed back distress during the verbal debrief, or via contacting the researcher or research supervisor. However, they may have contacted the signposted support services.

2.5. Video Interaction Guidance (VIG)

Further details about the processes involved in VIG are outlined here to provide context to the study design, procedure and findings. VIG originated from ‘Video Home Training’ (VHT), a model of supporting caregiver-infants dyads from the Netherlands (Biemans, 1990), and was developed in collaboration with UK and international colleagues (Kennedy et al., 2010). Whilst VIG is now utilised across professions (e.g. social workers, psychologists, teachers, medical doctors, nurses, health visitors) in varied contexts (Kennedy et al., 2011), there will be a focus on how it is delivered with caregiver and infants to maintain relevance to this study.

2.5.1. Aims and Principles

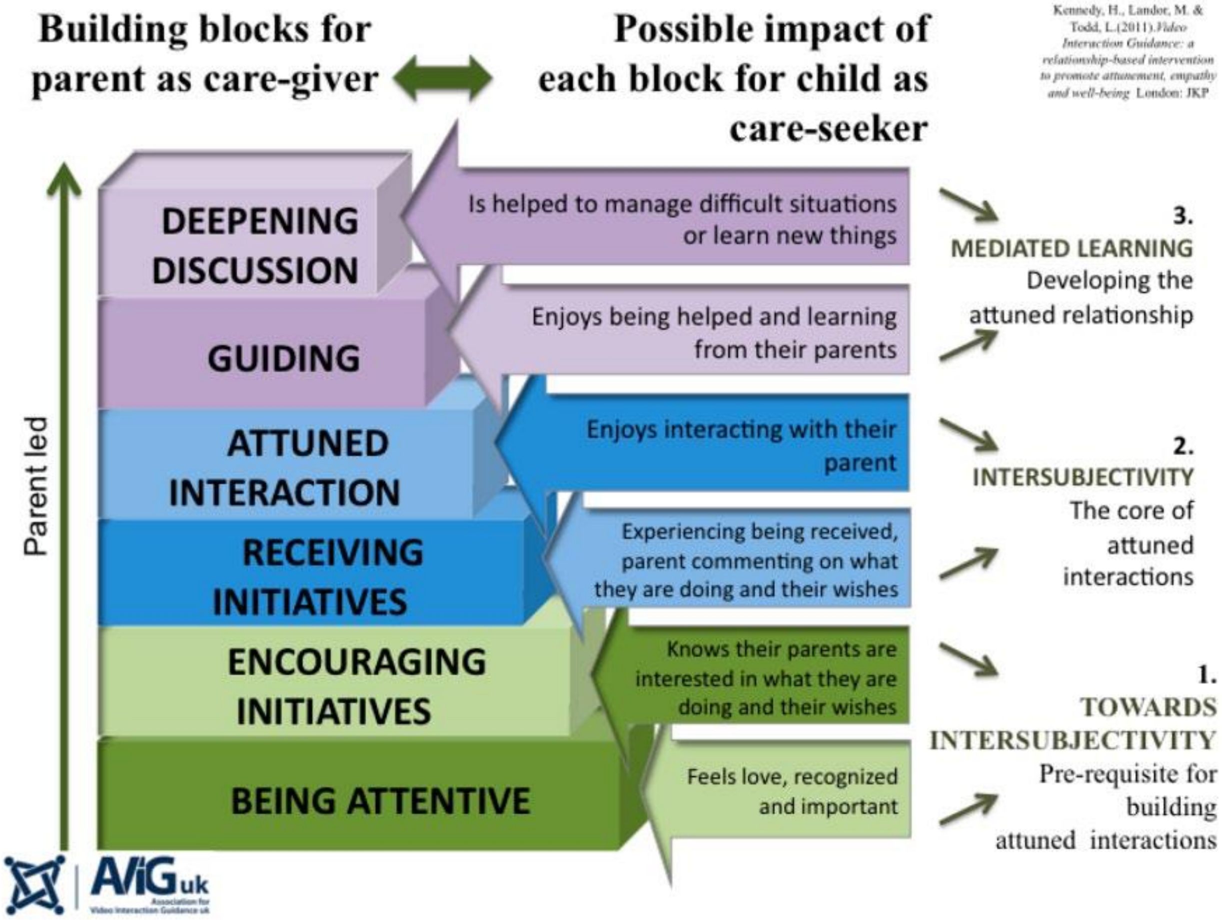
VIG is a relationship-based intervention that utilises video feedback to improve attuned communicative interactions between caregiver(s) and their child, through focusing on caregivers’ understandings of their infants cues and ways of responding to their infant (Kennedy et al., 2017). ‘Attunement’, originated from intersubjectivity theory, and has been defined within VIG as “a harmonious and responsive relationship where both partners (for instance, parent and baby) play an active role” (Kennedy et al., 2011 p. 23). The construct of intersubjectivity between caregiver and infant emphasises the role of the bidirectional connection when sharing emotional or mental material within communication, known as primary intersubjectivity

(Trevarthen, 1998). Secondary intersubjectivity is described as a more complex cognitive process that infants display from around 9 months, which supports that capacity to hold an object of reference in mind (i.e. shared attention; Trevarthen & Hubley, 1978). The construct of intersubjectivity is embedded throughout VIG, from highlighting moments of shared understanding between caregiver and infant, to how this is modelled within the relationship between caregiver and VIG practitioner in sessions, and the processes involved in VIG training and supervision (Kennedy et al., 2017).

The different levels of attuned interactions between caregivers and infants form the foundational principles of the intervention (See Appendix H). Attuned interactions are considered to build upon the caregiver initially ‘being attentive’ to their infant, and ‘encouraging initiatives’ from them (Kennedy et al., 2017). Caregivers then holding space, to ‘receive initiatives’ from their infant, sets up the context for ‘developing attuned interactions’. These stages form the basis of developing primary and secondary intersubjectivity (Trevarthen & Aitken, 2001), and precede ‘mediated learning’ within the intervention, which further develops the attuned relationship (Kennedy et al., 2017). This occurs when caregivers actively structure the infant’s environment by ‘guiding’ responses to be in a zone in which they can tolerate new learning (i.e. zone of proximal development; Holzman, 2018). The final principle refers to ‘deepening discussion’, whereby infants are provided with the knowledge, skills and space to manage new, challenging or conflictual situations. The foundations of attuned relationships and how they related to the VIG intervention is shown in Figure 2.

Figure 2

Foundations of VIG (Kennedy et al., 2017).



Kennedy, H., Landor, M. & Todd, L.(2011).*Video Interaction Guidance: a relationship-based intervention to promote attunement, empathy and well-being* London: JKP

Note. Foundations of attunement mapped within a VIG framework. Reprinted from “How does video interaction guidance contribute to infant and parental mental health and well-being?” by H. Kennedy, K. Ball and J. Barlow, 2017, Clinical Child Psychology and Psychiatry, 22(3), p. 502. Copyright [2017] by the Author(s). Reprinted with permission.

2.5.2. The VIG Process

Caregivers and infants are typically offered three ‘cycles’ of VIG, as this has been found to facilitate supportive change or new ways of understanding (Dodsworth et al., 2021; Doria et al., 2014). Each ‘cycle’ involves the steps outlined below (Celebi & Spring, 2020; Kennedy et al., 2011).

2.5.2.1. *Establishing the helping question:* the caregiver(s) undergo an initial assessment to clarify what they want help with and ways they may need support with their relationship with their child (Kennedy et al., 2017). Behaviourally focussed goals are co-constructed and underpin the relational aspects of the helping question (Kennedy et al., 2011).

2.5.2.2. *Scaffolding a situation to film:* VIG practitioners support the development of an activity to film caregivers' and infants' 'best possible interaction'.

2.5.2.3. *Film recording:* the caregiver and infant are video-recorded whilst carrying out the activity. The film lasts approximately 5-10 minutes. Filming does not need to be captured all in one shot, for example filming stops if the caregiver or infant appear distressed.

2.5.2.4. *Microanalysis and editing:* the film is reviewed in careful detail by the VIG practitioner and edited to display moments where aspects of attunement principles (in Appendix H) can be identified in interactions. This occurs in between sessions, out of sight from caregiver(s). Captured moments of misattunement are purposefully discarded.

2.5.2.5. *The shared review:* the practitioner and caregiver reflect upon the selected video clips together. They discuss what went well between the caregiver and infant, and highlight examples of attuned interactions in non-verbal or verbal 'contact principles' (Biemans, 1990). The VIG practitioner consciously embodies the principles of attuned interactions, in how they relate to the caregiver, to mirror the communicative patterns developing between caregivers and infants (Kennedy et al., 2017).

2.5.2.6. *Generalising the experience:* the caregiver is invited to reflect on their experience of the shared review and is supported to consider how they may want to utilise what has been covered going forwards. Attending to the 'exceptions' of successful interactions is facilitated to co-construct new narratives about their capacity to parent (Morgan, 2000; White, 2007). The initial helping question is re-visited, and discussions may involve setting up filming in another cycle.

2.5.3. VIG Training and Supervision

The Association of Video Interaction Guidance UK (AVIGuk) regulates UK VIG practitioner training. Following an initial short introductory course addressing underpinning principals, theory and practice, VIG trainees practice under supervision (Šilhánová & Sancho, 2011). The VIG Skills Development Scale is utilised as a competency framework to monitor training development (AVIGuk, 2023). Accreditation typically takes 18-24 months, and trainees must have had at least six clients and 15 hours of supervision; advanced VIG practitioners or VIG supervisors undergo further training (AVIGuk, 2023). Mirroring how VIG operates with caregivers, the training is practitioner-led, and VIG trainees learn through a strength-based approach using video-feedback (Šilhánová & Sancho, 2011). Video Enhanced Reflective Practice (VERP) is a form of training and reflective practice that uses VIG principles and procedures for professional development and improving communication skills (Strathie et al., 2011).

2.6. Procedure

2.6.1. Recruitment

Participants were recruited via word of mouth through the researcher's contacts, social media (e.g. Facebook, Twitter), and professional networks, groups and organisations (e.g. relevant BPS faculties, charities or private organisations). A research poster (See Appendix J) was produced to support study circulation. Participants could sign up to the study via contacting the researcher's UEL email address or providing their name and email on a Qualtrics survey. As mentioned, Qualtrics served to manage contact information and obtaining informed consent.

2.6.2. Participants

Primary recruitment targeted accredited VIG practitioners or those in VIG training, who work in perinatal teams or other aligned services. There was a focus on recruiting practitioner psychologists or other psychological practitioners who are supervised by a practitioner psychologist. This was selected due to the importance of having knowledge and experience of working within the therapeutic relationship and delivery of VIG. A minimum of six VIG cases were required for depth of experience, as this is the minimum requirement to meet accreditation (AVIGuk, 2023). The inclusion of infants up to 2 years was chosen to ensure the study did not exclude those working in infant services that support families with children up to 2-years-old. Excluding a substantial proportion of infant workers may have restricted the pool of potential participants and limit applicability of findings.

Inclusion criteria was as follows:

- VIGuk accreditation achieved OR undergoing accreditation training.
- Received VIG supervision from a qualified practitioner psychologist OR received practitioner psychologist qualification.
- Worked with six or more VIG cases with caregivers and infants aged 0-2.

2.6.3. Interview Schedule

An interview schedule was produced to examine how VIG practitioners consider their own and their clients' culture in VIG delivery, supervision and/or training (See Appendix I). Interview questions or themes reported in previous literature, examining cross-cultural aspects of parenting interventions were used as guidance. A draft interview schedule was discussed in research supervision and minor changes were made based upon supervisor's recommendations. Small changes to a few questions and prompts were made based upon the information generated in interviews.

2.6.4. Interviews

Interviews were conducted using the online video conferencing platform, Microsoft Teams. Microsoft Teams recording and transcription features were utilised to capture participant responses. Interviews were scheduled according to a convenient time for participants. Interview length ranged from 45-90 minutes. One interview took place over two meetings to accommodate participant needs. See section 2.4. for procedure for obtaining informed consent and debriefing.

2.6.5. Transcription

As mentioned, automatic transcription was facilitated by Microsoft Teams. These were downloaded onto Microsoft Word and checked against the audio-visual recorded meeting. Changes were made due to AI errors, to introduce punctuation for legibility, and to facilitate anonymisation. For example, by changing names and replacing identifiable information with brackets.

2.7. Analysis

2.7.1. Rationale

The interview transcripts were analysed using Reflexive Thematic Analysis (RTA). RTA was chosen over other similar approaches to qualitative analysis. For example, template thematic analysis (King, 2012) is a method involving creating a structured codebook and applying it to the data. Whereas, RTA has been described as a methodology, given its flexibility in how it is implemented, and coding involves developing meaning from the data, 'actively generating' codes (Braun & Clarke, 2021). This is also in contrast to interpretative phenomenological analysis, which garners rich accounts of individual experiences (Smith et al., 2009). However, RTA facilitates bringing together patterns of meaning across the data set; this allows for diversity and difference in experiences to be accommodated for and lends itself to developing relevant, clinically useful and practical findings (Braun & Clarke, 2021).

RTA was also chosen as it is a theoretically flexible method that can be adapted to suit the philosophical assumptions of the research process, methods, and aims (Braun & Clarke, 2022). RTA within critical realism enabled the researcher to ask both general and more specific questions, in order to centre the participants' voice in the study findings (Braun & Clarke, 2021), together with considering how social-cultural constructions of experience framed responses (Willig, 2013). RTA recognises the inherent role of researcher subjectivity in the process of theme construction and interpretation (Braun & Clarke, 2021). The embedded reflexivity in the analytic process provides opportunity to understand how the researcher's position and assumptions influence the interviewing and analysis process (Elliott et al., 1999). Codes and themes developed were discussed in research supervision to benefit the researcher's understanding, analytic interpretations and reflexiveness (Braun & Clarke, 2022).

2.7.2. Strategy

The analysis was undertaken using software for qualitative data analysis, Nvivo (version 1.7.1; QSR International Pty Ltd, 2020). Braun and Clark's (2006) six-phase guidelines underpinned the process of RTA. Whilst the phases are recursive and involve researcher reflexivity, a simplified version of the analysis journey was outlined below for clarity.

2.7.2.1. *Phase one: data familiarisation:* the researcher immersed themselves in the data by re-watching the interviews recorded on Microsoft Teams before they were deleted for confidentiality and anonymity. Processing the automated interview transcripts, so that they accurately represented the interview, contributed to data familiarisation, as well as re-reading the final transcript version. Initial analytic insights or notions were noted down throughout this phase.

2.7.2.2. *Phase two: coding:* the entire data set was worked through systematically to identify where features of the data set provided meaning or relevance to the research questions, and code labels encapsulating the concept were applied. Both semantic level codes (literal interpreted surface meaning of the data) and latent codes (capturing an underlying, implicit understanding of the data) were utilised where it generated appropriate meaning. Given the exploratory nature of the study, a predominately inductive orientation to the data was utilised, whereby coding and themes are driven by participant responses (Braun & Clarke, 2012). An inductive approach, whereby coding and themes are shaped by existing literature also informed how meaning was generated from codes, as it is impossible to remove the influence of prior engagement with previous literature (Braun & Clarke, 2012). Data extracts were then collated according to codes (See Appendix K for example codes and an extract from an annotated transcript).

2.7.2.3. *Phase three: initial themes generation:* initial codes were synthesised according to patterns of meaning across the dataset. Codes appearing to share a key concept were grouped together and organised into candidate 'themes' and 'subthemes' (See Appendix L for initial thematic map).

2.7.2.4. *Phase four: reviewing themes:* coded data and themes were reviewed by the researcher and the research supervisor in supervision to consider whether themes reflected a coherent narrative, accurate to the data set. Coded data extracts were relocated to better fit the candidate themes and subthemes. Changes made to themes, such as merging or collapsing themes to better fit a coherent narrative and the codes represented. The entire dataset was re-read to ascertain fit onto the thematic map. See Appendix M for a thematic map developed during this phase.

2.7.2.5. *Phase five: defining and naming themes:* a short analytic narrative was written about each theme to support defining themes according to the coded extracts they represented. Themes were named in consultation with the research supervisor to ensure they concisely and accurately encapsulates the codes represented. Themes were modified if it became apparent that there was no longer meaningful fit with codes, and the thematic map was finalised.

2.7.2.6. *Phase six: writing the report:* analytic notes, reflexive journal extracts, finalised codes and thematic map, and quotes from data extracts were synthesised into a coherent narrative about the data. Where a specific term or phrase could be abstracted from the data, this was placed in the narrative in quotes alongside the acknowledged participant.

2.8. Reflexive Statement

Researcher reflexivity has been defined as the “turning of the researcher lens back onto oneself to recognize and take responsibility for one’s own situatedness within the research” processes and created study contexts (Berger, 2015, p. 220). This is particularly important for qualitative research; ethical research practice requires the ongoing process of bringing awareness to how researcher values, assumptions and life experiences, may embed themselves within the study design and influence the analysis process (Braun & Clarke, 2022; Oates et al., 2021). Locating ones’ position enables readers to consider how researcher partiality may present itself (Braun & Clarke, 2022).

Wilkinson (1988) identified different levels to which researchers can influence knowledge production and study findings. Personal reflexivity refers to the influence of the researcher’s values (Wilkinson, 1988). I am aware of how my position as a

White, middle-class, Jewish, cis-gendered woman shaped my interest in, and interaction with the research topic. My experiences will shape how I consider the role of cultural understandings within therapeutic support. I acknowledge how my positions of social privilege may manifest, potentially closing off areas of exploration, and considered this within reflexive processes. I have employed functional, disciplinary and epistemological reflexivity in order to consider how the study's methodology, theoretical and philosophical assumptions have influenced the process of knowledge production (Wilkinson, 1988; Willig, 2013). Further considerations and researcher reflexivity is outlined in section 4.7.

Reflexive journaling throughout the analysis process helped me to consider how personal feelings, reactions, or choices made in the study methodology or analysis may have shaped how meaning was created. These were discussed in research supervision to help further develop my reflexivity.

3. RESULTS

3.1. Overview

This section will outline the findings from the reflexive thematic analysis (RTA) of participants' interview data. Participant demographics will be reported to provide background context to the sample and findings. A thematic map will be presented to provide a summary of the themes and sub-themes generated in investigation of the research questions. This will be further outlined in the narrative of the researcher's interpretations, which will be supported with data extracts from participant responses.

Example codes, annotated transcript, the development of the thematic map and example data extracts are shown in Appendix K, L, M, N.

3.2. Demographics

Nine practitioners working within perinatal and parent-infant services were interviewed between November 2022 and January 2023. Two additional eligible participants who expressed interest were unable to attend a scheduled interview. Participant demographics are reported in Table 1. To protect anonymity, the demographic data is grouped by self-identified ethnicity, age, background professional training (relevant to the research study), experience in parent-infant work, region working in, and level of VIG accreditation. Participants who had more than one background professional training and worked across regions are represented twice.

Table 1

Demographics of participant sample

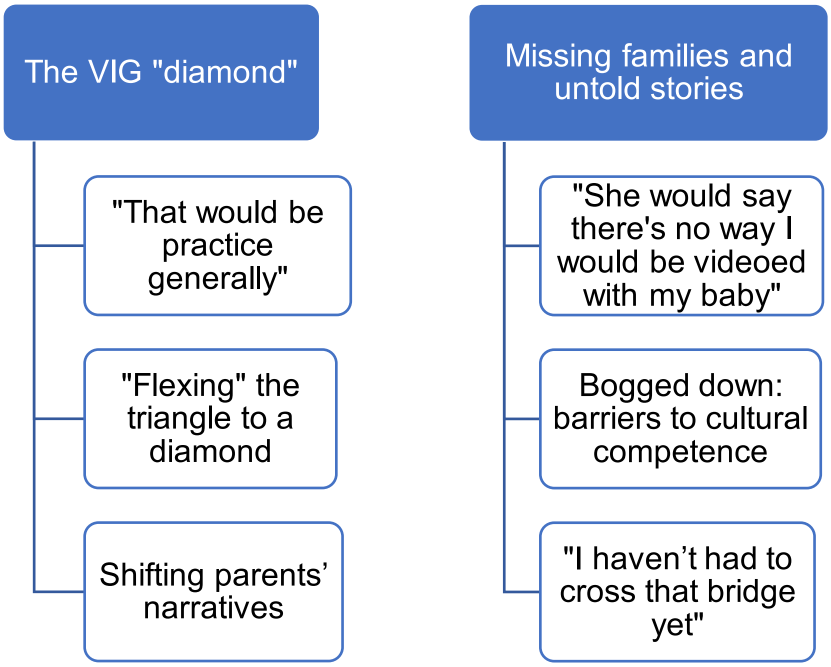
Demographics	N
Ethnicity	
White British	6
White Irish	1
White/White other	2
Gender	
Female	8
Male	1
Age	
30-39	3
40-49	2
50-59	4
Background professional training	
Clinical psychology	6
Parent-infant psychotherapy	3
Nursery nurse	1
Experience in parent-infant work	
<5	2
6-10	4
11-15	1
16-20	2
Region	
East Midlands	1
South West	2
South East	1
North West	2
East England	2
London	1
Wales	1
VIG accreditation level	
Trainee	1
Accredited	5
Advanced	1
Supervisor	2

3.3. Reflexive Thematic Analysis: Thematic Map

Coded data extracts were synthesised into an initial thematic map utilising RTA, outlined in Appendix L. After further refinement, initial themes were merged to generate the following two main themes: *The VIG “diamond”* and *Missing families and untold stories*, and a total of six subthemes, as outlined in Figure 3.

Figure 3

Thematic map



3.4. Theme 1: The VIG "Diamond"

The first theme captures participants' reports and descriptions of culturally competent practice in the delivery of VIG. The diamond metaphor is an extension of the VIG triangle (an integral theoretical concept within VIG practice which uses a three-point triangle to describe the relationship between the practitioner, caregiver and recorded video), to a "diamond" (P2), with the fourth point representing the dynamic ways in which cultural factors might be considered within practice. Participants' shared descriptions of cultural competence fed into each aspect of the interconnected relationships between practitioner, caregiver and recorded video, and the caregiver-infant dyad. The diamond also represents the multifaceted, intersectional, and all-encompassing role of culture shaping experience and its involvement within culturally competent practice.

> "Everyone's got their own, like, diamond of culture, and that, um, for us not to be so limited in our definitions of culture, and it's not just about someone's race or ethnicity or, country of origin, is absolutely not about that, because culture is embedded into everything." (P2)

“That would be practice generally” (P7) explores how non-VIG skills and therapeutic practices shape how participants felt able to create the VIG “diamond’ within caregiver-infant VIG sessions. “*Flexing*” (P8) *the triangle to a diamond* describes participants’ views on how the VIG model can explicitly or implicitly be shaped to consider clients’ culture and context within interactions. *Shifting parents’ narratives* developed as participants talked about the ways in which parenting norms, values and expectations were held in mind and considered within VIG sessions.

3.4.1. Subtheme 1: “That Would be Practice Generally”

Most participants discussed in some way or another how their personal experiences provided a “benchmark” (P5) for how they operated within the world, their own expectations about relationships, family dynamics or parenting. This contributed to their knowledge about the caregiver-infant interactions they were using within VIG.

> “We all have our own stuff. And if you, I guess if you…because of your own experiences, lean to that, kind of, more that that style…then I wonder what you would pick up on, in your editing, as to whether you would really, truly see a baby's initiative…I think, v- very, very much so what you see in the infant so…yeah, we all bring to it our own lens, don't we, which is shaped by our culture and our upbringing and our own trauma or whatever that is.” (P2)

Others shared how personal experiences, particularly around being parented or parenting themselves, facilitated how they felt able to empathise with the caregivers experience, and understand what the caregiver they were working with was thinking or feeling.

> “When I'm with the mum in the moment, I'm really really trying hard to put her at ease because I know I would have found it hard to talk about my parenting.” (P1)

Participants discussed how they brought their reflections of these personal experiences to “supervision” (P2, P3, P4, P5, P6) to support processing this information. This might be to unpack what the caregiver was bringing or use the reflective space to consider how to work as a more neutral practitioner, such as to "tolerate" (P5) difficult feelings. Whilst a few practitioners mentioned these conversations could happen in "VIG supervision" (P3) there was a consensus that there was more space within their general "clinical supervision" (P2, P5) from a non-VIG supervisor, particularly as VIG supervision ends after practitioners have completed a VIG training pathway (such as accreditation, advanced, or supervisor roles). This was relevant for the participants in this study who were no longer in training, or were a supervisor. However, for some of the conversations it was not clear if participants were referring to their experiences within VIG-specific supervision or their general clinical supervision, so there may be some overlap with where these conversations took place.

> "I guess it would come into the supervision…[what comes from having that discussion in supervision?]…being more aware of different cultural differences and how they impact, and being able to, erm, take that back to, kind of, working with the, with the, families as well. So that, [I am] kind of, more open in regards to, to thinking about their cultural differences and how that might impact, or any blind spots that I might have." (P4)

Participants spoke of the importance of an awareness of what their own "stuff" (P2, P3, P6, P7) was, i.e. personal experiences, cultural norms or expectations. Some discussed that this was facilitated within supervision. This was thought to support with separating these personal assumptions from what the client may be bringing to the session, or how caregiver-infant interactions may be interpreted. This skill then enabled participants to bring the work back to the clients' goals or considering what might help the infant in their cultural context.

> "I suppose in this kind of context…it's important to sort of hang on to your own feelings, but also explore actually…not let your feelings, sort of, make you have assumptions about, what their experience is, and what the solution is… trying not to make assumptions that your, kind of, values are and experiences are always, umm, you know, is it, is the way it is…it's almost that sort of noticing your own reaction, but then, kind of, stopping to think about what that

> means and, um, and you know, when you, when you feel like something is good or something is bad. And…going back to what the baby thinks.” (P7)

> “Your own…sort of ideas about culture to be able to know when you're kind of assuming something I guess…I think one of the main things is being aware of what your own, sort of, value systems are. Cause if you, if you're not aware of your own, then it's very difficult to know how, you know, to, kind of, spot it, kind of, leaking into the conversation.” (P8)

A couple of participants also reported that personal therapy had been beneficial to support with managing how personal experiences may influence their VIG practice.

> “I had a, yeah, quite critical and, um shouty at points Dad, and I think for, for years that, kind of, made working with Dad's really quite intimidating for me. That was kind of a process that I went through then, in my own therapy, and think, to kind of, become more umm, just aware of that, and kind of change how I felt about that, and that made, kind of, then working with fathers very different and much easier.” (P5)

Participants also discussed how they considered clients’ culture, context, or appreciated how this may influence the work outside of the VIG sessions, such as within team “referral meetings” (P3) or “reflective practice” (P2) sessions or within the “initial assessment” (P6, P7). Others noted that this may happen in VIG sessions, but they are not VIG specific skills, suggesting that this is part of wider practice.

> “I don't know if I then include, kind of, say that was part of the, or fed into the VIG work, or just something me as a, practitioner in in the infant mental health team would, um, kind of support a family with. In terms of the actual, you know, like the…cycles of the videoing and then the…reflections.” (P5)

Several participants discussed how their professional training background prior to, or outside of, VIG training shaped the therapeutic orientation within which they deliver VIG and their clinical skill set. This gave a backdrop against which they discussed their practice, including how they considered their own or their clients culture within their VIG work. Whilst some participants reflected upon how their training improved their skills to consider culture within their practice, this was not always the case.

> “I guess I’m always thinking systemically…Um, and the person might, um they might talk about something in the family that alludes to culture or something like that.” (P3)

> “I try to be more curious about them, and kind of not to think so much about my culture. Might be some bias that I have that I'm not quite aware sometimes, but obviously being trained, psychoanalytically, you are thinking a lot of the transference and countertransference communications and something that gets stirred up in me, might be because, particularly because of my bias or where I'm from. So I'll be curious about that, whether I bring it up with the patient, which I think is helpful or not, that's different thing.” (P9)

The influence of prior training and clinical skills on culturally competent VIG delivery was acknowledged within the concerns that participant 3 shared, regarding whether non-psychological practitioners would be able to facilitate “safe” (P3) VIG practice. P3 reported that community practitioners, who are due to undergo VIG training after they received funding to do so, may need to be upskilled in their therapeutic practice in order to facilitate the facets of VIG delivery that are required for culturally competent practice.

> “I think that…there's something else that needs to go alongside that actually to help people, um, reach a level of competency, but also to be able to have these richer discussions… it's maybe a different way of thinking about things that is different to what, what they normally do in their day job. And then to expect them to then, um, yeah, suddenly, know how to have all those conversations and, how to have clinical supervision on those. It's a, it's a big ask, I think so, yeah. There's something I think needs to go alongside it.” (P2)

3.4.2. Subtheme 2: “Flexing” the Triangle to a Diamond

This subtheme describes how there are also facets of VIG that support culturally competent practice. The VIG values, beliefs and principles were considered as enabling practitioners to work in a “person-centred” (P5, P6) way, that meant accommodating caregivers’ needs and goals within the session. The VIG principles of “tuning in” or “attune(ment)” (P1, P6, P8), such as giving “time” and “space” (P2) were described as facilitating conversations about clients’ context within VIG sessions. Participants discussed how this helped them adopt an open and non-judgemental approach to what the caregiver was bringing.

> “One of the guiding principles is the, kind of, receiving what people bring and, erm, being very attuned to…actually whatever somebody brings, having a way in which you talk about that in, in a way that is very accepting, is not, kind of, confrontational, that is, kind of, more of a curious kind of stance rather than, sort of from, challenge.” (P8)

Participants also identified ways in which they considered the caregiver’s cultural contexts specifically within the VIG cycle. This included when establishing the helping question; the lens with which they viewed interactions when “editing clips” (P2); to feedback in the shared review; or “looking at the” (P1, P7) clips in the shared review with the caregiver. “Watch[ing] myself on my shared review” (P3) was highlighted as an opportunity for reflection upon how the practitioner was responding to what the client was bringing, to support maintaining a curious and non-biased stance.

> “When you record yourself and do a shared review, which you then take to your supervision, you're watching yourself. And I notice a lot more, what I've done and said in a session with someone. Then I would, had I not have recorded my session, so it', it's the micro analysis of, of yourself for the supervision has been really, really helpful…or power, you know, um, or like say interjecting and interrupting somebody and…not waiting for a pause. So that kind of, you know, just being aware of those sorts of processes.” (P3)

A few participants also reflected on their use of language within VIG sessions. Use of language was considered something that might improve accessibility of the sessions. Whilst there was some hesitancy reported about how to deliver VIG with an interpreter (see Theme 2 below), those who did reflect on their language within sessions described how they were able to meet their clients' needs. For example, through reflecting upon accessibility of their own language use, the non-verbal nature of videos supporting communication, and the use of an interpreter.

"The language I use is quite important, um, and to be mindful of the language that I've used, that's something that has come up in my supervision that to think about the words that I'm using, um, that's not alienating the client." (P3)

Contracting around recording and sharing of the video was reported by a few participants to take into account considerations around modesty, such as required clothing or the gender of the professionals that would see the video.

> "I had a lady who, in a clinic, she was wearing a headscarf, but when I saw her at home, she wasn't wearing it, because it was a home and she, because we're filming and obviously for her its important not to show her hair. Um, that was important, to keep the confidentiality of that. So I'd think that was maybe something that I considered." (P9)

Participants also outlined that they have included wider family members in the shared review. Others (who had not yet done this) mentioned how this hypothetically could be implemented to tailor the intervention to best meet the needs of the system around the caregiver and infant. Participants also discussed that they would consider who else was around at home when they are filming and whether this may impact how "comfortable or uncomfortable someone feels." (P7)

> "Where I work now…[there are] lots of families from South Asian community, and, a lot of them live in, kind of, extended families. So there's lots of people around. So, sometimes the question is around actually, is it more appropriate for us to meet in a children centre, where it's just you and baby, or do, do you feel safe with other people here and, exploring some of that." (P2)

Several participants shared that cultural factors are not "explicitly" talked about within VIG sessions or training (P2, P3, P7), and referred to the more "subtle" (P8) ways in which they may hold in mind cultural considerations during their VIG work. Some participants were able to disclose some of the ways that cultural factors shaped the intervention by informing how the client, or their interactions with their infant are thought about.

> “Because the baby will have got used to their, cult-, you know, the...family of origin…I guess that the sort of differences [in styles of interacting]. I…think about…and try and keep your eye on, actually, what does the, you know, what does baby think…so I have noticed, you know, in some…dyads where the mum, yeah, might be, kind of, much more animated and lively, and…I suppose…I think it was ok, you know, a higher level or stimulation was ok...for the baby.” (P7)

Some participants reported that cultural factors are involved in the VIG sessions, but struggled to offer examples of how their VIG practice may reflect them. This led to adopting a more general consideration of how either their own or their clients’ experiences, values, and expectations intersect with VIG practice. Participants reflected upon how these processes may be present, but were unsure whether it changed their VIG practice.

> “It's [cultural factors] all-encompassing, it's just comes in as, as it is.” (P9)

> “it's not something that I would explicitly, talk about, in terms of the VIG work…I probably haven't explicitly said, drawn attention to it…it can, sort of, come in and seep in, but that's not like a (pause) a sort of defined thing that we would be discussing, it's just, that's just by chance of that happened to come up in a conversation…it's almost like this, this sort of like, implicit thing that I just hold and know.” (P3)

3.4.3. Subtheme 3: Shifting Parents’ Narratives

This subtheme developed to capture participants’ descriptions of the processes and outcomes of their VIG work, and their experience of bringing clients’ contexts to the work. Participants also reflected upon wider societal discourses that may influence the caregiver-infant relationship and their VIG practice. They discussed that VIG provided a space to unpack the ideas caregivers held about themselves. Participants noted how this was often wrapped up in negative views about parenting proficiency, and struggling with “confidence” (P3, P7, P8) to be “good enough” (P4, P8). Some considered that the “positive” (P1, P7) and “strengths” (P2, P4, P5, P8) focussed nature of the work supported them in counteracting negative narratives.

> “I just think it's a lovely way in which you can help people form a different narrative that is about themselves. So, lots of mothers have a dominant narrative which is of themselves as not good enough, or, focusing very heavily on things that they are not doing. And there's a lot of shame and guilt… it's often around, kind of, confidence or feeling good enough as a mother.” (P8)

> “Towards the end, she got all her sisters in the room to look at the clips because she'd felt such shame about not bonding with her baby at first.” (P1)

Participants also reflected upon how clients used VIG sessions for discussions around their partner’s or family’s expectations of the caregiving environment. These conversations not only offered a space for caregivers to pause and reflect on their current context, but also a chance to change things, or go against norms or expectations within their system, if that felt difficult for them.

> “I suppose, thinking about that kind of hierarchy of family, where grandparents often have a rule of, this is how you should do, so that kind of disempowerment of…I suppose I would use VIG as an opportunity for that person to explore how they might want to do it…kind of, opening space for if they're doing something, and then they recognise that's different from, what would be expected, to kind of, think about well, is that OK for them?...Is that a problem? And if it is OK for them, then how do we use that platform that, which is VIG, to kind of expand on that?” (P6)

A couple of participants also recognised the responsibility they had in facilitating change, and meeting the client at an appropriate level of challenge.

> “How do you keep a system where, erm, you can think about it increasing a mother's confidence, but also…being sensitive to the environment…the system around that mother.” (P8)

All participants discussed viewing the videoes provided concrete feedback of the caregiver-infant interaction, which becomes a “power(ful)” (P3, P4, P6, P8), memorable and influential tool to address the narratives caregivers hold about themselves.

> “Parents are able to see for themselves [on video], let's say something that they had not been able to see in their minds. So very often they would be quite tearful looking at the image, and they would say, I didn't see myself like this, I didn't know I'm doing that.” (P9)

Participants not only felt that the VIG videos provide a tool to create changes to the way caregivers see themselves, but also can have an influence on how professionals perceive a caregiver. Participant 2 reflected upon how professionals are not immune to becoming trapped within negative discourses, and how VIG can provide an opportunity to create changes to narratives at a team-wide level. However, in circumstances such as this, it could be seen that it is the client’s role to shift negative narratives that the team has about them. Given the inherent power imbalances in this, it could create a highly harmful environment for the caregiver. It may be appropriate in this case to consider whether implementing VIG as a team would be more ethical and appropriate to tackle issues that are held within the team.

> “a lot of, her behaviours towards baby would…[be] deemed quite negative[ly]…she gave permission for us to share some clips at one of her team around the family meetings…I guess the interactions with both the children were, were quite worrying, and a lot of professionals were worrying…the system had got incredibly negative about this family… the team around her had got really stuck…in a really unhelpful narrative…And there was something, that happened within VIG, that allowed a bit of a shift in that narrative.” (P2)

3.5. Theme 2: Missing Families and Untold Stories

This theme captures participants' reports about families missing from their practice, and the notion of 'culture' was sometimes missing from VIG practitioners' practice. Participants reported that there were families that were not accessing VIG, and were not being supported by perinatal mental health services. There were untold, unheard, unknown stories about culture within the communication between caregivers and participants, and between participants and the researcher (Pearce, 2004).

"She would say there's no way I would be videoed with my baby" (P2) encapsulates the ways inequity in access and take-up within VIG were discussed, and how some of the processes that were described within VIG may be more difficult to bear for people who are already feeling vulnerable in the context of epistemic mistrust (a concept that suggests trusting can be very difficult for those who have experienced prior relational harms; Fonagy & Allison, 2014) and a lack of inclusive services. The theme *Bogged down: barriers to cultural competence* suggests what might prevent a better relationship between VIG and cultural competence. Participants described how learning, acquiring, and delivering VIG did not help to widen the lens and consider their own and families' cultural contexts. The theme *"I haven't had to cross that bridge yet"* (P6) captures how participants related to the study topic and how they were sometimes hesitant to consider cultural factors in their VIG practice.

3.5.1. Subtheme 1: "She Would Say There's No Way I Would be Videoed with my Baby"

Some participants began reflecting on the demographic make-up of their VIG caseloads during the interviews. Participants said this was not "diverse" (P5, P6, P8) within their services, and that there is "an additional diverse lack within VIG" (P8). Many participants discussed that the clients on their caseload within their service and within VIG were "nearly all" or "majority" or "often" "White" (P1, P3, P5, P8). The option to decline VIG if it does not suit the caregiver's presentation or preferences was also highlighted by participants. Whilst some participants did not consider this to be an issue, having an alternative intervention offer could end the curiosity to explore the inequality within who is able to benefit from a VIG intervention and who is not. P8 reflected on who takes up the VIG offer, and their response implies that perhaps there is more thought to be had about why families accept or decline VIG, in order to attempt to understand why families are both missing from, and missing out on, the intervention.

> “It's interesting when we think about who actually wants to, kind of, engage in video interactive guidance and, the, when, I think of the people who have I’ve just done video interactive guidance with, it's largely, erm, you know, nearly all white, women, of similar kind of age group.” (P8)

Other discussions suggested that there were ways in which engagement is revisited. This may be particularly helpful if caregivers wanted (or needed) more time to consider the option of VIG, and still receive support in different ways.

> “We may revisit it [VIG] with people. So sometimes we might, um, provide some individual work, er, or a group, and then, kind of, revisit it again once they build up a really good therapeutic relationship. So, it could be, kind of, weaved into another piece of work.” (P2)

An additional layer of inaccessibility may be related to current understanding or awareness of VIG amongst wider healthcare staff, although this wasn’t always the case as another participant thought that VIG fit well within the perinatal services.

> “The team don't refer into VIG as much, erm, so there's, a bit of a kind of promotional issue in the team, like it's not, something that people hold in their minds, first of all.” (P3)

All participants reflected upon how the process of recording and sharing video clips could be difficult for caregivers to tolerate. Participants reported understanding and empathy around how “(un)comfortable” (P7, P8) this might be. For example, P9 discussed caregivers experiencing issues with “body image or [an] eating disorder” may face during recording and viewing themselves. Most of the participants discussed how, in their experience, they felt that it was useful to build up rapport, and they reflected on the importance of establishing “trust” (P1, P4, P6, P8, P9) from the caregiver before they implemented VIG. Some described that VIG can be received as daunting, for “a mum and baby, who…[are] not at their…best” (P6) to be put in such a “vulnerable” (P5, P8) position.

> “I had a, one mum and baby, who I’d thought, would be really valuable to use VIG with. Umm, but she was very, very reluctant because she found it very difficult to trust anybody or trust that, that material would be confidential, that it would somehow be, you know, online.” (P4)

> “You're asking for a quite, a significant leap of faith to undertake being videoed by somebody and then the view that you're going to be criticised. So, I think that, um, a challenge is always just trying to get that initial buy in.” (P6)

Participants discussed some of the strategies they implemented to build up trust and rapport with caregivers before they began VIG. Many discussed how they would “normalise” (P6, P7, P8) apprehension, offer another intervention first to get to know their client, such as through “baby massage” (P1), or by putting the potential client in touch with “previous service users” (P5) who have already experienced VIG.

> “We would always, sort of, encourage people and, sort of, anyway normalise, the, sort of, anxiety about being videoed, and obviously explain about confidentiality, and how the, who's gonna get to see the videos, and how they're used. And, you know, everything about that to, sort of, help people feel, um, reassured hopefully about, about the process.” (P7)

> “Before I take the film, I will talk to them about, and they say might feel…awkward kind of, ways to gonna relax them a little bit…trying to talk to them about it, you know what the experience is like, you know, and how they might feel, they might find it odd, or, you know, they'll be, wouldn't be talking while they’re with their baby. Sometimes a baby looks at me. A lot of the time because I'm holding the camera. I'll spend a lot more time, a longer time, usually to relate, so they, they relax in.” (p9)

The relative positions of power that the “professional” “white” “women” (P8) hold may influence how they receive or benefit from the intervention. Thus, VIG could exclude caregivers who have been through, and continue to experience, systemic harms within their environment.

> “I think, um, lots of families don't want to be videoed, particularly when they have already, feeling a lot of shame and stigma about their relationship with their child, to then add on a professional coming in, with a, a camera.” (P2)

> “It's interesting that people that I've just done VIG as a standalone [without engagement work], have all been, erm, women that have been, professional women, that, erm, are, you know, from, white, you know (laughs) it's, it's just not very diverse.” (P8)

Participants’ expressed uncertainty in terms of what work could be done to improve accessibility. Suggested ideas included asking caregivers directly “if there's some aspect of the intervention that…is just very jarring, or…that isn't fitting” (P8), conducting “research” (P6, P9), seeking answers from resources within a “community-based context” (P3). Whereas, others were not sure how to progress.

> “I guess it’s one of those things, isn’t it, that you don’t know that things are different, until you-…what’s it called, unconscious incompetence. You know, you don’t even know that things are different, because you don’t know, even what to be curious about.” (P7)

3.5.2. Subtheme 2: Bogged Down: Barriers to Cultural Competence

Some participants discussed that in order to follow VIG principles and procedures within the VIG cycle, aspects of the session can be quite “directive” (P9) in what they are meant to be attending to, discussing, or reflecting about. Some participants reflected on all the things they need to hold in mind during the session or supervision, and suggested that VIG implementation can at times feel quite burdensome.

> “I'm really tolerant with children, but it is a real distraction, and the VIG people will show you examples of work where it's just the mum and the VIG practitioner. And it all goes a lot more smoothly, but I've had babies chucking dummies at me. Babies throwing up, or babies pooing, or you know. I've had one toddler move the table away that I had my camera on… it's a bit chaotic, so that the practical elements for me are...tricky.” (P1)

A couple of practitioners reflected upon the impact of some of the boundaries in place during VIG implementation. They considered that as a result of this focussed approach, aspects of VIG processes may narrow the lens within which caregivers’ cultural contexts are thought about.

> “I guess closes some of the conversation down in a bit, in a way, because it, it kind of becomes really focused.” (P2)

> “I guess that's where it's not always a focus on supervision because you're looking at the items and then choosing clips where you think that you're, kind of, really bringing that.” (P8)

Whereas P9 was more reconciled about what the intervention offered, and the finite boundaries of what VIG could offer compared to other interventions.

> “VIG…it’s not a parent-infant psychotherapy…so (laugh) its offered in that environment (laugh)… the parent talks to you and you receive the parent, and then you look at the video. So you have this triangle, so you can't go out of it, if you go out of it, and the parents starts talking, as in parent psychotherapy, that’s not VIG. You know, doing a short turn interaction, so you've been told to interfere. Stop that, and, kind of, focus again on the video. And so it's very directive, where in psychotherapy, if somebody wants to talk to me about the culture, then I'll be spend a whole session on the culture, and that's what important, that's what they want to talk to me about today.” (P9)

Participants also discussed ways in which cultural context could fit into protocols, but for it to be considered, clients needed to “bring” (P8, P9) it to the session, or for it to be “brought” (P2) by practitioners to VIG supervision (such as within the helping question). Some participants were describing this hypothetically, as they had not experienced this in their sessions or supervision at all. The processes that have to be followed within VIG may inadvertently lead to some of these conversations being missed. Without a practitioner who can identify what might be present within implicit communication, a person-centred approach which places responsibility on the client to explicitly consider aspects related to their culture has the potential for culturally blind or harmful applications of VIG. It may not be possible for clients to voice these, given the unequal power dynamics between practitioner and client.

> “So I think if their helping question had a cultural aspect to it, then it would very much be very present within our work…my kind of role there is to use VIG to explore their helping question, and if that has aspects of something that would fit into culture then it still has to be driven by them.” (P6)

> “it's not really been something that's kind of been a big, kind of, focus of the, kind of work, because it's whatever the person kind of brings...I guess that's maybe because one of none of my helping questions for supervision have been how do I incorporate culture into a discussion.” (P8)

Upon reflecting about the VIG training, several participants discussed how cultural considerations were not part of the initial training course agenda, or within the checklist of competencies that practitioners need to achieve in order to become accredited. Whilst aspects of the model felt appropriate to consider clients’ presenting needs, the particular skills employed for culturally competent VIG practice were not directly covered in the training.

> “[Do you think your VIG training may have helped you think about these things at all?] Umm I, unless I could have missed it, I'm not sure really how much it did come into the VIG training…Yeah, I don't think it was really, er, highlighted as far as I can remember.” (P4)

Several participants also discussed difficulties experienced when initially grasping the VIG model and the different aspects that they needed to implement in the sessions. They reflected upon the time it may take to feel confident enough to consider more nuanced, and perhaps less VIG specific, aspects of communication between practitioners and clients, which in their view included culture.

> “When you're in the moment with the parent, you’re thinking “I've gotta get through all these things to include on the video” It's a bit of a distraction…sometimes I think the training itself, and…I’m not alone in thinking this…it can affect the quality of your interaction because you're trying to get so much in on the video…you're trying to make sure it's filmed, right…You've got to make sure you've said this, and said that, and, really holding mind, but there can be all sorts going off on the houses, so it is quite a stressful thing and, I think, just doing the training sometimes might affect that.” (P1)

> “I think like any intervention, when you’re working and you're learning it, there's something about getting something, kind of, always like working through the motions to get it. So that you don't have as much headspace I think for all the other stuff that you want to include, and that, there's so much you do want to include that I wonder if you can become a bit almost, not blind sided, but a bit like, super focused in on getting it right…but then there's something about as you progress through, it, it frees up…that space to think about…that [client’s context].” (P2)

This may also include willingness to use interpreters within VIG sessions. As stated in Theme 1, language use had been considered by a few as something that could be incorporated flexibly into VIG sessions to meet the needs of the caregiver. However, the potential for using interpreters to be “complex” (as described by P2 who described successfully using an interpreter) or “challenging” (P3) may put off some from trying.

> “I've never used VIG with an interpreter. I don't know how that would, kind of, would, because a lot of it's to do with, kind of, the, kind of, attunement and being able to kind of receive and kind of, like receive the initiatives that, you know, a person kind of brings and so it's, umm, I don't know how, I've never

> had that experience…I don't know how that would, how that would feel, whether some of the essence of the video would be lost.” (P8)

Participants described how there are different aspects of VIG that they need to hold in mind when delivering the sessions and within VIG supervision. This may require a lot of headspace, which may displace or get in the way of some practices that were discussed in Theme 1. Having to get to grips with the model in the early stages of their VIG practice may exacerbate this difficulty. The VIG training may not support managing the competing demands of VIG practice required for culturally competent practice.

3.5.3. Subtheme 3: I Haven’t Had To Cross That Bridge Yet

Most practitioners discussed how they felt considerations about culture did not “come up” (P1, P5, P6, P9) in their work, and what culturally competent VIG practice could look like was missing from their answers.

> “Not really. In all honesty, yeah. (pause)…It's not an explicit thing that's talked about, no.” (P3)

P9 expressed ambivalence as to whether cultural considerations were relevant to their practice, or whether implementation of VIG is changeable to meet this. Their response implied that they relied upon the notion that VIG is built upon universal constructs and techniques, thus with universal applicability. Perhaps adopting this stance meant that taking culture into account was not considered to be a priority.

> “When you ask me about cultural thinking, do I really need be more mindful of, that, of different culture, or you know, so, but like specifically thinking about it, not really, because usually it's for everyone, it doesn’t have limitations. It doesn't kind of say it's just for these people, and this, or something, or you know, as, as, we’ve seen its, really great and its quite flexible, so…maybe I just take it for granted. I don't know.” (P9).

Others were curious about why they did not feel able to answer questions related to cultural competence within VIG practice, suggesting that perhaps aspects related to client’s culture or context are being missed.

> “So I suppose, is there something to reflect on there? Isn't it that for me, it hasn't been spoken about it, but is that because it actually hasn't come up, or it did come up but because we didn't ask the question and talk about it, that it's been missed. So, er, I couldn't say which one of those it is, but I suppose it definitely something to reflect upon because it hasn't come up. So therefore, on the basis of working with eight or nine clients and, it hasn't been spoken about directly, then there's probably something to kind of really think about that.” (P6)

Others reported they could not “remember” (P3, P9) whether they had these conversations within VIG sessions or within VIG supervision, or reports were at times tentative and vague. Perhaps suggesting a passivity, or uncertainty, in how culture is considered.

> [whether conversations about culture come up in…VIG supervision or VERP] “Umm, yeah I mean, I think I think they do, maybe (pause) (sigh), I mean, yeah, they do. Umm, (pause) whether they always come up, I don't know. You know, whether it's sort of, but, but they certainly do arise, um.” (P7)

Many of the participants said that due to their caseload being mostly White British families, their work did not lend itself to considering cultural factors. This reflected a belief that ‘culture’ belonged to marginalised groups, and comprised of othering narratives and language. Some participants also discussed that the White British families were assumed to have similar cultural needs to them. This was then given as justification that it therefore did not need to be addressed.

> “that might be our, our population here, that it's not, kind of di-, diverse yeah, in, um, yeah, particularly diverse. So, I'm just trying to imagine, kind of working with it, where there was, yeah, far more diversity in terms of populations, cultural, er, diversity. Um (pause) then there might be kind of

> more relevant, kind of, yeah, questions that have come, would have come up for me, but they haven't so far in my role here, yeah.” (P5)

Many of the participants reflected that they found the topic, or aspects related to the interview questions novel and “interesting” (P1, P3, P5, P7, P8) to them. Participants also reflected that the interview left them feeling “curious” (P9) or “think(ing)” (P2, P3, P4, P6, P7, P8) more about how to consider their own cultural contexts and their clients’ when delivering VIG.

> “I think it's, it's helpful actually to make me think about some, some of these things and how we ensure we are being culturally competent when we're using something that is really technical, um yeah. It's its pertinent to think about isn't it.” (P2)

> “Erm, it's interesting because it's like not something I've really, really reflected on directly like this and now I am…It’s really helped me think about culture in my V-, in my work in general. So yeah, thank you for that.” (P3)

Some participants discussed that they thought it would be useful to learn about culturally competent practice from peer VIG practitioners, and use this to generate ideas for how to think about cultural context within their practice.

> “I suppose at that point then that's where having that kind of VIG community, being part of that kind of, er, wider VIG network would be really helpful in thinking how others may have explored that.” (P6)

4. DISCUSSION

4.1. Overview

This section begins by summarising and contextualising the current study's findings within the prior literature. This is followed by a discussion of its implications and clinical recommendations, as well as a critical evaluation of the study's quality, and consideration of main strengths and limitations. The researcher's reflexivity is then considered, followed by concluding remarks.

4.2. Summary of Research Findings

The current study aimed to explore the experiences of VIG practitioners working with caregivers and infants across cultures, and their perspectives on culturally competent delivery of VIG. The first research question examined VIG practitioners' experiences of delivering VIG with caregivers and infants when working across cultures. VIG was found to be facilitated with caregivers and infants across cultural contexts, and participants reflected about how VIG sessions incorporated conversations about narratives belonging to the caregiver and their family system. Participants also reflected on the lack of representation of families from minoritised groups, within the families participating in VIG. They reported that the engagement efforts required to build up rapport before delivering VIG varied. This suggested inequalities in uptake and delivery of VIG.

The second research question looked at how practitioners approach VIG in the context of their own and clients' cultural background, and the relevance of considering cultural factors when delivering VIG. Participants reflected on the ways in which they addressed cultural context within their work, through explicit and more implicit, subtle means, and utilising their own therapeutic skills (in addition to VIG-specific skills) to facilitate culturally competent sessions. However, there were challenges to how they adopted this approach, namely how culture was considered as belonging to the 'other', and could be seen as secondary and potentially missed within VIG implementation. Whilst participants reported eagerness to improve VIG uptake and culturally competent practice, there was also some ambivalence, and vagueness reported with the study topic; suggesting it was relatively novel and had not been given much prior consideration.

These findings together indicate that there are differences in practitioners' experiences of delivering VIG to caregivers and infants, and how cultural context is incorporated into their work. Both the challenges shared, and the positive experiences discussed have implications for future research and practice. They can suggest ways in which culturally competent practice can be implemented by VIG trainers, VIG practitioners and clinical supervisors who support with day-to-day clinical practice.

4.3. Contextualising Findings

4.3.1. What Are The Experiences of VIG Practitioners Working With Caregivers and Infants Across Cultures?

Participants' accounts of their experiences working with caregivers and infants across cultures involved both commonalities as well as contrasting experiences in terms of creating a context for cultural considerations. The two themes, *The VIG "diamond"* and *Missing families and untold stories* captures experiences of how VIG can involve inclusive cultural practices, as well as the limiting aspects of the work.

Theme one, *the VIG "diamond",* relates to how participants framed their experiences working across cultures. The theme was developed in response to participants' descriptions of how they implement VIG with families across cultures. This suggests the VIG model has the potential to be implemented flexibly and fluidly to meet cultural needs of caregivers and infants. It is important that the model enables evolving implementation, to accommodate the dynamic nature in which cultural factors change between individuals and their environment over time (Bornstein & Esposito, 2020). This is particularly salient given previous research has suggested that caregiver-infant interactions are greatly shaped by cultural factors (Bornstein & Esposito, 2020). Further detail on how participants considered cultural factors within their work is outlined in response to the second research question. Participants described attending to cultural factors and holding this in mind to consider how this may be influencing emotional processes throughout the sessions. This suggests skill in mentalising the wider context of the caregiver and infant, and paying attention to, and considering what they might be thinking or feeling (Fonagy et al., 1991). Skills in mentalisation and reflective function are understood to be vital in sensitively and appropriately attending to infants' needs (Alvarez-Monjarás et al., 2019; Slade, 2005). This is considered important for the practitioner to represent and model for the caregiver within VIG; it provides the opportunity for caregivers to experience receiving an attuned interaction, and in turn, potentially leads to an improvement in their reflective function for their infant (Kennedy et al., 2017).

The subtheme *shifting parents' narratives* encapsulated how caregivers' cultural stories were told, shared, and considered within the intervention. Participants discussed how both caregivers' personal narratives, and influences from familial or societal discourses, shaped the course of the sessions and what was considered the goal for change. Fitton (2008) similarly highlighted the importance of paying attention to the cultural narratives within stories that underpinned surface level communication within mother-infant sessions, and support with reframing how the client wants to work according to their own personal meanings.

Participants reflected upon their clients' feelings of guilt or shame in response to the idea of being recorded for VIG. Feelings of guilt or shame were also reported during VIG sessions, related to caregivers' concerns about not being a 'good enough' mother for their infant. The idea that mothers are under scrutiny and feel judged is a common cultural narrative in the West, as suggested by the constrained and limited notions of what motherhood should be in mainstream Western media (Heffernan & Wilgus, 2018). Literature suggests that this critique and judgement also comes from mothers themselves (Orton-Johnson, 2017). Research examining fathers' experiences also suggest pressurising cultural narratives around gender roles and the "perfect" parent, which may lead to similar feelings for dads (Scheibling & Milkie, 2023). Thus VIG's strengths-based approach meets this cultural need in the face of negative discourses around parenthood or difficulties navigating cultural stories. These ideas mirror narrative therapy theories that highlight instances of exception to the dominant negative narrative, known as 'unique outcomes', can enrich the 'problem-saturated' stories (Gonçalves et al., 2009; Morgan, 2000). This has been postulated to underpin VIG mechanisms of change within prior literature (Kennedy et al., 2017). Participants also reflected upon the role of video-feedback facilitating this process. Perhaps the video provide externalisation for the caregivers to develop alternative richer stories of themselves within their wider context (Gonçalves et al., 2009).

Dawson and Bain’s (2022) research suggested that watching videos of other mother-infant interactions can support mothers to shift how they view interactions, and move away from culturally-prescribed narratives (e.g. stigmatising ideas about what a ‘good mother’ should be) that an interview about parenting an infant elucidated. In this study the participant was watching videos of other mothers and infants interacting, however, when receiving VIG, caregivers watch videos of themselves. Perhaps opportunities to reconsider alternative narratives is more difficult when watching videos back of yourself with your infant. Furthermore, the authors’ conclusions were drawn from one out of eight interviews, and it would be interesting to know what they found from the other participants’ data.

Theme two, *missing families and untold stories* encapsulates how participants’ reported experiences suggested some caregivers and infants were not able to access VIG, and cultural richness was sometimes lacking within the practitioners’ delivery of those accessing VIG. This can be considered in light of the LUUUTT model, a systemic model of communication that supports the consideration of kinds of storied experiences: the acronym LUUUTT represents the stories that are *lived* (events that are experienced), stories *unknown* (information that is missing), stories *untold* (purposefully not shared) and *unheard* stories (not acknowledged or recognised; Pierce & Pierce, 1998). Stories *told* denotes to the meaning and inferences made from stories, and the process of *telling* stories considers how individuals can communicate their storied experiences and narratives held about themselves (Pierce & Pierce, 1998). The missing aspects of storied experiences amongst participants’ reports of their work with caregivers and infants may be “closing down” newfound avenues and developments of culturally competent VIG practice. The social GGRRAAACCEEESSS (Burnham, 2012) are often woven within these stories, for example the positions that are socially minoritised within sexual orientation, religion, gender, ‘race’ or ethnicity may have remained unspoken. This may be particularly more likely when practitioners hold more power and socially privileged positions over clients. The findings suggests that perhaps unvoiced and/or invisible aspects of cultural experiences were unnoticed within caregiver-infant VIG sessions; these facets often remained unexplored within participants' reported experiences of working with caregivers and infants across cultures.

The subtheme *"she would say there's no way I would be videoed with my baby"* captures the accessibility issues within VIG at both the individual practitioner and societal level, highlighting the unknown, untold, or unheard stories within the experiences of VIG practitioners working with caregivers and infants across cultures. Participants' reports of their VIG caseloads mostly consisting of White British women is suggestive of the wider inequalities that caregivers from socially minoritised statuses can experience in access and treatment within NHS services (Knight et al., 2022). However, given some participants' reflections that the bottleneck of inequality is further exacerbated within VIG, there may be something that is providing additional barriers to access and engagement within VIG itself. Perhaps the level of trust that participants discussed that needs to be established for VIG delivery to feel safe within the intervention, is not possible for those who have experienced epistemic mistrust. This is particularly salient for caregivers from racialised and minoritised groups, who may have been let down by services in the past by being subjected to racism, cultural misunderstandings and incompetent service delivery (Awe et al., 2022; Birthrights, 2022; Watson et al., 2019). This could prevent families from feeling able to access VIG.

All participants reported experiences around building therapeutic rapport to facilitate engagement and 'buy-in'. This has similarly been found within the literature on culturally adapted parenting interventions. This study supports previous findings that developing a sense of safety amongst clients is particularly important within the context of epistemic mistrust, and the value placed on building a relationship and trust prior to delivering the intervention (Beasley et al., 2017; López-Zerón et al., 2021; Osman et al., 2022; Self-Brown et al., 2011).

López-Zerón et al. (2021) similarly found that participants considered it useful to hold a space for difficult emotions or experiences prior to beginning the intervention.

However, Beasley et al. (2017) found participants suggested detailed ways to facilitate awareness and buy in from their target population, and identified how to resolve barriers to attendance. Specific ideas to resolve engagement and retention issues of clients within this study were less clear. Perhaps the notion of requiring engagement strategies does not necessarily negate the possibility of cultural competence, but rather ensures they do not lead to further exclusion. It could be argued that greater levels of reflexivity and careful thought can both clarify how to reduce the inequalities within access to services, and in turn generate action.

4.3.2. How Do Practitioners Approach VIG in the Context of Their Own and Clients' Cultural Background, and What Is The Perceived Relevance of Considering Cultural Factors?

Participants' reports varied, and they described contrasting experiences and perceptions that involved both appreciating and overlooking cultural factors within themselves, their clients and within VIG. The two themes *the VIG "diamond"* and *missing families and untold stories* captures this dichotomy.

Participants reflected upon their general awareness and incorporation of cultural context, and how that feeds in to VIG practice; as identified in the subtheme *"that would be practice generally"*. The notion of general therapeutic skills as a foundation for culturally competent interactions within VIG was not a feature in the existing literature research examining culture within interventions for caregivers. Considering research outside of the field of parenting or parent-child interventions can contextualise this finding. Prior literature has suggested that some of the skills participants mentioned are important for developing a good working therapeutic relationship that benefits all interactions (Bennett-Levy & Thwaites, 2007). Culturally competent practice does not require 'added' components to practice, but it is incorporated into every interaction and way of working with clients. For example, participants reflected upon the importance of unpacking their own cultural context, assumptions, and bias through reflexivity, which was most often facilitated by participants' supervision. Supervision is a routine and necessary component of any practitioner psychologists' practice, set up to support proficiency and reflection upon and appraise the work (Health and Care Professions Council, 2015). In addition, having a space to consider the client's cultural context outside of VIG sessions was considered important, and some participants suggested this thinking time then fed into VIG delivery. Perhaps this could explain Luis Sanchez et al.'s (2022) findings that minimal adaptations were reportedly made to PCIT on the basis of clients' culture; perhaps the intervention did not need to be specifically changed to incorporate cultural context, as it is part of general practice with everyone that is seen.

The subtheme *"flexing" the triangle to a diamond* elucidates how participants had experienced tailoring VIG delivery to the cultural and contextual needs of caregivers and infants. The term "flexing" (reported by P8) was purposefully and carefully chosen to represent the fluid, dynamic and morphological ways participants implicitly or explicitly considered culture within VIG sessions, and in accordance with the researcher's definition of culturally competent practice. There was a deliberate decision to move away from the language of *cultural adaptation*, as this can be associated with othering narratives and prescribed changes that can incorrectly stereotype families and their cultural needs (Self-Brown et al., 2011). Whilst study findings challenge the notion of cultural 'adaptations', the processes within the current study utilised participants' constructions of cultural factors within practice, of which drew upon notions of an additive approach to cultural considerations, often found in the prior literature. This will be explored next.

Participants reflected upon how the VIG cycle could be implemented in a way that was sensitive to families' cultural needs. A few participants reflected on language use and what considerations they made during VIG sessions. Previous literature examining cultural considerations within parenting interventions has also considered language use. Preston et al. (2019) suggested the cultural information inherent in language use and communication about emotions and experiences was required to be understood in order to facilitate culturally 'sensitive' and meaningful therapeutic environments. Studies examining practitioners experiences and reflections on cultural adaptations to parenting interventions frequently discussed the role of language, intonation, pace, or metaphorical analogies or idioms used in programmes to aid understanding or relevance (Beasley et al., 2017; López-Zerón et al., 2021; Luis Sanchez et al., 2022; Osman et al., 2022; Roulette et al., 2017; Self-Brown et al., 2011). However specific language considerations within culturally salient communication appeared to be less of a priority in the current study. There was little attention paid to VIG terminology or related aspects that may be salient to consider when working with families. This may be related to VIG's video-feedback method, and a lesser role for language than in other parent-training or caregiver-infant therapy.

It is relevant to explore the acceptability of the processes within the VIG cycle, such as setting the helping question, and contracting around video recording/editing and viewing with clients. Participants' reported experiences of including and considering the wider family network as part of their clients' cultural contexts, which is consistent with prior research. Roulette et al. (2017) and Self-Brown et al. (2011) found that participants considered it culturally relevant to enable caregivers involved in childrearing to attend the intervention, such as wider family members or neighbours. Participants in the current study also reflected upon how they consider cultural factors during the interpretation of clients' goals and their interactions with their infant. This is consistent with previous literature, suggesting that cultural contexts are highly salient in shaping caregiver beliefs, expectations and goals (Holden & Smith, 2019), and in turn how caregivers interact with their infant (Bornstein & Lansford, 2010; as discussed in section 4.3.3)

The subtheme *"I haven't had to cross that bridge yet"* concerns how participants' constructions of culture, and its relevance to VIG practice created the conditions for *missing families and untold stories* theme. Many participants considered culture to belong to those who were not White British. This categorises families into binary 'white and 'non-white' groups, and considers only the latter group to have *cultural* needs. This creates harmful othering narratives that can lead to stereotyping and prejudicial interactions with clients (Akbulut & Razum, 2022). This also means that families perceived to be White British were stripped of their cultural identity; and cultural context was not seen as something to be curious about with them. Given all participants self-identified as White, culture was seen as something that is 'different' to them. Interestingly, this was not how participants defined culture, what it meant to them and what their own personal cultural identity was (at the beginning of the interview). However, there was a varying ability to respond to initial questions about culture, perhaps signifying varied ability in either unpacking and/or connecting to a definition of ‘culture’.

Participants approached the topic of cultural considerations within VIG with curiosity and novelty, and some appeared uncertain or stuck, about how to develop cultural competency within their VIG practice. This is contrasting to prior literature examining cultural competence and adaptations within parenting and parent-child interventions, which suggested that practitioners had clearer ideas about their client’s cultural needs, and accordingly how to consider these in the intervention (Beasley et al., 2017; López-Zerón et al., 2021; Osman et al., 2022; Roulette et al., 2017; Self-Brown et al., 2011). However, a sense of caution or uncertainty has been reported in studies examining the influence of practitioners’ whiteness within therapy spaces (Ahsan, 2020).

Similar to the current study, prior studies have found participants have reported it relevant to consider how cultural knowledge is attained. Osman et al. (2022) and Preston et al. (2019) found that participants suggested including a practitioner with local knowledge aids the development of cultural considerations. Studies present contrasting arguments about whether personal experience is required to understand the cultural needs of the client (Luis Sanchez et al., 2022; Osman et al., 2022; Self-Brown et al., 2011). Peer support, and knowledge sharing amongst practitioners, was thought to be useful to develop cultural knowledge and share good practice (Self-Brown et al., 2011).

The subtheme *bogged down: barriers to cultural competence* suggested the mechanisms within which culture may be overlooked within VIG practice. Some participants said that they would only be able to consider their clients’ or their own cultural context if it was explicitly discussed, thus VIG may not be conducive to fully open and fluid exploration about cultural factors. Whilst some participants were able to share how their cultural understandings fed into how they delivered VIG, there was a sense that elements of VIG’s person-centred protocols may mean cultural context would only be considered if the client discussed it. Furthermore, participants did not consider cultural considerations to be a standard practice or agenda item within VIG supervision. Prior literature that has examined addressing conversations about ‘race’ or considering culture in therapeutic spaces has found it is more often led by the client (e.g. Knox et al., 2003; Pethe-Kulkarni, 2017) and white therapists’ discussions about ‘race’ may be avoided due to the emotionally charged nature of these conversations for them (Ahsan, 2020; Cardemil & Battle, 2003; Knox et al., 2003; Ong, 2021). Whilst it is important not to conflate ‘culture’ with the construction of ‘race’, they can interlink, and perhaps some of the VIG processes may have been utilised to avoid uncomfortable feelings these conversations may generate. Participants in this study also discussed how less experienced VIG practitioners may feel less able to incorporate cultural factors within their work. Though these can be overcome with experience and/or guidance.

4.3.3. The Cultural Approach to Parenting (Bornstein, 2012)

Bornstein’s (2012) cultural approach to parenting could be utilised to suggest how participants consider cultural factors within their VIG practice with caregivers and infants. The varied responses about whether and how participants considered cultural factors within VIG delivery could be tapping into both the *universality* argument and *culture-specific* aspects of parenting within caregiver-infant interactions (Bornstein & Esposito, 2020). Participants who were less inclined to consider cultural factors may be drawing upon the more *universal* aspects of parenting form and function (Bornstein, 2012). Participants who used cultural factors to guide how they worked might instead be considering *cultural-specific* aspects of parenting (Bornstein, 2012).

However, attachment theory is the dominant paradigm heavily woven into participants’ clinical training and into the principles of VIG; and this may be influencing how participants consider cultural factors within their VIG practice. Hypothesised cultural influences of caregiver-infant interactions (Bornstein, 2012; Bornstein & Esposito, 2020) were not reportedly brought into the VIG training in understanding and facilitating change to caregiver-infant interactions. Thus, as participants reported, understandings of cultural differences within caregiver-infant interactions may have been drawn from participants’ other training or experience. This could explain how some participants were able to draw upon their prior training, experience or knowledge to uphold the VIG model and recognise the potential for cultural similarities and differences (Bornstein, 2012).

The findings suggest that similarities and differences between caregiver-infant dyads could be represented within the cultural approach to parenting (Bornstein, 2012). However, it is unclear whether the framework could be fully integrated into VIG in its current form. VIG training and practice may not yet recognise differences with caregiving form and function across cultures. This was highlighted in participants' uncertainty in their responses about how to incorporate cultures that are unknown to them. The framework may support VIG practitioners to implement a more inclusive view of caregiver-infant interaction, and an appreciation for the fluidity of underpinning form that guides function. Ongoing learning and reflexivity within supervision and peer group spaces to share and reflect upon knowledge and experience, could support bringing these skills into wider practice. In addition, this can support with developing confidence and skills to confront Whiteness within practice (Ong, 2021).

4.4. Implications and Recommendations

The study findings indicate that VIG practitioners can consider and incorporate cultural context within their VIG practice, whilst also experiencing some difficulties in how this is adopted within VIG delivery. In addition, there are limits in who can access VIG. Cultural considerations within VIG practice were deemed relevant for the delivery of culturally competent care. Implications for future research, psychology practice, training, and policy will be outlined below. Two participants took part in the response validation and provided feedback on the study findings, which was incorporated into recommendations.

4.4.1. Research

As prior research examining cultural considerations within perinatal and parent-infant interventions was lacking, the current study was exploratory and had a wide focus. Whilst it may not be possible to separate intersecting identities, it may be useful to explore specific aspects that feed into cultural experiences in more depth, such as gender, ethnicity, 'race', sexual orientation, religion, or class. Future research could examine cultural competence within other interventions that target the caregiver-infant relationship.

Following the current study's findings, a study looking further into the potential barriers to accessing VIG could elucidate the difficulties found with access and engagement. It may be useful to include families who have received VIG in research, to address what may facilitate or hinder engagement. Including caregivers suggestions to improve cultural competence has been successful within the parenting intervention literature (e.g. Kim et al., 2010; Osman et al., 2016). However, it is important not to rely only on caregivers' reports, in order not to place the burden on them to improve practice.

The results of the study also suggested that caregivers belonging to minoritised groups may be disproportionately affected by barriers to VIG. It might be beneficial to research VIG practitioners' experiences and perspectives through Discourse Analysis (Wetherell et al., 2001b, 2001a). This would enable examination of participant responses with a specific detail and focus on unspoken aspects of communication and power when considering culture during VIG processes (Wetherell et al., 2001b, 2001a). This is discussed in more detail in context to the limitations of the study in section 4.5.4.3 below.

Whilst the current study was conducted with a perinatal focus, it would be interesting to consider whether the recommendations from this study can also be applied in other settings. Further research could examine whether VIG delivery in other contexts (such as different child ages or with staff teams) provide different findings, that can further contribute to cultural competence within VIG delivery.

4.4.2. Clinical Practice

In the response validation, theme one, the VIG "diamond", was considered to be a memorable model that could be incorporated into the core concept of VIG, with direct implications for practice. As suggested by participants, learning from peer practitioners, such as through peer supervision sessions (i.e. VIG intervision; Dodsworth, 2020) can support implementing the components of the VIG "diamond". As there are already systems in place to facilitate sharing learning and good practice amongst peers, this can feasibly be integrated into routine clinical work.

The subtheme *“she would say there’s no way I’d be videoed with my baby”* highlights not only the difficulties with accessing VIG, but the careful consideration that needs to be employed during the introduction to, and beginning of, the intervention. Participants suggest explicitly paying attention to queries or concerns that caregivers may have, to help support with managing uncertainty about receiving VIG. Curiosity about what might be going on for the caregiver will also facilitate “time” and “space” to build up trust and the therapeutic relationship. In addition, knowing the caregiver better before engaging in VIG could support the caregiver to feel safe and comfortable, and in turn possibly more able to engage in VIG. This may also open up conversation about cultural context, and in turn, how this can be considered within the intervention.

4.4.3. Training

The results suggested that developing proficiency in the approach can be challenging, and holding in mind VIG principles and methods can dominate sessions at the expense of culturally competent care. This suggests a need to consider how current training methods can support practitioners to work more flexibly. Incorporating explicit considerations about culture into VIG supervision and training could ensure context is not being lost within the training phases.

Training to support general skills in working with caregivers and infants and the therapeutic relationship may also help with culturally competent VIG practice. Participants suggested that prior training informed how they managed their own personal assumptions, and shaped how they incorporated cultural context within their work. Supporting the development of general clinical skills and practice may be particularly pertinent for practitioners who have not received therapeutic training in other orientation prior to VIG.

4.4.4. Policy

Participants’ reports about inequalities in access for caregivers from minoritised backgrounds is part of a wider problem (e.g. Womersley et al., 2021). The study highlights the need to close the accessibility gap, and reduce inequalities of NHS care within the perinatal period. This involves improving community services’ implementation to support pregnancy, caregiver mental health, and physical health outcomes for minoritised families (PHE, 2020b). Clinicians in leadership positions, including educational and clinical psychologists, have a duty to recognise the influence of systemic racism in perpetuating inequalities within care and to implement structural changes and strategy, that lead to anti-racist action (Birthrights, 2022; Kapadia et al., 2022). Such as, coordination and collaboration with service users, staff, and key stakeholders to establish action plans that can facilitate sustainable change and improve delivery of care; facilitating services tailored to the local population that is served will contribute to personalised, safer care (Gohir, 2022). This can create the environmental shift required to reduce the conditions that marginalise and 'other' families.

4.5. Critical Evaluation

The current study's quality was examined using Yardley's (2008; 2000) guidelines, which were developed to support qualitative researchers to appraise, improve and establish research quality. Principles underpinning these guidelines have been found to be largely similar across a myriad of previously published recommendations developed to support high quality qualitative research (Cohen & Crabtree, 2008). The suggested areas of critique were deemed appropriate to address quality in this study.

4.5.1. Sensitivity to Context

The socio-cultural and political context that the study exists within was understood and reflected upon within procedures. The researcher examined the prior literature and theoretical context surrounding the study, as outlined in section 1.0. The socio-cultural setting of participants' reports was reflected upon, and considered during analysis and interpretation of findings. For example, reflections on systemic issues of inequality and racism within perinatal care, and how they shaped analysis, was discussed in research supervision and attended to within reflexivity logs. The researcher adopted an open, non-judgemental position to participants' responses, and supported expression of opposing perspectives. Participants were invited to review their transcript and the analysis to facilitate this process, so the findings are sensitive and relevant to a wider community of clinicians, particularly VIG practitioners and VIG trainers.

4.5.2. Commitment and Rigour

Commitment to the topic was shown by the researcher’s in-depth involvement with study materials and proficiency in methodological approach. The researcher was working in a parent-infant service for the majority of the time in which the study was carried out. This facilitated thorough engagement in caregiver-infant literature, therapeutic practice, and implementation of VIG. The researcher also undertook the VIG initial introductory training before study analysis was conducted. This supported the researcher to understand the experiences of the participants and shaped how study implications were considered. The researcher has a continued interest and commitment to delivering culturally competent practice, and had the opportunity to reflect upon culturally competent work with caregivers and infants in clinical and research supervision. Research supervision supported making skilled methodological choices.

Rigour was established through obtaining an adequate sample size within the estimated parameters, and demonstrated by generating findings that answered the research questions and suggested implications. The researcher watched webinars, and read teaching resources and germane literature (e.g. Braun & Clarke, 2022) to familiarise themselves with, and understand the principles of the chosen analysis. The researcher followed suggested guidelines to conduct in-depth data analysis and utilised research supervision to support analytic choices and reflexivity.

4.5.3. Coherence and Transparency

Study aims, methodology and findings reflect a coherent epistemological and ontological position. The critical realist stance adopted was appropriate to examine qualitative interviews of VIG practitioners with reflexive thematic analysis (RTA; see section 2.2. above).

Transparency was achieved through thorough and detailed reporting of the stages carried out within RTA, provided in the section 2.7.2. Each analytic step was accounted for within the appendices, along with evidence that interpretations were drawn from the data. Providing data extracts in the results section supports the researcher’s interpretative claims. Reflexivity was facilitated throughout the analysis process via reflexive logs and discussions in research supervision. The researcher found supervision discussions particularly useful to consider how personal experiences and assumptions shaped the study topic; and personal reactions to participants’ interviews were reflected upon, to consider how these influenced the research process.

4.5.4. Impact and Importance

The study added novel information addressing the gap in literature examining how culture is considered within caregiver-infant interventions within the perinatal period. The findings concern inequalities and cultural insensitivities within NHS services. The study provides an opportunity to raise awareness of how culture is considered within VIG. Having these conversations with practitioners facilitated them to consider culture within practice, and afforded valuable insights on VIG delivery (see section 4.4.).

4.6. Strengths and Limitations

4.6.1. Timing

It is important to consider the wider context in which the study was carried out, and implications this had for study processes and outcomes. As previously mentioned, maternity services and services that support families in the perinatal period have been in receipt of recent government funding as part of a national effort to reduce health inequalities an improve quality of care (DoH, 2022). However, recent reports (arguing for a clear strategy and approach to reducing harms to minoritised families within the perinatal period) have drawn attention to the systemic racism that needs addressing, that money alone cannot resolve. It is important that studies examine how to implement interventions that do not perpetuate systems of harm. With that in mind, this study broadly examined aspects relating to culture and VIG practice. Whilst this topic area was exploratory given the lack of prior research into the area, a more focussed lens on specific aspects of experience could now provide more detailed accounts: for example, participants’ reflections of on how their own ‘race’, ethnicity, religion, or gender is incorporated into VIG delivery, and what efforts might be undertaken to improve the experiences of those who hold marginalised identities.

4.6.2. Sample

Participation was voluntary, self-selected and based on self-report. Whilst this type of sample is prone to recall bias due to memory limitations and social desirability (Althubaiti, 2016), participants' reports suggested that they felt comfortable to express their views, including a lack of experience. However, video-calling interview methods may have contributed to some of the silences or 'forgetting' around culturally competent care. It is possible that the video-calling interview methods create emotional distance between the researcher and participant, influencing how comfortable participants' felt and what they felt able to share. One participant commented on the method of interview and suggested online interviewing was helpful and flexible. Additionally, this recruitment methods enabled recruiting participants with busy clinical schedules, from all over England and Wales. This may have made interviewing more accessible and supported with achieving an adequate sample size.

Whilst determining adequacy of data and sufficiency of sample size is not contingent on how many participants are interviewed (Vasileiou et al., 2018), the sample size fell within the lower end of the estimated number of required interviews, and findings may have been limited by the small sample size. Only interviewing nine participants may have limited the diversity of the sample characteristics, and in turn representation of the views of VIG practitioners. All participants self-identified as white, which may have contributed to a specific lens in how participants related to 'culture'. Although the range of self-identified ethnicities (White British, Irish, and other) were all valuable in offering a range of cultural experiences**.** Only one male participated in the study, which limited representation of male practitioners in this study, however this is largely representative of the gender demography of the psychological professionals workforce in South West England (83.64% female; Gallop et al., 2021). Time constraints meant that recruitment had to close after the appointed time, to begin the analysis. Furthermore, rich data that lead to meaningful findings was generated from the pool of participants, and further interview data collected was in accordance with codes already generated. This suggests that enough data was gathered, data was suitably 'saturated' (Guest et al., 2006) and thus the sample size was sufficient, particularly given the exploratory nature of the study (Vasileiou et al., 2018).

4.6.3. Analysis

The RTA fit the study's explorative approach and facilitated rich narratives about the experiences of VIG practitioners. However, RTA was not conducive to formally analysing the pragmatics of language (e.g., turn-taking, or hesitations in speech) that the researcher noticed. At times participants would go off tangent and need redirecting to the topic, and sometimes the researcher noticed responses that lacked clarity. Implementing a different analysis method, such as discourse analysis would enable formal analysis of the subject positions underpinning language (e.g. Wetherell et al., 2001b, 2001a). However, this method would have required different more specific and focussed research aims and questions. The researcher was able to incorporate some sense of these issues into the analysis during reflexive discussions with the research supervisor and in the reflexive log. Implementing RTA therefore was appropriate to the research aims and questions, and facilitated a good understanding of cultural competence in VIG training and delivery.

4.7. Reflexivity

As documented in the methods section, reflexivity was a central component of the analytic method, whereby the researchers personal assumptions and subjective experience are used as analytic resource (Braun & Clarke, 2006, 2022), which is common across qualitative research designs (Jamieson et al., 2023). Self-reflection is also required for conducting ethical research (Oates et al., 2021). Whilst aspects of experience will have remained unavailable (Finlay, 2002), utilising a reflexive log and supervision supported the researcher to facilitate bringing new perspectives into conscious awareness and guide decision making. Reflexivity was considered according to Wilkinson's (1988) stages outlined earlier; the first person is utilised to denote the personal nature of this experience and process.

4.7.1. Personal Reflexivity

My personal experience and values shaped the research processes and knowledge production. From the outset, I reflected upon how my personal experiences and intersection of my social GGRRAAACCEEESSS shaped how I considered my cultural identity. For example, the lens that I consider culture within is highly intertwined with my experiences of identifying as a White, middle-class, British, Jewish, woman. As my interest in cultural considerations within mental health and therapy developed, I familiarised myself with literature that examined how culture, ‘race’ and ethnicity relates to mental health and clinical psychology (e.g. Fernando, 2010; Patel et al., 2000). This shaped the lens within which the research developed.

I had initially assumed that participants had an interest and depth of experience in reflecting upon cultural context, given that they had volunteered to take part in a study about cultural competence within VIG practice. This then led to feelings of frustration when participants’ narratives around culture and cultural competence were thin and, at times, othering. Supervision helped me to move from a position of stuckness to curiosity. This supported providing further analytic insight.

I reflected upon how all participants self-reported as white, and wondered whether this influenced how the participants responded to me. For example, I wondered whether participants assumed shared experience with me, a white researcher, as they did for with white clients, or how this influenced how they felt during the interview and what information they shared. I was also aware of similarities between my experiences and that of my participants’, given that we all self-identify as white. I reflected upon how I do not consider myself separate from the research findings or implications.

I also reflected on the relationship with participants in terms of power dynamics, which reflected the social positions and professional qualifications held within each interviewer-researcher dyad. However, within the context of the interview, I held power over participants. As such, I attempted to put participants at ease during the interview process and was careful of how I responded to participants views, particularly when I considered these to be othering. For example, I was careful not to challenge participants in the interview, to avoid causing distress. This was also to avoid biasing the research process. However, non-verbal or implicit responses may have affected how participants’ felt and what they shared within interviews. I reflected upon my feelings when exposed to othering attitudes, and wondered whether feelings were generated from a concern about my own capacity to perpetuate othering narratives or cause harm. This motivated me to reflect upon, and look out for analytic blind spots, and interrogate decision making throughout the study.

I noticed how dissatisfaction with some participants' othering approach to culture, and difficulties reporting how cultural contexts were considered, began to influence how the coding developed. I noticed greater coding of responses that verbalised potential barriers to considering culture within VIG. This was discussed in research supervision and the analysis was reviewed and reconsidered. I also noticed a reluctance to include quotes that represented othering and discriminatory perspectives, in order not to alienate participants and to protect readers from harmful viewpoints. Reflexivity facilitated consideration of how these accounts would add to the research questions, and shaped how the findings were considered.

4.7.2. Functional, Disciplinary, and Epistemological Reflexivity

I was aware of the philosophical and methodological limitations, and how the chosen approach shaped knowledge production. I was aware of the ethical implications of interpreting data based upon participants' subjective reports of their experience, and drawing conclusions from facets of experience that were outside of conscious awareness (Willig, 2012), an issue that similarly has been discussed by psychoanalysis-informed researchers (e.g. Saville Young, 2009). To tap into participants' constructions of their experience, follow up questions were framed as much as possible using the participants' language.

In accordance with prior literature, participants' own definition of culture was elicited at the beginning of the interview to shape how this was considered. This was purposeful to facilitate generating accounts of prior experience as close to how participants thought about them at the time of practice, in order not to bias the interview process. However, it may have been useful to provide a definition of culture and culturally competent practice at the beginning of the interview, so that participants had a shared construction from which they considered the research questions. It would have been interesting to see if that shaped how participants reflected upon their practice. This was reflected upon, as some participants had reported that they had not considered culture in their VIG practice before, and expressed wanting to learn ways to think about it.

As noted earlier, the method of analysis limited the ability to interpret the flow of speech or conversation, as highlighted in section 4.6.3. This was discussed in research supervision as a limitation to an otherwise useful and appropriate analytic method.

4.8. Conclusion

This study explored VIG practitioners' experiences of working with caregivers and infants across cultures; and their perspectives on culturally competent delivery of VIG. Participants shared their experiences of some cultural considerations within VIG, as well as challenges, and some difficulties considering how to improve the cultural competence of their practice. Participants were interested in the study topic and were eager to facilitate change. The findings suggest the relevance for the conversation about culture, and the potential for all VIG practitioners to consider how cultural context is influencing them and their clients' perspectives. Whilst there may be specific aspects of VIG that can facilitate this, there are wider implications for how practitioners work with families in general, in terms of their therapeutic skills, and how they consider culture within their work. This research highlights the risks of missing families, and neglecting untold stories; and the importance of moving towards creating change within individual practice and wider VIG training and delivery. This also has implications for service-wide, organisational responsibilities and a role for policy committing to action to address systemic inequalities and injustice.

The research was novel in its focus on culturally competent care within caregiver interventions in the perinatal period. The paucity of prior research suggests there is a long way to go in understanding the role cultural context plays in shaping therapeutic interventions within the perinatal period. However, a communal effort to both contribute to gaining new knowledge, and sharing learning across professional groups, therapeutic modalities, stakeholders and contexts, can begin to bridge the gap in order to deliver the inclusive and meaningful care that families deserve.

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6. APPENDICES

Appendix A

Literature Search

Searches		**Result**
Database 1: PsychINFO: 1999 to 2024; English		
	DE "Parenting" OR DE "Parent Child Relations" OR DE "Father Child Relations" OR DE "Mother Child Relations" OR DE "Perinatal Period"	227
AND	AB (intervention or therapy or treatment or program*)	
AND	AND TI cultur*	
Database 2: Academic Search Ultimate: 1999 to 2024; English		
	DE "PARENT-child relationships" OR DE "ADOPTION" OR DE "ATTACHMENT behavior in children" OR DE "BEST interests of the child (Law)" OR DE "CHILD abuse" OR DE "EIDETIC parents test" OR DE "ELECTRA complex" OR DE "EMOTIONAL incest" OR DE "FAMILY relationships of older people" OR DE "FATHER-child relationship" OR DE "FILIAL piety" OR DE "MOTHER-child relationship" OR DE "PARENT-adult child relationships" OR DE "PARENT-infant relationships" OR DE "PARENT-student relationships" OR DE "PARENT-teenager relationships" OR DE "PARENTAL acceptance" OR DE "PARENTAL deprivation" OR DE "PARENTAL influences" OR DE "PARENTAL notification (Medical law)" OR DE "PARENTAL overprotection" OR DE "PARENTAL preferences for sex of children" OR DE "PARENTAL rejection" OR DE "PARENTIFICATION" OR DE "PARENTING" OR DE "SEPARATION-individuation" OR DE "STEPCHILDREN" OR DE "STEPFATHERS" OR DE "STEPMOTHERS" OR DE "UNWANTED children" OR DE "PERINATAL period")	220
AND	AB (intervention or therapy or treatment or program*)	
AND	TI cultur*	
Database 3: CINHAL: 1999; English		
	"perinatal period" or "parent child" or "mother child" or "father child" or "caregiver child"	90
AND	AB (intervention or therapy or treatment or program*)	
AND	TI cultur*	
Database 4: Scopus: 1999 to 2024; English		
	TITLE-ABS-KEY ("perinatal period" OR "parent child" OR "mother child" OR "father child" OR "caregiver child")	220
AND	ABS (intervention OR therapy OR treatment OR program*)	
AND	TITLE (cultur*)	

Appendix B

University of East London Ethics Application and Approval

UNIVERSITY OF EAST LONDON

School of Psychology

APPLICATION FOR RESEARCH ETHICS APPROVAL FOR RESEARCH INVOLVING HUMAN PARTICIPANTS

(Updated October 2021)

FOR BSc RESEARCH;
MSc/MA RESEARCH;
PROFESSIONAL DOCTORATE RESEARCH IN CLINICAL, COUNSELLING & EDUCATIONAL PSYCHOLOGY

Section 1 – Guidance on Completing the Application Form (please read carefully)	
1.1	Before completing this application, please familiarise yourself with: ▪ British Psychological Society's Code of Ethics and Conduct ▪ UEL's Code of Practice for Research Ethics ▪ UEL's Research Data Management Policy ▪ UEL's Data Backup Policy
1.2	Email your supervisor the completed application and all attachments as ONE WORD DOCUMENT. Your supervisor will look over your application and provide feedback.
1.3	When your application demonstrates a sound ethical protocol, your supervisor will submit it for review.
1.4	Your supervisor will let you know the outcome of your application. Recruitment and data collection must **NOT** commence until your ethics application has been approved, along with other approvals that may be necessary (see section 7).
1.5	Research in the NHS: ▪ If your research involves patients or service users of the NHS, their relatives or carers, as well as those in receipt of services provided under contract to the NHS, you will need to apply for HRA approval/NHS permission (through IRAS). You DO NOT need to apply to the School of Psychology for ethical clearance. ▪ Useful websites:

	https://www.myresearchproject.org.uk/Signin.aspx https://www.hra.nhs.uk/approvals-amendments/what-approvals-do-i-need/hra-approval/ ▪ If recruitment involves NHS staff via the NHS, an application will need to be submitted to the HRA in order to obtain R&D approval. This is in addition to separate approval via the R&D department of the NHS Trust involved in the research. UEL ethical approval will also be required. ▪ HRA/R&D approval is not required for research when NHS employees are not recruited directly through NHS lines of communication (UEL ethical approval is required). This means that NHS staff can participate in research without HRA approval when a student recruits via their own social/professional networks or through a professional body such as the BPS, for example. ▪ The School strongly discourages BSc and MSc/MA students from designing research that requires HRA approval for research involving the NHS, as this can be a very demanding and lengthy process.
1.6	If you require Disclosure Barring Service (DBS) clearance (see section 6), please request a DBS clearance form from the Hub, complete it fully, and return it to applicantchecks@uel.ac.uk. Once the form has been approved, you will be registered with GBG Online Disclosures and a registration email will be sent to you. Guidance for completing the online form is provided on the GBG website: https://fadv.onlinedisclosures.co.uk/Authentication/Login You may also find the following website to be a useful resource: https://www.gov.uk/government/organisations/disclosure-and-barring-service
1.7	Checklist, the following attachments should be included if appropriate: ▪ Study advertisement ▪ Participant Information Sheet (PIS) ▪ Participant Consent Form ▪ Participant Debrief Sheet ▪ Risk Assessment Form/Country-Specific Risk Assessment Form (see section 5) ▪ Permission from an external organisation (see section 7) ▪ Original and/or pre-existing questionnaire(s) and test(s) you intend to use ▪ Interview guide for qualitative studies ▪ Visual material(s) you intend showing participants

Section 2 – Your Details

2.1	**Your name:**	**Miriam Woolfman**
2.2	**Your supervisor's name:**	**Dr. Matthew Jones Chesters**
2.3	**Name(s) of additional UEL supervisors:**	**Dr. Camilla Rosan**
		3rd supervisor (if applicable)
2.4	**Title of your programme:**	**Doctorate in Clinical Psychology**

2.5	**UEL assignment submission date:**	**23/05/2023** Re-sit date (if applicable)

Section 3 – Project Details

Please give as much detail as necessary for a reviewer to be able to fully understand the nature and purpose of your research.

3.1	**Study title:** Please note - If your study requires registration, the title inserted here must be the same as that on PhD Manager	Practitioner experiences of delivering Video Interaction Guidance with caregivers and infants: Toward Culturally Competent Care
3.2	**Summary of study background and aims (using lay language):**	The proposed study aims to fill a current gap in the literature by qualitatively exploring how practitioner psychologists implement Video Interaction Guidance (VIG) with caregivers and infants across cultures. A small scale study suggested effectiveness and acceptability of VIG in families from minoritised ethnic backgrounds (Chakkalackal et al., 2021). However, the methods in which culturally competent practice is implemented, and ways caregivers' experiences and preferences are considered during the intervention were not specifically examined. The results of this study can inform clinical psychologists' and allied professionals' practice, improve the support for caregivers and inform practitioner training. In particular, this research can reduce inequalities for racialised caregivers in perinatal services.
3.3	**Research question(s):**	What are the experiences of VIG practitioners working with caregivers and infants across cultures? What is the perceived relevance of considering cultural factors when delivering VIG?
3.4	**Research design:**	Qualitative methodology, delivering semi-structured interviews to approximately 12 participants (psychologists delivering VIG within perinatal/parent-infant services)
3.5	**Participants:** Include all relevant information including inclusion and exclusion criteria	Participants must have received accredited VIG training and be either a practitioner psychologist or supervised by a practitioner psychologist Participants must have worked with caregivers and

		infants in the perinatal period and up until 2 years of age. The inclusion of up to 2 years is to ensure the study does not exclude those working in infant services that support families with children up to 2 years old. Excluding a substantial proportion of infant workers may restrict the pool of potential participants and limit applicability of findings. Participants must have had delivered VIG with at least 5 cases of caregivers and infants to ensure there is depth of experience.
3.6	**Recruitment strategy:** Provide as much detail as possible and include a backup plan if relevant	Participants will be recruited via word of mouth through the researcher's contacts, social media, and professional networks and groups, e.g. XXXXXXX. Primary recruitment method would be targeting those working in perinatal teams or other aligned services, with a focus on practitioner psychologists in those teams or other psychological practitioners who are supervised by a practitioner psychologist. This was selected due to the importance of knowledge and experience of considering the processes within the therapeutic relationship and delivery of VIG, that is a key part of practitioner psychologists' way of working (Health and Care Professions Council, 2015) but not a compulsory practice of VIG. Participants will sign up and access information about the study through a survey on the Qualtrics XM Platform™. They will enter basic contact information about themselves and email address there, which I will then follow up from. The site will serve to manage sending out of the information sheet, consent form and debriefing form.
3.7	**Measures, materials or equipment:** Provide detailed information, e.g., for measures, include scoring instructions, psychometric properties, if freely available, permissions required, etc.	Participant information sheet, debrief sheet, consent form, semi-structured interview.
3.8	**Data collection:**	Participants will be provided an information sheet and asked to sign a consent form confirming that they have read and understood what they can

	Provide information on how data will be collected from the point of consent to debrief	expect from taking part in the study and what will happen to their data. Participants will attend an online interview on Microsoft Teams, which will be recorded to support with later transcription. Participants will be offered a chance to speak about their experiences of being interviewed and will be provided with debriefing information (verbally and written).	
3.9	**Will you be engaging in deception?**	**YES** ☐	**NO** ☒
	If yes, what will participants be told about the nature of the research, and how/when will you inform them about its real nature?	If you selected yes, please provide more information here	
3.10	**Will participants be reimbursed?**	**YES** ☐	**NO** ☒
	If yes, please detail why it is necessary.	Participants will be entered into a draw to receive Love2Shop vouchers	
	How much will you offer? Please note - This must be in the form of vouchers, not cash.	£50 Love2Shop vouchers	
3.11	**Data analysis:**	Interviews will be recorded using Microsoft Teams. These will be uploaded to university's secure online platform (Microsoft Stream). Recordings will be transcribed and deleted as soon as transcription has been checked and completed. The interview transcripts (data) will be analysed using Reflexive Thematic Analysis (TA; Braun & Clarke, 2006, 2021), which undergoes the following process: familiarisation with interview transcripts, initial codes generated from the data, codes are then collated into themes. Themes are reviewed and refined, and checked back against the initial data set (interview transcript). Themes are then defined and named, and then written up into the thesis. Research supervisors will have input in terms of discussing allocated codes and themes and supporting with inter-rater reliability. Participants will be provided the option of being contacted after undergoing analysis of transcripts to review the themes and model generated from the whole data	

		set. Participants will be asked whether they would like to be contacted for this when gathering informed consent to take part in research. This process can improve the practicality and credibility of the findings – known as respondent validation or member checking . The processes of this will be described in the study write up in order to accurately represent their involvement and to avoid tokenism (Birt et al., 2016).

Section 4 – Confidentiality, Security and Data Retention

It is vital that data are handled carefully, particularly the details about participants. For information in this area, please see the UEL guidance on data protection, and also the UK government guide to data protection regulations.

If a Research Data Management Plan (RDMP) has been completed and reviewed, information from this document can be inserted here.

4.1	**Will the participants be anonymised at source?**	**YES** ☐	**NO** ☒
	If yes, please provide details of how the data will be anonymised.	Please detail how data will be anonymised	
4.2	**Are participants' responses anonymised or are an anonymised sample?**	**YES** ☒	**NO** ☐
	If yes, please provide details of how data will be anonymised (e.g., all identifying information will be removed during transcription, pseudonyms used, etc.).	All identifying information will be removed during transcription and pseudonyms will be used in the transcript and write up. Minimal demographic information will be collected. Care will be taken to ensure that as far as possible, participants cannot be identified from what they have said. Demographic information that is reported will not be tied to any participant. Participants will be informed in the information sheet that quotes from the interview may be used in the final write up of the study. Participants will have the opportunity to check over their transcript, and asked if there were anything they would like to remove from the analysis or to not be quoted on. Participants will be reminded of this in the debrief.	
4.3	**How will you ensure participant details will be kept confidential?**	Qualtrics XM Platform™ is secure, encrypted and will keep participant's basic contact information	

		confidential. A spreadsheet including names and contact details will be created to record the individuals who express an interest in taking part in the study to serve as a waiting list. Documents such as this containing contact information will be stored separately from the demographic information and the anonymised/pseudonymised transcripts. Recorded interviews will be written up into anonymised/pseudonymised transcripts and anonymised/pseudonymised records of demographic information, then deleted. All data with personal or sensitive information (e.g. participant contact information, consent forms) will be stored in separate folders on the UEL OneDrive for business account to protect anonymity.
4.4	**How will data be securely stored and backed up during the research?** Please include details of how you will manage access, sharing and security	Contact information will be processed through Qualtrics XM Platform™, a secure and encrypted platform, which is backed up regularly, and enables sole access by the research team, through Multi-Factor Authentication. All other data will be stored on UEL OneDrive for business (a secure and encrypted online storage platform provided by the university), which is backed up at regular intervals. It will be accessed via the researcher's password protected personal laptop or via a password protected UEL network account on campus computers. Anonymised/pseudonymised data such as interview transcripts and demographic information will be shared with research supervisors (Dr. Matthew Jones Chesters and Dr. Camilla Rosan) to allow for checks and research guidance via OneDrive secure links. They may also be shared with examiners.
4.5	**Who will have access to the data and in what form?** (e.g., raw data, anonymised data)	Only the researcher has direct access to the raw data and contact information. This may be shared with research supervisors Dr. Matthew Jones Chesters and Dr. Camilla Rosan if required for checks or guidance. Research supervisors Dr. Matthew Jones Chesters and Dr. Camilla Rosan and the examiners will have access to the anonymised/pseudonymised data.

4.6	**Which data are of long-term value and will be retained?** (e.g., anonymised interview transcripts, anonymised databases)	The study write up will be considered as having long term value to the wider field and thus will be shared publicly via UEL's data repository when the project is completed and passed by examiners. Documents pertaining to analysis, demographic information and the anonymised/pseudonymised interview transcripts may be required to support with dissemination activities for the research and sharing the findings with participants. During this time, the data will be stored in the researcher supervisor's OneDrive for business account. Only the researcher and the researcher's supervisor will have access to this data. Other data that remains that is not considered to have long-term value will be deleted from UEL OneDrive for Business account and the Qualtrics XM Platform™, after the project is completed and passed by examiners.	
4.7	**What is the long-term retention plan for this data?**	Data that is kept post study completion will be stored for 3 years to support with dissemination activities for the research. After this time period, the only data that will remain will be that which is included in the study write up and other reports/documents pertaining to public dissemination activities. All other data will be deleted.	
4.8	**Will anonymised data be made available for use in future research by other researchers?**	**YES** ☐	**NO** ☒
	If yes, have participants been informed of this?	**YES** ☐	**NO** ☐
4.9	**Will personal contact details be retained to contact participants in the future for other research studies?**	**YES** ☐	**NO** ☒
	If yes, have participants been informed of this?	**YES** ☐	**NO** ☐

Section 5 – Risk Assessment

If you have serious concerns about the safety of a participant, or others, during the course of your research please speak with your supervisor as soon as possible. If there is any unexpected

occurrence while you are collecting your data (e.g., a participant or the researcher injures themselves), please report this to your supervisor as soon as possible.				
5.1	**Are there any potential physical or psychological risks to participants related to taking part?** (e.g., potential adverse effects, pain, discomfort, emotional distress, intrusion, etc.)	**YES** ☒	**NO** ☐	
	If yes, what are these, and how will they be minimised?	To understand practitioners' experiences, interview questions may cover challenging or sensitive subjects, which may lead to emotional distress. To mitigate this, participants will be provided information about where to seek support should they be feeling distressed. Participants' wellbeing will also be spoken about during debriefing.		
5.2	**Are there any potential physical or psychological risks to you as a researcher?**	**YES** ☒	**NO** ☐	
	If yes, what are these, and how will they be minimised?	There is a chance of emotional distress to the me, the researcher if participants speak of a difficult, distressing or uncomfortable experience. I have experience of supporting people who disclose distressing information and have shown to be able to deal with such discussions without any significant psychological harm. I will receive supervision from my research supervisors and will receive support if need be.		
5.3	**If you answered yes to either 5.1 and/or 5.2, you will need to complete and include a General Risk Assessment (GRA) form (signed by your supervisor). Please confirm that you have attached a GRA form as an appendix:**	**YES** ☒		
5.4	**If necessary, have appropriate support services been identified in material provided to participants?**	**YES** ☒	**NO** ☐	**N/A** ☐
5.5	**Does the research take place outside the UEL campus?**	**YES** ☒	**NO** ☐	

	If yes, where?	**Research is carried out remotely either on UEL campus or at the home of the researcher.**	
5.6	**Does the research take place outside the UK?**	**YES** ☐	**NO** ☒
	If yes, where?	Please state the country and other relevant details	
	If yes, in addition to the General Risk Assessment form, a Country-Specific Risk Assessment form must also be completed and included (available in the Ethics folder in the Psychology Noticeboard). Please confirm a Country-Specific Risk Assessment form has been attached as an appendix. Please note - A Country-Specific Risk Assessment form is not needed if the research is online only (e.g., Qualtrics survey), regardless of the location of the researcher or the participants.	**YES** ☐	
5.7	**Additional guidance:** ▪ For assistance in completing the risk assessment, please use the AIG Travel Guard website to ascertain risk levels. Click on 'sign in' and then 'register here' using policy # 0015865161. Please also consult the Foreign Office travel advice website for further guidance. ▪ For on campus students, once the ethics application has been approved by a reviewer, all risk assessments for research abroad must then be signed by the Director of Impact and Innovation, Professor Ian Tucker (who may escalate it up to the Vice Chancellor). ▪ For distance learning students conducting research abroad in the country where they currently reside, a risk assessment must also be carried out. To minimise risk, it is recommended that such students only conduct data collection online. If the project is deemed low risk, then it is not necessary for the risk assessment to be signed by the Director of Impact and Innovation. However, if not deemed low risk, it must be signed by the Director of Impact and Innovation (or potentially the Vice Chancellor). ▪ Undergraduate and M-level students are not explicitly prohibited from conducting research abroad. However, it is discouraged because of the inexperience of the students and the time constraints they have to complete their degree.		

Section 6 – Disclosure and Barring Service (DBS) Clearance			
6.1	**Does your research involve working with children (aged 16 or under) or vulnerable adults (*see below for definition)?** If yes, you will require Disclosure Barring Service (DBS) or equivalent (for those residing in countries outside of the UK) clearance to conduct the research project	**YES** ☐	**NO** ☒
	* You are required to have DBS or equivalent clearance if your participant group involves: (1) Children and young people who are 16 years of age or under, or (2) 'Vulnerable' people aged 16 and over with particular psychiatric diagnoses, cognitive difficulties, receiving domestic care, in nursing homes, in palliative care, living in institutions or sheltered accommodation, or involved in the criminal justice system, for example. Vulnerable people are understood to be persons who are not necessarily able to freely consent to participating in your research, or who may find it difficult to withhold consent. If in doubt about the extent of the vulnerability of your intended participant group, speak with your supervisor. Methods that maximise the understanding and ability of vulnerable people to give consent should be used whenever possible.		
6.2	**Do you have DBS or equivalent (for those residing in countries outside of the UK) clearance to conduct the research project?**	**YES** ☒	**NO** ☐
6.3	**Is your DBS or equivalent (for those residing in countries outside of the UK) clearance valid for the duration of the research project?**	**YES** ☒	**NO** ☐
6.4	**If you have current DBS clearance, please provide your DBS certificate number:**	**XXXXXXXX**	
	If residing outside of the UK, please detail the type of clearance and/or provide certificate number.	Please provide details of the type of clearance, including any identification information such as a certificate number	
6.5	**Additional guidance:** ▪ If participants are aged 16 or under, you will need two separate information sheets, consent forms, and debrief forms (one for the participant, and one for their parent/guardian).		

	▪ For younger participants, their information sheets, consent form, and debrief form need to be written in age-appropriate language.

Section 7 – Other Permissions

7.1	**Does the research involve other organisations (e.g., a school, charity, workplace, local authority, care home, etc.)?**	**YES** ☐	**NO** ☒
	If yes, please provide their details.	Please provide details of organisation	
	If yes, written permission is needed from such organisations (i.e., if they are helping you with recruitment and/or data collection, if you are collecting data on their premises, or if you are using any material owned by the institution/organisation). Please confirm that you have attached written permission as an appendix.	**YES** ☐	
7.2	**Additional guidance:** ▪ Before the research commences, once your ethics application has been approved, please ensure that you provide the organisation with a copy of the final, approved ethics application or approval letter. Please then prepare a version of the consent form for the organisation themselves to sign. You can adapt it by replacing words such as 'my' or 'I' with 'our organisation' or with the title of the organisation. This organisational consent form must be signed before the research can commence. ▪ If the organisation has their own ethics committee and review process, a SREC application and approval is still required. Ethics approval from SREC can be gained before approval from another research ethics committee is obtained. However, recruitment and data collection are NOT to commence until your research has been approved by the School and other ethics committee/s.		

Section 8 – Declarations

8.1	**Declaration by student. I confirm that I have discussed the ethics and feasibility of this research proposal with my supervisor:**	**YES** ☒
8.2	**Student's name:** (Typed name acts as a signature)	**Miriam Woolfman**

8.3	**Student's number:**	**XXXXX**
8.4	**Date:**	**26/09/2022**
Supervisor's declaration of support is given upon their electronic submission of the application		

School of Psychology Ethics Committee

NOTICE OF ETHICS REVIEW DECISION LETTER

For research involving human participants

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

Reviewer: Please complete sections in blue | **Student:** Please complete/read sections in orange

Details

Reviewer:	**Fiorentina Sterkaj**
Supervisor:	**Matthew Jones Chesters**
Student:	**Miriam WOOLFMAN**
Course:	**Prof Doc Clinical Psychology**
Title of proposed study:	Please type title of proposed study

Checklist

(Optional)

	YES	NO	N/A
Concerns regarding study aims (e.g., ethically/morally questionable, unsuitable topic area for level of study, etc.)	☐	☐	☐
Detailed account of participants, including inclusion and exclusion criteria	☐	☐	☐
Concerns regarding participants/target sample	☐	☐	☐
Detailed account of recruitment strategy	☐	☐	☐
Concerns regarding recruitment strategy	☐	☐	☐
All relevant study materials attached (e.g., freely available questionnaires, interview schedules, tests, etc.)	☐	☐	☐
Study materials (e.g., questionnaires, tests, etc.) are appropriate for target sample	☐	☐	☐
Clear and detailed outline of data collection	☐	☐	☐
Data collection appropriate for target sample	☐	☐	☐
If deception being used, rationale provided, and appropriate steps followed to communicate study aims at a later point	☐	☐	☐

If data collection is not anonymous, appropriate steps taken at later stages to ensure participant anonymity (e.g., data analysis, dissemination, etc.) – anonymisation, pseudonymisation	☐	☐	☐
Concerns regarding data storage (e.g., location, type of data, etc.)	☐	☐	☐
Concerns regarding data sharing (e.g., who will have access and how)	☐	☐	☐
Concerns regarding data retention (e.g., unspecified length of time, unclear why data will be retained/who will have access/where stored)	☐	☐	☐
If required, General Risk Assessment form attached	☐	☐	☐
Any physical/psychological risks/burdens to participants have been sufficiently considered and appropriate attempts will be made to minimise	☐	☐	☐
Any physical/psychological risks to the researcher have been sufficiently considered and appropriate attempts will be made to minimise	☐	☐	☐
If required, Country-Specific Risk Assessment form attached	☐	☐	☐
If required, a DBS or equivalent certificate number/information provided	☐	☐	☐
If required, permissions from recruiting organisations attached (e.g., school, charity organisation, etc.)	☐	☐	☐
All relevant information included in the participant information sheet (PIS)	☐	☐	☐
Information in the PIS is study specific	☐	☐	☐
Language used in the PIS is appropriate for the target audience	☐	☐	☐
All issues specific to the study are covered in the consent form	☐	☐	☐
Language used in the consent form is appropriate for the target audience	☐	☐	☐
All necessary information included in the participant debrief sheet	☐	☐	☐
Language used in the debrief sheet is appropriate for the target audience	☐	☐	☐
Study advertisement included	☐	☐	☐
Content of study advertisement is appropriate (e.g., researcher’s personal contact details are not shared, appropriate language/visual material used, etc.)	☐	☐	☐

Decision options

APPROVED	Ethics approval for the above-named research study has been granted from the date of approval (see end of this notice), to the date it is submitted for assessment.
APPROVED - BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES	In this circumstance, the student must confirm with their supervisor that all minor amendments have been made **before** the research commences. Students are to do this by filling in the confirmation box at the end of this form once all amendments have been attended to and emailing a copy of this decision notice to the supervisor. The supervisor will then forward the student’s confirmation to the School for its records. **Minor amendments guidance:** typically involve clarifying/amending information presented to participants (e.g., in the PIS, instructions), further

	detailing of how data will be securely handled/stored, and/or ensuring consistency in information presented across materials.
NOT APPROVED - MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED	In this circumstance, a revised ethics application **must** be submitted and approved **before** any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application. **Major amendments guidance:** typically insufficient information has been provided, insufficient consideration given to several key aspects, there are serious concerns regarding any aspect of the project, and/or serious concerns in the candidate's ability to ethically, safely and sensitively execute the study.

Decision on the above-named proposed research study

Please indicate the decision:	**APPROVED**

Minor amendments

Please clearly detail the amendments the student is required to make

Major amendments

Please clearly detail the amendments the student is required to make

Assessment of risk to researcher

	YES	**NO**
	☒	☐

Has an adequate risk assessment been offered in the application form?	If no, please request resubmission with an **adequate risk assessment.**	
If the proposed research could expose the researcher to any kind of emotional, physical or health and safety hazard, please rate the degree of risk:		
HIGH	Please **do not approve a high-risk** application. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not be approved on this basis. If unsure, please refer to the Chair of Ethics.	☐
MEDIUM	Approve but include appropriate recommendations in the below box.	☐
LOW	Approve and if necessary, include any recommendations in the below box.	☒
Reviewer recommendations in relation to risk (if any):	Please insert any recommendations	

Reviewer's signature

Reviewer: (Typed name to act as signature)	**Dr Fiorentina Sterkaj**
Date:	**28/10/2022**

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Ethics Committee

RESEARCHER PLEASE NOTE

For the researcher and participants involved in the above-named study to be covered by UEL's Insurance, prior ethics approval from the School of Psychology (acting on behalf of the UEL Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

For a copy of UEL's Personal Accident & Travel Insurance Policy, please see the Ethics Folder in the Psychology Noticeboard.

Confirmation of minor amendments

(Student to complete)

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data	
Student name: (Typed name to act as signature)	Please type your full name
Student number:	Please type your student number
Date:	Click or tap to enter a date
Please submit a copy of this decision letter to your supervisor with this box completed if minor amendments to your ethics application are required	

Appendix C

Ethics Amendment to Contact Participants to Review Analysis and Approval

University of
East London

School of Psychology Ethics Committee

REQUEST FOR AMENDMENT TO AN ETHICS APPLICATION

For BSc, MSc/MA and taught Professional Doctorate students

Please complete this form if you are requesting approval for proposed amendment(s) to an ethics application that has been approved by the School of Psychology

Note that approval must be given for significant change to research procedure that impact on ethical protocol. If you are not sure as to whether your proposed amendment warrants approval, consult your supervisor or contact Dr Trishna Patel (Chair of School Ethics Committee).

How to complete and submit the request	
1	Complete the request form electronically.
2	Type your name in the 'student's signature' section (page 2).
3	When submitting this request form, ensure that all necessary documents are attached (see below).
4	Using your UEL email address, email the completed request form along with associated documents to Dr Trishna Patel: t.patel@uel.ac.uk
5	Your request form will be returned to you via your UEL email address with the reviewer's decision box completed. Keep a copy of the approval to submit with your dissertation.
6	Recruitment and data collection are **not** to commence until your proposed amendment has been approved.

Required documents	
A copy of your previously approved ethics application with proposed amendment(s) added with track changes.	**YES** ☒
Copies of updated documents that may relate to your proposed amendment(s). For example, an updated recruitment notice, updated participant information sheet, updated consent form, etc.	**YES** ☒

A copy of the approval of your initial ethics application.	**YES** ☒

Details

Name of applicant:	**Miriam Woolfman**
Programme of study:	**Professional Doctorate in Clinical Psychology**
Title of research:	**Practitioner experiences of delivering Video Interaction Guidance with caregivers and infants: Toward Culturally Competent Care**
Name of supervisor:	**Dr. Matthew Jones Chesters**

Proposed amendment(s)

Briefly outline the nature of your proposed amendment(s) and associated rationale(s) in the boxes below

Proposed amendment	**Rationale**
To contact participants after undergoing analysis of transcripts to review the themes and model generated from the whole data set. Participants will be asked whether they would like to be contacted for this when gathering informed consent to take part in research.	This process can improve the practicality and credibility of the findings – known as respondent validation or member checking . The processes of this will be described in the study write up in order to accurately represent their involvement and to avoid tokenism (Birt et al., 2016).
Proposed amendment	Rationale for proposed amendment
Proposed amendment	Rationale for proposed amendment
Proposed amendment	Rationale for proposed amendment

Confirmation

Is your supervisor aware of your proposed amendment(s) and have they agreed to these changes?	**YES** ☒	**NO** ☐

Student's signature

Student: (Typed name to act as signature)	**Miriam Woolfman**
Date:	**28/11/2022**

Reviewer's decision		
Amendment(s) approved:	**YES** ☒	**NO** ☐
Comments:	Please enter any further comments here	
Reviewer: (Typed name to act as signature)	**Trishna Patel**	
Date:	**29/11/2022**	

Appendix D

Participant Information Sheet

Version: 3; Date: 29th November 2022

PARTICIPANT INFORMATION SHEET

Video Interaction Guidance:
Toward Culturally Competent Care

Contact: Miriam Woolfman Email: u2075234@uel.ac.uk

You are being invited to participate in a research study. Before you decide whether to take part or not, please carefully read through the following information which outlines what your participation would involve. Feel free to talk with others about the study (e.g., friends, family, etc.) before making your decision. If anything is unclear or you have any questions, please do not hesitate to contact me on the above email.

Who am I?

My name is Miriam Woolfman. I am a postgraduate student in the School of Psychology at the University of East London (UEL) and am studying for a Doctorate in Clinical Psychology. As part of my studies, I am conducting the research that you are being invited to participate in.

What is the purpose of the research?

I am conducting research into practitioner experiences of delivering the parenting intervention Video Interaction Guidance (VIG), and cultural factors related to its delivery. My research findings will hopefully suggest how to promote better delivery and access of VIG.

Why have I been invited to take part?

To address the study aims, I am inviting VIG practitioners working in services supporting caregivers and infants to take part in my research. If you are a psychologist or psychotherapist, or receive supervision from someone who is, and deliver VIG to caregivers and infants aged 0-2 you are eligible to take part in the study. It is entirely up to you whether you take part or not, participation is voluntary.

What will I be asked to do if I agree to take part?

If you agree to take part, you will be asked to participate in an informal interview lasting 40-60 minutes over Microsoft Teams.

- In the interview, you will be asked questions about your experience of delivering VIG in the service you work in. This will involve questions about how you offer VIG to families, the things you may like or find challenging about delivering the intervention, and aspects about your experience related to your cultural identity.
- The interview will be recorded over Microsoft Teams for transcription purposes.
- Please find a quiet and private space to speak.
- You can choose to be entered into a draw to receive £50 Love2Shop vouchers.

Can I change my mind?

Yes, you can change your mind at any time and withdraw without explanation, disadvantage or consequence. If you would like to withdraw, you can do so at any time. This can be before or during the interview. If you withdraw, your data will not be used as part of the research.

Separately, you can also request to withdraw your data from being used even after you have taken part in the study, provided that this request is made within 3 weeks of the data being collected (after which point the data analysis will begin, and withdrawal will not be possible).

Are there any disadvantages to taking part?

- I will be asking you questions about your experiences of delivering VIG to caregivers and infants and some personal questions about your own background, culture and experiences of parenting. Given the sensitive nature of the topic area, it may bring up feelings of emotional distress or discomfort.
- You will get the opportunity to speak about how you are feeling after the interview, and you will be given information about who you can contact for further support if needed.

How will the information I provide be kept secure and confidential?

- You will not be identified by the data collected, on any material resulting from the data collected, or in any write-up of the research. Your interview will be recorded, and you will be assigned a pseudonym when it is written up into an interview transcript, so that your personal details will not appear in any reports. Any demographic information collected will not be tied to any specific participant in the write up.
- The interview transcript will be deleted after transcription has been completed.
- Contact details will be stored in a secure, password protected, digital folder until the study has been completed and findings have been disseminated, then they will be deleted.

- All files and data related to the research will be stored on the university's secure password protected online platform. Any transfer of data will be sent via secure university emails.
- The researcher and research supervisors will have access to the raw and anonymised data. Examiners will also have access to the anonymised/pseudonymised data for the purposes of grading.

For the purposes of data protection, the University of East London is the Data Controller for the personal information processed as part of this research project. The University processes this information under the 'public task' condition contained in the General Data Protection Regulation (GDPR). Where the University processes particularly sensitive data (known as 'special category data' in the GDPR), it does so because the processing is necessary for archiving purposes in the public interest, or scientific and historical research purposes or statistical purposes. The University will ensure that the personal data it processes is held securely and processed in accordance with the GDPR and the Data Protection Act 2018. For more information about how the University processes personal data please see www.uel.ac.uk/about/about-uel/governance/information-assurance/data-protection

What will happen to the results of the research?

The research will be written up as a thesis and submitted for assessment. The thesis will be publicly available on UEL's online Repository [Registry of Open Access Repositories, ROAR]. Findings will also be disseminated to a range of audiences (e.g., academics, clinicians, public, etc.). This might be through journal articles, conference presentations, talks or blogs. In all material produced, your identity will remain anonymous, in that, it will not be possible to identify you personally as personally identifying information will either be removed or replaced. This includes quotes or extracts of the conversation we have used in the report as evidence of study findings.

You will be given the option to check over your transcript and let me know if there was anything you would like to remove from the analysis or to not be quoted on.

You will be given the option to review the themes and model developed in the analysis to provide feedback on.

You will be given the option to receive a summary of the research findings once the study has been completed for which relevant contact details will need to be provided.

Anonymised research data (such as interview transcripts) will be securely stored by Dr. Mathew Jones Chesters for a maximum of 3 years, following which all data will be deleted.

Who has reviewed the research?
My research has been approved by the School of Psychology Research Ethics Committee. This means that the Committee's evaluation of this ethics application has been guided by the standards of research ethics set by the British Psychological Society.

Who can I contact if I have any questions/concerns?

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me.

Miriam Woolfman Email: u2075234@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact my research supervisor: Dr. Matthew Jones Chesters, School of Psychology, University of East London, Water Lane, London E15 4LZ,
Email: m.h.jones-chesters@uel.ac.uk

or

Chair of School Research Ethics Committee: Dr. Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ.
(Email: t.patel@uel.ac.uk)

Thank you for taking the time to read this information sheet

Appendix E

Participant Consent Form

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Video Interaction Guidance:
Toward Culturally Competent Care

Contact: Miriam Woolfman Email: u2075234@uel.ac.uk

	Please initial
I confirm that I have read the participant information sheet dated 29/11/2022 (version 3) for the above study and that I have been given a copy to keep.	
I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
I understand that my participation in the study is voluntary and that I may withdraw at any time, without explanation or disadvantage.	
I understand that if I withdraw during the study, my data will not be used.	
I understand that I have 3 weeks from the date of the interview to withdraw my data from the study.	
I understand that the interview will be recorded using Microsoft Teams	
I understand that my personal information and data, including video recordings from the research will be securely stored and remain confidential. Only the research team will have access to this information, to which I give my permission.	
It has been explained to me what will happen to the data once the research has been completed.	
I understand that short, anonymised quotes from my interview data may be used in material such as conference presentations, reports, articles in academic journals resulting from the study and that these will not personally identify me.	
I would like to receive a summary of the research findings once the study has been completed and am willing to provide contact details for this to be sent to.	
I would like to be contacted to review my transcript and am willing to provide contact details for this to be sent to.	
I would like to be contacted to review the themes/model generated in the analysis and am willing to provide contact details for this to be sent to.	
I agree to take part in the above study.	

Appendix F

Data Management Plan

UEL Data Management Plan

Completed plans must be sent to researchdata@uel.ac.uk for review

If you are bidding for funding from an external body, complete the Data Management Plan required by the funder (if specified).

Research data is defined as information or material captured or created during the course of research, and which underpins, tests, or validates the content of the final research output. The nature of it can vary greatly according to discipline. It is often empirical or statistical, but also includes material such as drafts, prototypes, and multimedia objects that underpin creative or 'non-traditional' outputs. Research data is often digital, but includes a wide range of paper-based and other physical objects.

Administrative Data	
PI/Researcher	**Miriam Woolfman**
PI/Researcher ID (e.g. ORCiD)	XXXXXXXXXXX
PI/Researcher email	u2075234@uel.ac.uk
Research Title	Practitioner experiences of delivering Video Interaction Guidance with caregivers and infants: Toward Culturally Competent Care
Project ID	N/A
Research start date and duration	September 2022 – September 2023

Research Description	The proposed study aims to fill a current gap in the literature by qualitatively exploring how practitioner psychologists implement Video Interaction Guidance (VIG) with caregivers and infants across cultures A small scale study suggested effectiveness and acceptability of VIG in families from minoritised ethnic backgrounds (Chakkalackal et al., 2021). However, the methods in which culturally competent practice is implemented, and ways caregivers' experiences and preferences are considered during the intervention were not specifically examined. The results of this study can inform clinical psychologists' and allied professionals' practice, improve the support for caregivers and inform practitioner training. In particular, this research can reduce inequalities for racialised caregivers in perinatal services. Practitioner psychologist trained in VIG will be recruited to partake in semi-structured interviews about their experiences of delivering the intervention within parental and parent-infant services. Data gained from interviews will be analysed using a Reflexive Thematic Analysis approach (Braun & Clarke, 2006, 2021) to generate themes which encapsulate the experiences of the practitioners interviewed.
Funder	N/a – a student project for professional doctorate
Grant Reference Number (Post-award)	N/a
Date of first version (of DMP)	09/09/2022
Date of last update (of DMP)	4th October 2022
Related Policies	e.g. Research Data Management Policy
Does this research follow on from previous research? If so, provide details	No
Data Collection	

What data will you collect or create?	• Spreadsheet of contact information for participants and interested participants, their assigned participant numbers in .xlsx format, **contains personal data.** • Consent forms completed in .pdf format. **Contains personal data** (approx. 12 files). • Interview data will **contain both personal and special category data** (approx. 12 files in .mp4 format). An interview schedule will be developed so that a standard format is followed. • Transcripts in .docx format (all personally identifiable information will be removed/altered in the transcripts, and the recordings will be subsequently deleted). • A spreadsheet of demographic information for participants (i.e., ethnicity, religion, training) recorded next to their corresponding participant number in .xlsx format, containing some **special category data** (but no names, address or contact information). This is to anonymise the interview data. • Documents in .docx format pertaining to the analysis and write up of the data.
How will the data be collected or created?	Data collection Recruitment • Participants will sign up and access information about the study through the Qualtrics XM Platform™. They will enter basic contact information about themselves and email address there, which I will then follow up from. The site will serve to manage sending out of the information sheet, consent form and debriefing form. A spreadsheet including names and contact details will be created to record the individuals who express an interest in taking part in the study. This is to keep track of everyone who gets in contact or consents to be contacted by the researcher about the project, to ensure that no one is missed, and to act as a list of participants for the researcher to use to contact for the study, which will cease once enough data has been gathered (approx. 12 interviews). More than 12 participants may be contacted if a participant withdraws or more data is required in accordance with data saturation (as this is only an estimate). After the data collection has been completed, the data on Qualtrics XM Platform™ will be deleted. Research data • Semi-structured interviews with approximately 12 VIG practitioners. The interviews will be semi-structured and an interview schedule has been developed to guide discussion. Due to the explorative nature of this research project, the interview schedule is only intended as a guide to facilitate discussion and participants will be encouraged to share their

experiences freely (i.e., not rigidly bound by the interview schedule).

- Participant consent forms will be signed electronically in .docx format and then stored in .pdf format and saved on the researcher's UEL OneDrive for business. All copies that are sent to the researcher's email will be erased after they are uploaded onto the UEL OneDrive.
- Interviews are expected to last for approximately 40-90 minutes in length and will be conducted and recorded remotely using Microsoft Teams installed on the interviewer's laptop. An auto-transcription of the recording will be downloaded from Microsoft Teams and checked through for accuracy. At the point of transcription, all identifying information will be removed and the file will be saved under the assigned participant number on OneDrive. The recording, saved by Teams automatically on Microsoft Stream will then be deleted.
- The demographic information collected (identified in previous section) will be asked as part of the interview and recorded into the demographics spreadsheet by the researcher during transcription, next to the participant's allocated number. This data will be used to contextualise the sample and not linked to specific participants in the transcribed document or when reported in the study.

Data organisation

- All data will be stored in two folders entitled "Thesis Project" and "Sensitive data Thesis Project".
- "Thesis Project" folder is for all pseudonymised or non-identifiable data including:
    - "Data analysis" – folder holding documents involving the analysis of the data. This may involve documents involved in coding the data, identifying initial themes/sub-themes from the data, and transcript quotes. As well as thematic maps. These are likely to be mainly word documents in .docx format.
    - "Interview transcripts" – folder holding the pseudonymised interview transcripts in .docx format. They will be saved by the allocated participant number (e.g. P1).
    - "Participant demographics" – will hold the spreadsheet of demographic information retrieved from the interview during transcription alongside their corresponding participant number in .xlsx format. Demographic information will be kept to a minimum, collecting only what is deemed most relevant to this study.
    - "Project write up" – this folder will include all documentation corresponding to the write up of the

	project. Documents within this are expected to mainly be in word .docx format. • "Sensitive data Thesis Project" folder is for storing all data which will have identifiable information in. This is kept for the purposes of recruitment, for participants to withdraw their data has been collected if requested, or for participants to be contacted about the results of the project if they request to. The documents are kept in a different folder as they contain identifiable personal data about participants/potential participants (but not special category data) and so needs to be stored separately from the pseudonymised data. This folder will be made up of three folders: o "Participant contact information" – this folder will contain the spreadsheet with the name and contact details of individuals who expressed an interest in taking part in the study, alongside their assigned participant number. o "Participant consent forms" – this folder will hold the signed consent forms saved to the participant's allocated number (e.g. P1).
Documentation and Metadata	
What documentation and metadata will accompany the data?	We will not use a formal disciplinary metadata standard but will prepare a README file containing descriptions of: the research aims; data collection methods and instruments; quality assurance protocols; folder structure and file-naming conventions. Additionally, template study information such as posters, advertisements, participant information sheets, blank consent forms and generic debrief letters, semi-structured interview schedule in .docx format will be included.
Ethics and Intellectual Property	
Identify any ethical issues and how these will be managed	- We will be collecting personal and special category data, and confidentiality is an ethical issue pertinent to this project, as we will be interviewing a small population about a sensitive subject matter. - Interviews will be de-identified upon transcription. Interview recordings will need to be handled securely, so access will be restricted to the PI and supervisor, stored on UEL-managed services and deleted after transcripts have been checked. The transcripts will be stored separately from the pseudonymisation log which could be used to re-identify participants (further information in the 'Storage and Back-up' section). - Participants will receive information about the study before their consent is requested. This will document how their

	data will be anonymised, pseudonymised, kept confidential and securely stored, how the results of the study will be reported in the write up of the thesis and plans for dissemination. In addition, the right to withdraw during the recruitment or interview process, or to remove their data within a specific time frame after the interview has been conducted will be outlined. This is to ensure participants are fully informed about how their data will be used and stored before agreeing to take part in the study. - In compliance with GDPR principles, we will only use data for the purposes it was obtained, retain only for as long as necessary, store within the EU on UEL OneDrive, and gain written consent from participants for collection, storage, archiving, and sharing of anonymised data. - Personal identifiable data that is collected will be kept to a minimum and the interview transcripts (data) that is analysed will be pseudonymised and will not include any identifiable information (e.g. names, specific dates, places). Identifiable information linking participants to their interview transcript will be stored in a separate file from the interview transcripts. This data will be collected to enable participants to withdraw from the study if requested, or to be sent a summary of the study findings after data analysis and write up is complete, if requested. However, after analysis is complete the link between specific transcript and personal identifiable information will be removed, making the data anonymised. - Special category data will be collected to provide demographic information / context to the study but it will be stored separately from personal data and from the interview transcripts to reduce likelihood of identification from the psynonymised interview transcripts or in the final study write up. Special category data collected will be kept to what is minimally necessary.
Identify any copyright and Intellectual Property Rights issues and how these will be managed	**N/a**
Storage and Backup	

How will the data be stored and backed up during the research?	All data will be stored on UEL OneDrive for business (a secure and encrypted online storage platform provided by the university), which is backed up at regular intervals. Recordings of the interviews will temporarily be stored on the interviewer's personal UEL Microsoft Stream Library (where recordings are stored automatically) whilst it undergoes transcription and accuracy checks. Basic contact information will also be stored on Qualtrics XM Platform™ whilst data collection is ongoing, which is frequently backed up. Qualtrics XM Platform™ is a secure and encrypted platform. After data collection has been completed – data stored on Qualtrics will be transferred and stored OneDrive and deleted from Qualtrics. Data volume is not expected to exceed the storage provided in the UEL OneDrive for business account.
How will you manage access and security?	Data stored on OneDrive is encrypted, access is limited to me and secured through Multi-Factor Authentication. My password-secured laptop will be used to access UEL storage, but no data will be stored locally on the laptop itself and synching of files will be deactivated. Qualtrics XM Platform™ requires access through the Multi-Factor Authentication set up by me, the researcher. Data will be shared with research supervisors (Dr. Matthew Jones Chesters and Dr. Camilla Rosan) to allow for checks and research guidance. Interview transcripts may also be shared with examiners. I will share data with my supervisors and examiners upon request using OneDrive secure links. All data with personal or sensitive information (e.g. participant contact information, consent forms) will be stored in separate folders on the UEL OneDrive for business account to ensure anonymity. Raw data may be shared with research supervisors Dr. Matthew Jones Chesters and Dr. Camilla Rosan if required for checks or guidance.
Data Sharing	
How will you share the data?	The final write up of the project will be shared to the public through the UEL's Research Repository. A version will also be sent to participants who wish to receive a copy, and the researcher plans to prepare the project for dissemination in a public peer reviewed journal.

Are any restrictions on data sharing required?	Only anonymised or Pseudonymised data will be included in the study write up and shared – this includes demographic information and quotes or extracts from interview transcripts. The demographic information shared will not be tied to a specific interview transcript to maintain confidentiality.
Selection and Preservation	
Which data are of long-term value and should be retained, shared, and/or preserved?	The study write up will be considered as having long term value to the wider field and thus will be shared publicly via UEL's data repository when the project is completed and passed by examiners. Documents pertaining to analysis, demographic information and the anonymised/pseudonymised interview transcripts may be required to support with dissemination activities for the research and sharing the findings with participants. During this time, the data will be stored in the researcher supervisor's OneDrive for business account. Only the researcher and the researcher's supervisor will have access to this data. Other data that remains that is not considered to have long-term value will be deleted from UEL OneDrive for Business account after the project is completed and passed by examiners.
What is the long-term preservation plan for the data?	Data that is kept post study completion will be stored for 3 years to support with dissemination activities for the research. After this time period, the only data that will remain will be that which is included in the study write up and other reports/documents pertaining to public dissemination activities. All other data will be deleted.
Responsibilities and Resources	
Who will be responsible for data management?	Miriam Woolfman – PI for student project DoS –Matthew Jones Chesters
What resources will you require to deliver your plan?	UEL Microsoft 365 suite including OneDrive for Business. Microsoft Teams Qualtrics XM Platform™ (of which the School of Psychology has a license for)

Review	
	Please send your plan to researchdata@uel.ac.uk **We will review within 5 working days and request further information or amendments as required before signing**
Date: 04/10/2022	Reviewer name: Leo Watkinson Assistant Librarian (Open Access)

Appendix G

Participant Debriefing Information

PARTICIPANT DEBRIEF SHEET

Video Interaction Guidance:
Toward Culturally Competent Care

Contact: Miriam Woolfman Email: u2075234@uel.ac.uk

Thank you for participating in my research study on practitioner experiences of delivering the parenting intervention Video Interaction Guidance (VIG), and cultural factors related to its delivery. This document offers information that may be relevant in light of you having now taken part.

How will my data be managed?

The University of East London is the Data Controller for the personal information processed as part of this research project. The University will ensure that the personal data it processes is held securely and processed in accordance with the GDPR and the Data Protection Act 2018. More detailed information is available in the Participant Information Sheet, which you received when you agreed to take part in the research.

What will happen to the results of the research?

The research will be written up as a thesis and submitted for assessment. The thesis will be publicly available on UEL's online Repository [Registry of Open Access Repositories, ROAR]. Findings will also be disseminated to a range of audiences (e.g., academics, clinicians, public, etc.). This might be through journal articles, conference presentations, talks or blogs. In all material produced, your identity will remain anonymous, in that, it will not be possible to identify you personally as personally identifying information will either be removed or replaced. This includes quotes or extracts of the conversation we have used in the report as evidence of study findings. Please let me know if there is any part of our conversation that you do not want to be included in quotes in the final write up.

You will be given the option to receive a summary of the research findings once the study has been completed for which relevant contact details will need to be provided.

Anonymised research data will be securely stored by Dr. Matthew Jones Chesters for a maximum of 3 years, following which all data will be deleted.

Just as a reminder, you have 3 weeks from today to request any or part of your interview from today to be removed from analysis. You can also request to review your transcript for accuracy or to provide elaboration. You can request to review the themes and model developed in the analysis phase for feedback. Please let me know if you would like to do so.

What if I been adversely affected by taking part?
It is not anticipated that you will have been adversely affected by taking part in the research, and all reasonable steps have been taken to minimise distress or harm of any kind. Nevertheless, it is possible that your participation – or its after-effects – may have been challenging, distressing or uncomfortable in some way. If you have been affected in any of those ways, you may find the following resources/services helpful in relation to obtaining information and support:

Mind Infoline: 0300 123 3393
Their Infoline provides an information and signposting service. They're open 9am to 6pm, Monday to Friday (except for bank holidays).

Aashna
https://www.aashna.uk
Provides a list of therapists working to recognise the ways in which culture, faith, religion, colour, social background, sexuality, gender and neurodiversity affect people's experiences.

BAATN (The Black, African and Asian Therapy Network)
www.baatn.org.uk
Provides a list of therapists from Black, African and Asian backgrounds, and signposts to local mental health and advocacy services.

Project 5
https://www.project5.org
A not-for-profit offering self-help resources and free one-to-one support for NHS staff.

Resources for professional practice:
Equality, Diversity, Inclusion & Anti-Racism workstream
https://www.bps.org.uk/member-networks/division-clinical-psychology/equality-diversity-inclusion-anti-racism
A workstream within the BPS' Division of Clinical Psychology that "meet as a task force to review, amend and further develop the DCP draft action plan aimed at supporting and enhancing EDI within the DCP, specifically in response to concerns over whiteness, marginalisation and racism."

Anti-racist book club

http://www.antiracistbookclub.co.uk
A reflective practice community for psychologists and therapists.
“We support each other in raising our individual and collective consciousness regarding our social narratives and structures; including Whiteness, Colonialism, Islamophobia, Anti blackness, Antisemitism … and in doing so develop our antiracist practice.”

Who can I contact if I have any questions/concerns?

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me: Miriam Woolfman, email: u2075234@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact

My research supervisor: Dr. Matthew Jones Chesters, School of Psychology,
University of East London, Water Lane, London E15 4LZ,
Email: m.h.jones-chesters@uel.ac.uk

or

Chair of School Research Ethics Committee: Dr Trishna Patel, School of Psychology,
University of East London, Water Lane, London E15 4LZ.
Email: t.patel@uel.ac.uk

Thank you for taking part in my study

Appendix H

VIG Attunement Principles and Guidance (Kennedy et al., 2011)

Being attentive	· Looking interested with friendly posture · Giving time and space for other · Turning towards · Wondering about what they are doing, thinking or feeling · Enjoying watching the other
Encouraging initiatives	· Waiting · Listening actively · Showing emotional warmth through intonation · Naming what the child is doing, might be thinking or feeling · Using friendly and/or playful intonation as appropriate · Naming what you are doing, thinking or feeling · Looking for initiatives
Receiving initiatives	· Showing you have heard, noticed the other's initiative · Receiving with body language · Being friendly and/or playful as appropriate · Returning eye-contact, smiling, nodding in response · Receiving what the other is saying or doing with words · Repeating/using the other's words or phrases
Developing attuned interactions	· Receiving and then responding · Checking the other is understanding you · Waiting attentively for your turn. · Having fun · Giving a second (and further) turn on same topic · Giving and taking short turns · Contributing to interaction / activity equally · Co-operating - helping each other
Guiding	· Scaffolding · Extending, building on the other's response · Judging the amount of support required and adjusting · Giving information when needed · Providing help when needed · Offering choices that the other can understand

	· Making suggestions that the other can follow
Deepening discussion	· Supporting goal-setting · Sharing viewpoints · Collaborative discussion and problem-solving · Naming difference of opinion · Investigating the intentions behind words · Naming contradictions/conflicts (real or potential) · Reaching new shared understandings · Managing conflict (back to being attentive and receiving initiatives with the aim of restoring attuned interactions)

Note. Principles of attuned interactions and guidance. Reprinted from “Video Interaction Guidance: A Relationship-Based Intervention to Promote Attunement, Empathy and Wellbeing” by H. Kennedy, M. Landor, and L. Todd., 2011, London: Jessica Kingsley Publishers. Copyright [2011] Kennedy, H. Reprinted with permission.

Appendix I

Interview Schedule

[Before this point we have had an email exchange to confirm study entry criteria and to send information about the study and asked to get in touch if they had any questions, and to sign consent form]

Introduction
Thank you so much for making the time to speak to me today. You will have read a little bit about my study before coming here but I just wanted to take a moment to set out the scene and talk you through the plan if that's ok. Then we will have around 40-60 minutes to work through the interview.

So, I have invited you here as I am interested in hearing about your experiences of delivering VIG. I'd like to gain a picture of what it is like working with families using VIG in your service/practice.

I also want to reassure you that I am not out to test of your VIG knowledge or your skill as a VIG practitioner in any way. It might be helpful for you to be aware that I am not trained in VIG and as such you are very much the expert in the intervention. It may actually be useful for me if you could clarify any VIG terms that you may use to ensure I fully understand what you are sharing.

I have some questions to guide our discussion, but please feel free to talk about things I haven't asked about, or other things that come to mind. Today I'll ask you to speak generally about your experiences, but I'll also ask whether you can think of some specific examples that will help give me a clearer picture. Do you have any questions at this point?

Informed consent
I would like to record this to ensure that I have captured everything that is discussed today. Only I will have access to this. It will be stored securely on an online platform and will be deleted after transcription is completed. Your participation is completely voluntary – feel free to end the session at any point in the interview. After we have completed the interview, I will be completing the transcription and starting analysis, if you decide you no longer want to include your interview in the analysis, please let me know in the next 3 weeks, this is due to the analysis process beginning. Is that ok? Do I have consent to record?

Demographics/General VIG questions
To begin with, I'd like to ask you some questions about you and your job. This will help people who read the research to contextualise it. The information you provide will be reported in a way that anonymises it, however these questions are optional to answer.

How you would you describe your ethnicity?
How would you describe your gender?
What is your age?
How you would describe your professional background e.g. CP, EP, social worker

What is the length of your experience in perinatal/parent-infant work?
How much do you do it in your job (e.g. days per week)
Where (broadly) do you work currently? E.g. Urban, Rural
When did you do your VIG training and what level are you? (Accredited, Advanced, Supervisor)

How much do you use VIG in your work? (estimated proportion of clients seen)

I'd like to ask about your experiences of implementing VIG with your client group. Please feel free to think back to your work with any and all of your clients that you have used VIG with.

- Prompt for positive experiences, shortfalls/challenges and how dealt with these, cases that stand out as going well or not so well.

Cross cultural VIG processes
I am interested in how you think about and work with culture in your VIG practice. To understand this, I firstly want to ask you a bit about you and your ideas about culture. How do you define culture and what does this mean to you?

How would you describe your personal cultural identity?

Now thinking about your VIG practice, do conversations about culture come up at all in your VIG practice with families?

- (Prompt for aspects associated with culture e.g. values, ethnicity, 'race', religion)
- Exploratory questions e.g. what was this like, what does it mean to you, how arose?
- Prompt for whether this influences the way VIG is delivered/practitioner at all

Have you noticed differences (or similarities) between your own culture and the culture of the family you are working with?

- how do you manage these
- Prompt for whether this influences the way VIG is delivered/practitioner at all

VIG training
Do you think your VIG training may have helped you think more about these things at all? (prompt for clarification if so)

Do you have any ongoing interests or training needs in terms of using VIG to work with families/those who belong to different cultural groups?

Supervision and VERP
Do conversations about culture come up in your VIG supervision or VERP?

- (Prompt for aspects associated with culture e.g. values, ethnicity, 'race', religion)
- If so, how have they arisen and what comes from the conversations?
- How have you found these? What aspects of these have been successful, what hasn't been so successful?

Do you reflect upon your own experiences of parenting or being parented? If so, how? Do you think this influences how you offer the intervention?
(Prompt for aspects associated with culture e.g. values, ethnicity, 'race', religion)

Summary and debriefing

Is there anything else that you think is important to add that we haven't spoken about?

Thank-you so much for your time today, it has been very valuable. As a reminder you are welcome to review your written transcript to clarify anything you said or identify if there is anything you would like to remove from the analysis or to not be quoted on. You selected you DO/DO NOT want to receive your transcript. You have stated that you DO/DO NOT want to be contacted with a summary of the results. You also DO/DO NOT want to feedback on your transcript. Is that still ok? You also have three weeks from today to request that your interview transcript is deleted completely.

How did you find our conversation and the experience today? Do you have any final questions that you would like to raise?

I will now send you written debriefing information, please get back in touch if you have any questions.

Prompts
What did that mean to you?
How did that affect you? What was that like for you?
Can you give an example?
What makes you say that?
Be silent and wait for elaboration.
Bring back to culture
Bring back to VIG
Pick up on words, gestures or phrases which seem significant, and ask about these.

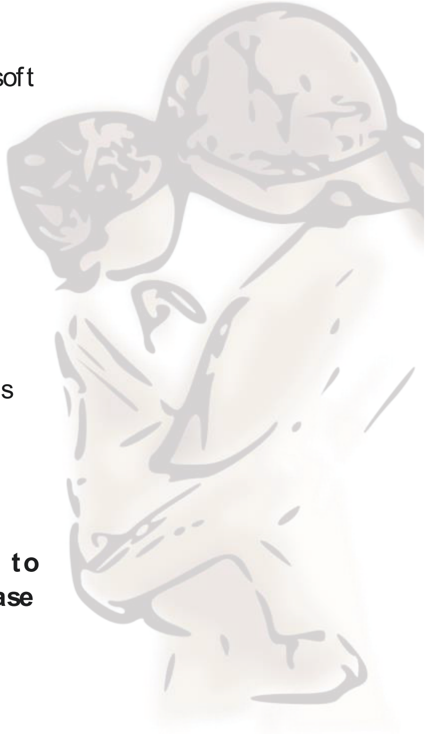
Appendix J

Recruitment Poster

Research study: participants needed

Are you trained in Video Interaction Guidance?

Do you deliver Video Interaction Guidance in perinatal or parent-infant services?



What does taking part involve?

40–60-minute informal conversation via Microsoft Teams
entry into £50 voucher draw for your participation

You are eligible for the study if:

you trained in VIG
You are a psychologist or psychotherapist, or receive supervision from someone who is
have experience of delivering VIG to caregivers and infants aged 0-2
are interested in talking about delivering VIG across cultures

If you would like more information or would like to be involved in my Doctoral research project, please sign up to the study via

Scanning the QR code:
or
Following this link:

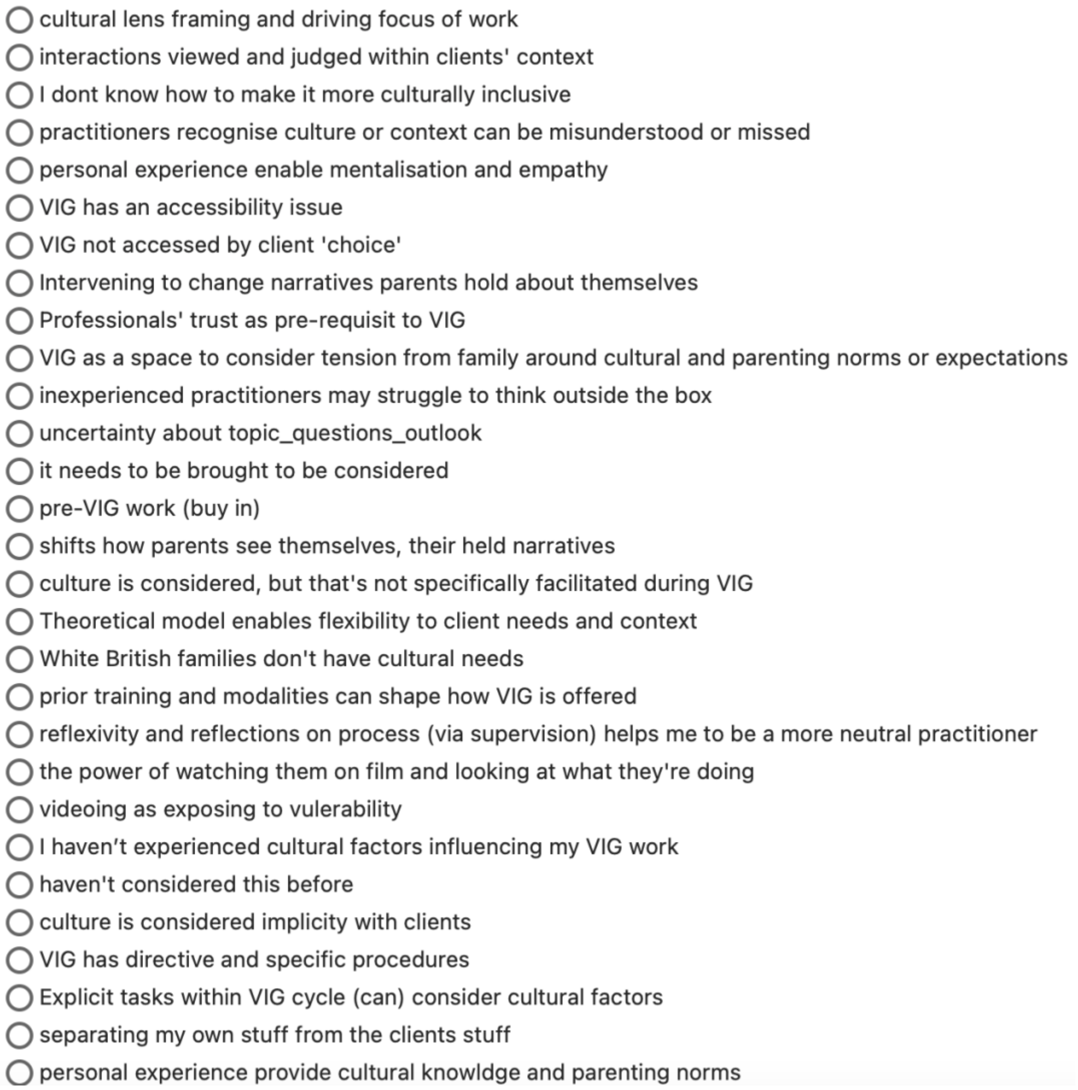
https://uelpsych.eu.qualtrics.com/jfe/form/SV_e5pbpla2vDUvoa2

or

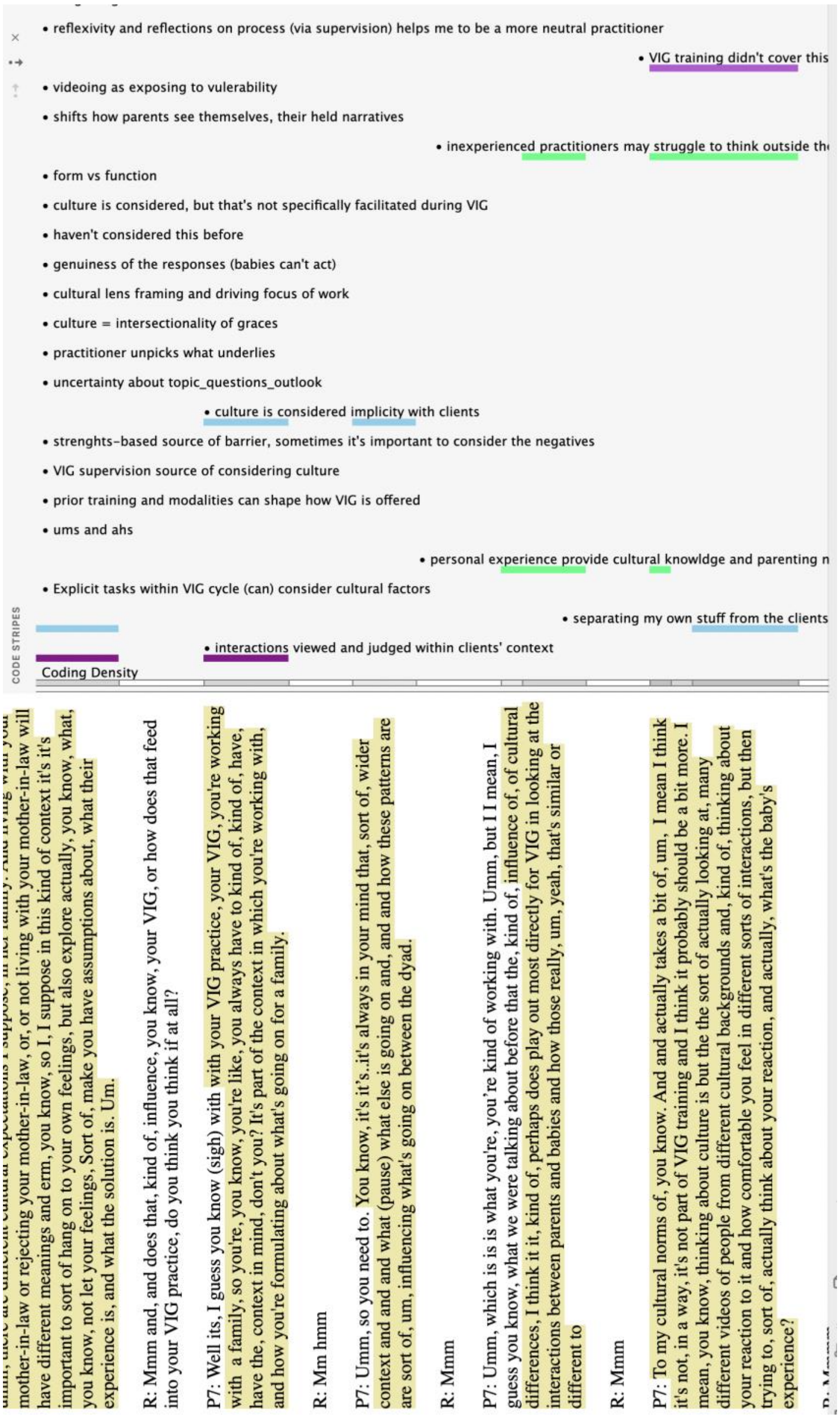
Contact Miriam Woolfman (Trainee Clinical Psychologist):
u2075234@uel.ac.uk

Appendix K

Example Codes and Coded Transcript



○ cultural lens framing and driving focus of work
○ interactions viewed and judged within clients' context
○ I dont know how to make it more culturally inclusive
○ practitioners recognise culture or context can be misunderstood or missed
○ personal experience enable mentalisation and empathy
○ VIG has an accessibility issue
○ VIG not accessed by client 'choice'
○ Intervening to change narratives parents hold about themselves
○ Professionals' trust as pre-requisit to VIG
○ VIG as a space to consider tension from family around cultural and parenting norms or expectations
○ inexperienced practitioners may struggle to think outside the box
○ uncertainty about topic_questions_outlook
○ it needs to be brought to be considered
○ pre-VIG work (buy in)
○ shifts how parents see themselves, their held narratives
○ culture is considered, but that's not specifically facilitated during VIG
○ Theoretical model enables flexibility to client needs and context
○ White British families don't have cultural needs
○ prior training and modalities can shape how VIG is offered
○ reflexivity and reflections on process (via supervision) helps me to be a more neutral practitioner
○ the power of watching them on film and looking at what they're doing
○ videoing as exposing to vulerability
○ I haven’t experienced cultural factors influencing my VIG work
○ haven't considered this before
○ culture is considered implicity with clients
○ VIG has directive and specific procedures
○ Explicit tasks within VIG cycle (can) consider cultural factors
○ separating my own stuff from the clients stuff
○ personal experience provide cultural knowldge and parenting norms



- reflexivity and reflections on process (via supervision) helps me to be a more neutral practitioner
- VIG training didn't cover this
- videoing as exposing to vulerability
- shifts how parents see themselves, their held narratives
- inexperienced practitioners may struggle to think outside th
- form vs function
- culture is considered, but that's not specifically facilitated during VIG
- haven't considered this before
- genuiness of the responses (babies can't act)
- cultural lens framing and driving focus of work
- culture = intersectionality of graces
- practitioner unpicks what underlies
- uncertainty about topic_questions_outlook
- culture is considered implicity with clients
- strenghts-based source of barrier, sometimes it's important to consider the negatives
- VIG supervision source of considering culture
- prior training and modalities can shape how VIG is offered
- ums and ahs
- personal experience provide cultural knowldge and parenting n
- Explicit tasks within VIG cycle (can) consider cultural factors
- separating my own stuff from the clients
- interactions viewed and judged within clients' context

mother-in-law or rejecting your mother-in-law, or, or not living with your mother-in-law will have different meanings and erm, you know, so I, I suppose in this kind of context it's it's important to sort of hang on to your own feelings, but also explore actually, you know, what, you know, not let your feelings, Sort of, make you have assumptions about, what their experience is, and what the solution is. Um.

R: Mmm and, and does that, kind of, influence, you know, your VIG, or how does that feed into your VIG practice, do you think if at all?

P7: Well its, I guess you know (sigh) with with your VIG practice, your VIG, you're working with a family, so you're, you know, you're like, you always have to kind of, kind of, have, have the, context in mind, don't you? It's part of the context in which you're working with, and how you're formulating about what's going on for a family.

R: Mm hmm

P7: Umm, so you need to. You know, it's it's..it's always in your mind that, sort of, wider context and and what (pause) what else is going on and, and and how these patterns are are sort of, um, influencing what's going on between the dyad.

R: Mmm

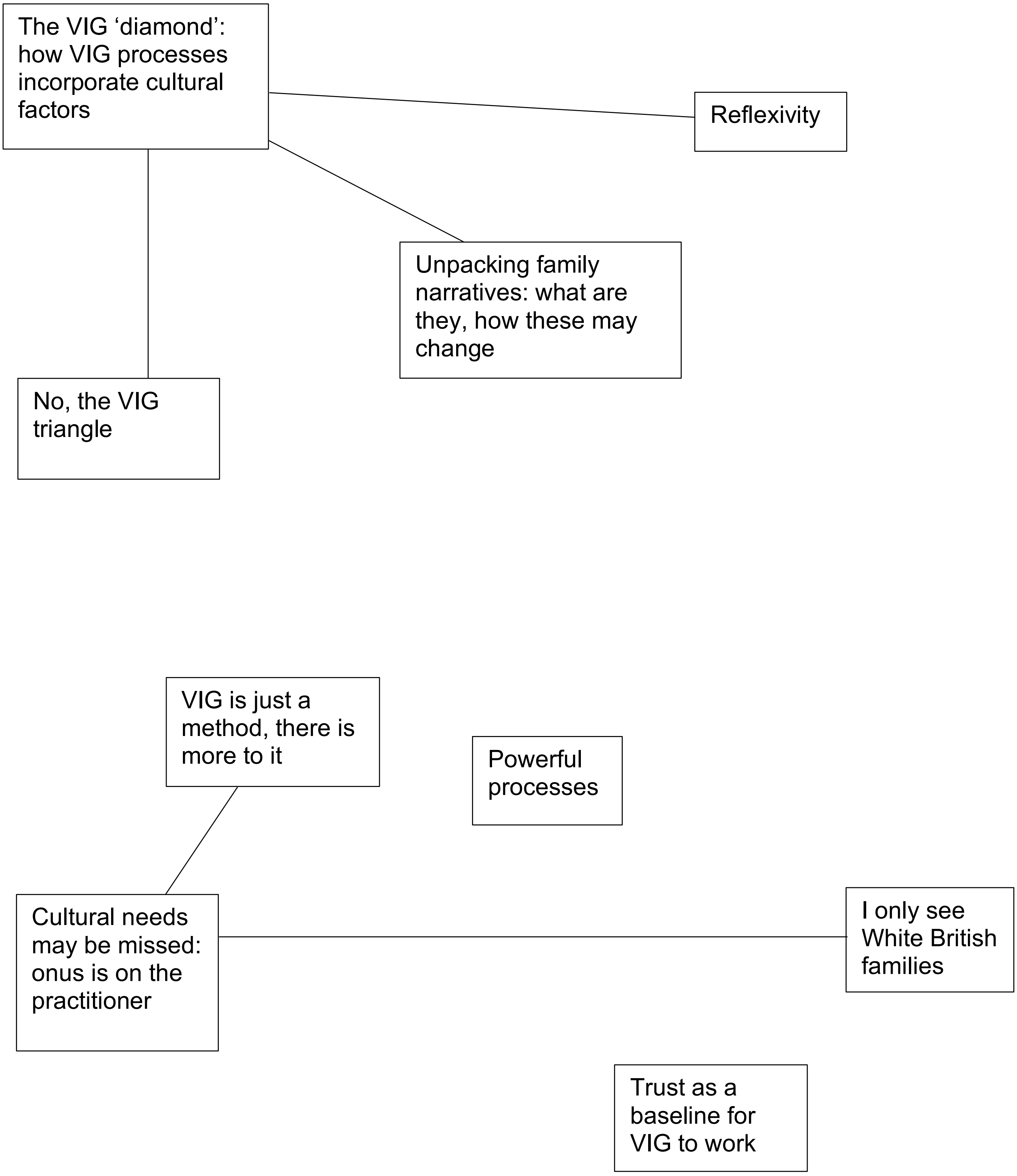
P7: Umm, which is is is what you're, you're kind of working with. Umm, but I I mean, I guess you know, what we were talking about before that the, kind of, influence of, of cultural differences, I think it it, kind of, perhaps does play out most directly for VIG in looking at the interactions between parents and babies and how those really, um, yeah, that's similar or different to

R: Mmm

P7: To my cultural norms of, you know. And and actually takes a bit of, um, I mean I think it's not, in a way, it's not part of VIG training and I think it probably should be a bit more. I mean, you know, thinking about culture is but the the sort of actually looking at, many different videos of people from different cultural backgrounds and, kind of, thinking about your reaction to it and how comfortable you feel in different sorts of interactions, but then trying to, sort of, actually think about your reaction, and actually, what's the baby's experience?

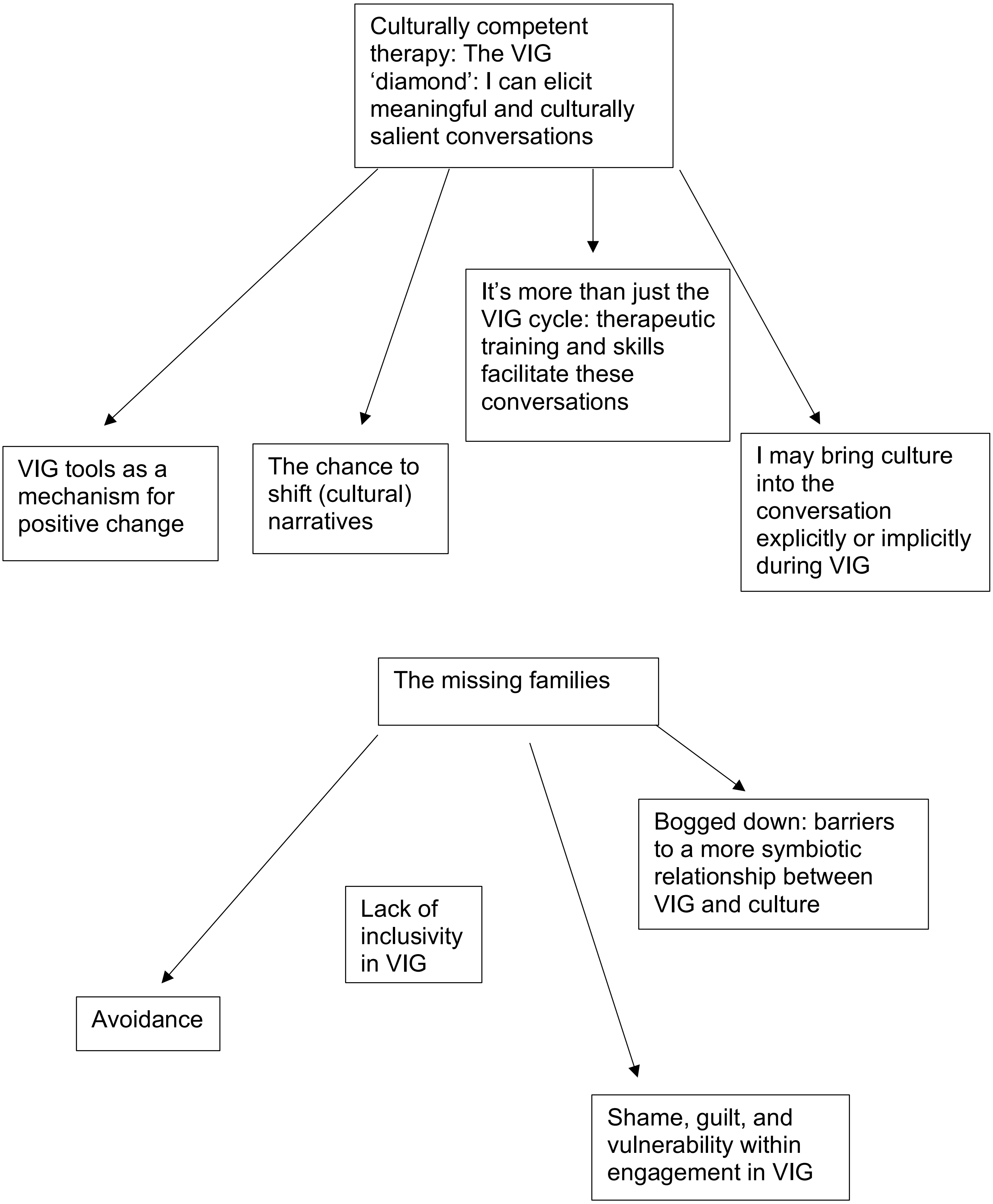
Appendix L

Initial Thematic Map



Appendix M

Refined Thematic Map



Appendix N

Additional Example Data Extracts for Themes

Theme 1: The VIG "diamond"	"That would be practice generally'	"what I feel comfortable with, and this is what I see is the way to do it, but that may not be the, the case within other families, and there are many different ways of parenting and parent-, being parented and, um. Yeah. So, kind of, it's, it's almost that sort of noticing your own reaction, but then, kind of, stopping to think about what that means and, um, and you know, when you, when you feel like something is good or something is bad. And, kind of, looking at actually, I guess, you know, as I said, that I think it's always about going back to what the baby thinks" (P7) "I suppose the only time it has come up is currently working now with this ongoing lady. Where, I suppose noticing, my own, kind of, bias of how you would parent, mm-hmm. And then just separating that out from what, what is that person's view?... I suppose, jus' trying to remove myself" (P6) "I think my thought, that it was included, kind of, just a standard when thinking about people and I d- and, some of that I wonder if, because the way it is with supervision as well". (P2) "It might come in to that pre work bit, when we're talking about, what are the current presenting problems, how do other people in your system experience the problem and see the problem. Um, so it might come as part of that formulation." (P3) "I think the things that I'm aware of that's probably more from my [professional psychology] training, umm, like family therapy sort of,

		elements of that training particularly perhaps.” (P5) “So, when I'm working with any parent, I try and just treat them as an individual and listen to what they're telling me because I don't want to assume anything. And then when I'm guided by them, that helps me respect their cultural practices and thoughts”. (P1)
	“Flexing” the triangle to a diamond	“I guess embedded in the model and the training is that sort of wanting to understand, what's going on for somebody and, and how they're making sense um, responding to what’s going on…You know, and culture is part of that.” (P7) “There's the whole idea of, like, the triangle with, kind of, the video, and you, and the parent, or the person you're doing VIG with. But that had to become a bit more like a diamond, um, to allow for the interpreter to, kind of, sit within it.” (P2) “It's more kind of I think it's very, very sort of, much more, subtle when it kind of comes, it's more of a, like, I guess that's, why, it's like I'm finding it hard to kind of pinpoint it particularly because that's, it's very, that's why it's always linked to the, kind of, helping, kind of, question…because it's more of the soft skill, I think. I think the problem that I'm finding is that it is something that, that is done, but it's in a kind of much more subtle way that you're kind of just going with, umm (sigh, pause) what, what is being brought and I can't, there's not a distinct conversation that is like” (P8) “there's a lady at the moment who comes from what I would, cl- call, class an upper class background who’s doing VIG, um, and that’s something I'm implicitly thinking

		about, like her home where she's at, um, how suitable that is. Like, there's a nanny, so would the nanny be around when we're doing the VIG work. So I'm thinking about these sorts of things, that makes sense" (P3) "her religious beliefs, which were Christian, um, was a significant part of her life, and one of the, kind of, kind of, aspects of ch-, of challenge for her…I suppose, that was then more explored around…what that meaning for her…that then became part of that work in just trying to understand, as we were going, just kept it as a, as a question underneath the help, helping question around transparency in the context of her religious beliefs" (P6)
	Shifting parents' narratives	"it really shifted how she, how she perceived herself as a mother, how she perceived her little girl and felt so much closer to her as a result and, whereas when we first started working together, she wasn't really, sort of, playing much with her, certainly wasn't getting down on the floor and playing together. But from, se' seeing the impact of that, um, in the video, she just, she started doing that more and more, really enjoyed it." (P5) "it sort of sometimes helps people to, erm, (pause) I guess, challenge maybe some of those, erm, dominant narratives that aren't, that they are finding, aren't very useful to them" (P8). "it does come up because conversations about parenting and what influences their parenting. Like, I worked with a family…and she said…as parents, they had different attitudes about parenting. So, when she was like, on the video, I'd show, like, the positive moments of

		interaction. And she said she would see that as a positive thing, where as her husband would see that as spoiling a child. So then you'd get into talking about different cultural practices within parenting" (P1) "They've all had really positive things to say about the experience and it seems to be something that's stuck in their minds as well, in terms of an intervention, something quite powerful about having the films and watching films rather than just a, a talking therapy, which is what I would do in other lines of my job" (P3).
Theme 2: Missing families and untold stories	"She would say there's no way I would be videoed with my baby"	"A lot of the people that I've done VIG with are White British…conversations would certainly come up about culture with quite a few of the families I work with, but some of those families that I work with might not be doing, or wanted to have done VIG." (P4) "we're not pressurizing anyone to do something that they're not comfortable with, or we have loads of methods that, in are the perinatal service, to kind of help them with. VIG is one of the options, it's not the only one, so they usually have a choice. Erm, so they still be seen and you still be offering treatment, so its, um, I didn't think it would be limits there, accessibility, put it this way to a service is there's any cultural, um something that might stand in the way." (P9) "I think sometimes, it being very strengths- based, um, it was actually almost a bit of a hindrance for some of the perinatal women I worked with…I can think of a a woman in particular, that she had such deeply entrenched er, narrative around, kind of, shame and guilt, not being good enough, being completely incompetent, like highly self-critical,

		really low…self-esteem…the way she saw herself and the world when she, she was actually quite interested in VIG because she thought actually maybe it's a bit of an antidote for kind of, it, but there was something when she was fine with it being videoed…something about, when we watched it back together, it just, seeing something back that completely didn't fit with her worldview and her view of herself. It, it, it really wasn't for her, and she just said, I can't. We had to stop halfway through, and she said, 'I can't. I can't do this. This isn't for me'…I'm not. I'm not in a place where I can sit and watch strengths of me and my baby' because it was almost too painful for her to see that, in a way, which sounds, yeah, but w- was, it was really tricky, actually, it was really tricky" (P2) "I have a, we do a lot of lengthy conversations about, it's very normal to feel apprehensive about being videoed. It's weird, and, normalizing that. Um, I voice a lot of the concerns that might be in people's minds because, people sometimes don't want to say um, so things like. 'Oh God. I'm, is my parenting gonna be completely torn apart in this. Am I gonna be videoed and you know, are they gonna, you know, see all the things that I can't do?' So it's kind of really helping people, really voicing that as this is, this is what a lot of people think that it might be. And this is what it is. This is what it actually is, and, this is how some of the ways in which. It can work, which, doesn't happen with other, you know, can't happen in other therapies. So, I guess it's one of the fundamental things is creating a safe base" (P8) "I've certainly had parents who just, who find it very emotional, sort of

		seeing, seeing themselves seeing their child on, and seeing, yeah, these, sort of, lovely little moments that they've, perhaps. Um, missed or not being aware of or, it's just been overshadowed by, sort of, more negative thinking, um, about themselves, and the child, and that's been quite painful to to then become aware of, or see, and kind of almost there's, um, sometimes a bit of grieving process that needs to happen, and in kind of in order to be able to acknowledge the good to grieve about how long, perhaps, that, that's been missed or or hasn't felt like it's been present and things like that." (P5)
	Bogged down: barriers to cultural competence	"what it means to have a baby that's fairly compliant is almost a bit of a badge of honour, as opposed to a more fractious baby who's difficult to soothe. There's something that very much plays out in in society, around, accepting the compliant babies much more, even if they're actually quite traumatised babies…that, we just don't se-, people don't see it as much. And and and I d', I'm not sure VIG quite knows, in, within its model, to support those babies, so much." (P8) "I think for me, it's always that kind of like, oh, I'm just a beginner. I'm not. I'm not there yet, so I need to get through my, my proper training and then maybe, I will be that person that can go off and, um use it in different creative ways" (P3). "with VIG training, you're essentially, you're bringing, you're bringing your own films, erm, but it's it's it's a, it's a different thing with VIG because you're picking out moments of exceptions, so you're not seeing a whole film..and there is something about looking at, whole films, and, and looking at the patterns within

		them that is quite useful…I think you, you, you gain much more of a sense of, actually what's going on in the relationship.” (P7) It's not like a routine thing that within supervision it would be like, OK, how does culture kind of fit? That's not, that wouldn't, it's really guided by what you want out of supervision. You know, your, your helping question within the supervision. (P8) “It could just get very technical, and people, kind of, like look at this clip and and and that spaciousness and that room to process and really think about it and really think about what's going on in the therapeutic relationship and um, that that's the bit that I worry could get a bit lost, I think. And it could become, just very, a very technical” (P2)
	“I haven’t had to cross that bridge yet”	“[in terms of the, um, VIG supervision that you have had, or the intervision, do conversations about culture come up there?] So I guess, to get, so, not in terms of erm, culture, sort of, yeah, different ethnicities or sort of” (P5) “I think it would be more like if there was a non-english speaking woman that comes in to, as a referral, then that's when we would start talking about it. So, we might talk about having a a translator for example to help us do an assessment…we probably make an assumption that the person is White and doesn't need any assistance or support.” (P3) “[reflecting about access and engagement within VIG] And whether any cultural things are getting in the way of that, that I haven't really thought about what maybe or that is, is, if is somebody is reluctant and anxious about using VIG, you know, because of how they feel about themselves or something, for me to

		keep in mind around, you know, is there any cultural, um, aspects of that, that make it more difficult, and being able to have that conversation with them." (P4) "I was…interested in your findings in terms of, you know, how might other practitioners, kind of, how it, if it's or, or, what you make of it, kind of." (P5) "If there were cultural adaptations already being made to support er, a mum being admitted, then I might probably think more about that in the VIG work. Umm. Whereas to date, (pause) there haven't been, for those who might be using VIG" (P6) "firstly it will be really important to know why, erm, and whether it feels very threatening having to be videoed. Erm, I don't know if there's some aspect of the intervention that feels, erm, that is just very jarring, or completely um, that isn't fitting. Erm, and because I've not. It's almost that you don't know until you've done it, so I, I think that is the difficulty, I'm a little bit apprehensive that my supervision will eventually come to an end, and these issues might arise, but I don't know what they'll be until..you know, I sort of encounter them." (P8) "a lot of the people that I've done VIG with are White British, so although, which is interesting in the sense of working with a wider variety of cultures, um, and that's given me something to think about in in itself…and whether any cultural things are getting in the way of that, that I haven't really thought about what maybe or that is, is, if is somebody is reluctant and anxious about using VIG, you know, because of how they feel about themselves or something, for me to keep in mind

		around, you know, is there any cultural, um, aspects of that, that make it more difficult, and being able to have that conversation with them” (P4) “so actually what would be really useful is having a clinical group of people, of VIG practitioners who have had that experience to share, kind of, learning. I think that would be really useful…And how you've been able to adapt to it, in a way that is, um, you know, that still aligns to the model, but it's been really, it's been helpful, I think that would be really key. So, a way in which you can have a group of people together. Um, to have those discussions as they come up.” (P8)