

Parental representations and disorganised attachment

Literature Review

Empirical Research Project

Reflective Commentary

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Submitted in partial requirement for the

Doctorate in Psychotherapy

(Child & Adolescent)

(Independent Psychoanalytic Child & Adolescent

Psychotherapy Association and The Anna Freud National

Centre for Children and Families)

DECLARATION

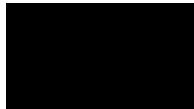
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ACKNOWLEDGEMENTS

I would like to thank my primary supervisor Michelle Slead for all her encouragement, patience and sustained support. I would also like to thank the supervisory team at the Anna Freud National Centre for Children and Families, including Nick Midgley, Evrinomy Avdi and Saul Hillman for all their teaching and support.

Secondly, I would like to thank Janine Sternberg and all the clinical teaching team at the Independent Psychoanalytic Child and Adolescent Psychotherapy Association, including my service supervisor Judith Thorp for giving me space and support to commit to this research whilst working clinically.

Lastly, I would like to thank my wife Renata Bakker for her love and support.

Abstract

This study explored parental representations in mothers whose infants were younger than one and went on to develop disorganised attachment. **Literature review.** The literature review examined the concepts of parental representation and disorganised attachment, their methodological development, assessment and research findings. It also reviewed the current theories of disorganised attachment, based on studying both parent-infant interactions and parental representations. **Empirical study.** The empirical study was an exploration of the processes that may contribute towards the formation of disorganised attachment in infants by analysing parental representations, assessed in the first year of the infant's life, in a sample of parents whose infants were classified as disorganised one year later. By using a qualitative exploratory approach, this study analysed parental representations differently from top-down quantitative coding protocols, hence its findings offered a useful insight and comparison with the current theories of disorganised attachment. **Reflective Commentary.** The dissertation ended with a reflective commentary, which traced and mapped out the process and experience of conducting this research.

Impact Statement

This study aimed to widen our understanding of parental representations and disorganised attachment.

The themes identified in the empirical study included emotional distress, maternal ambivalence, idealisation and helplessness. Situating these themes in the current literature on disorganisation offered some confirmation of the findings gained from quantitative coding protocols but also highlighted the fact that within these areas of caregiving representations might lie the representational precursors of disorganised attachment. This finding might impact and inspire further avenues of research in this area.

The literature review offered useful summaries of the findings around disorganised attachment but also research methods used to gain these, including various coding protocols applied to both representational and behavioural measures. These can be perused by researchers and clinical practitioners investigating these areas of interest.

In 2017, parts of the study were presented at the international conference hosted by the Society for Psychotherapy Research, focusing on psychotherapy practice and clinical implications of research.

The clinical implications are as follows.

The reviewed measures and findings around disorganised attachment can be used by clinicians when assessing the relational risk in the early parent-infant relationship, as well as throughout the clinical treatment when setting up and

reviewing the aims of treatments, for example those of parent-infant and parent-child psychotherapy.

In particular, this study identified and highlighted the overly positive caregiving representations that can lead to distortions in parental perceptions and behaviours, hence causing infant attachment disorganisation. These idealised versions of caregiving need to be monitored and addressed in clinical treatments.

The findings of this study can be used to inform all frontline practitioners working with infants and their parents, for example health visitors and GPs, alerting them to the relevant risks in parent-infant interactions but also caregiving representations as witnessed in their practice.

The early identification can lead to early treatment, preventing further deterioration in emotional wellbeing and mental health of these infants and their parents as well as reducing further cost to services and public health institutions.

The latter finding shows the potential impact of this study on public policy and those involved in formulating it.

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Part 1: Literature Review

Title: Parental representations and disorganised attachment

Candidate number: FJZM8

Word count: 8090

Abstract

Research has shown that infants categorised as having a disorganised attachment with a primary caregiver are at great risk for developing serious mental health difficulties later on in life. This paper reviews the literature on disorganised attachment, tracing its conceptual and methodological discovery as well as reviewing the measures devised to study it. The findings for those classified as disorganised are explored throughout.

Since attachments develop within the early parent-infant relationships, this paper reviews the parental aspect of the formation of disorganised attachment put forward in the research literature. The main focus is the concept of parental representation, its use, measures and research findings.

The theories of disorganised attachment based on studying both parent-infant interactions and parental representations are explored in some detail and evaluated. The themes identified within those include the importance of fear and atypical parental behaviours, the absence of parental response when faced with attachment distress, parental reflective functioning and segregated systems within caregiving representations.

Keywords: disorganised attachment, parental representation, parent-infant communication

1.1 Introduction

This literature review examines the concepts of parental representation and disorganised attachment, their methodological development, assessment and research findings.

The first section describes the concept of internal working models in the attachment theory as it is these that parental representations map out.

The second section highlights the first empirical studies of infant attachment, including the Strange Situation, and their findings. The concept of disorganised attachment is introduced and described. The next section returns to observational measures and findings, this time as applied to parental behaviour.

The following section charts the move to the level of representation within the attachment research, including the Adult Attachment Interview. The concept of parental representation and its assessment measures, including the Parent Development Interview, are explored here.

In the final section, the current theories of disorganised attachment are introduced and evaluated.

The literature review is not a systematic review but adopts a narrative style, following the chronological development of concepts and methods used to study parental representations and disorganised attachment. The scholarly databases systematically searched for the most relevant books and articles included ProQuest Central, Psychology Database and Psych INFO. The searches were open and flexible; the search terms were disorganised

attachment, parental representations and parent-infant communication. Only English-language publications were included.

1.2 Attachment and mental representation: internal working models

Bridging the psychoanalytic theory and behavioural sciences, John Bowlby originated a new developmental theory of interpersonal relationships called attachment theory. His first paper on the subject was called 'The nature of the child's tie to his mother' (Bowlby, 1958) and highlighted the fact that attachment behaviour develops within the early parent-infant relationship. Drawing on the evolutionary theory and ethological studies, Bowlby referred to attachment behaviour as adaptive and goal-directed, serving a function to humans, as it does to other mammals, and defined it as 'any form of behaviour that results in a person attaining or maintaining proximity to some other clearly identified individual who is conceived as better able to cope with the world' (Bowlby, 1988, pp. 26-27).

For a helpless and extremely vulnerable infant, the world is a confusing and dangerous place at times. It is at those times that attachment behaviour gets to be activated; it is infant's fight for survival that drives its proximity-seeking behaviour. Bowlby and others observed what happened to those infants and very small children that were separated from their parents for prolonged periods of time, due to hospitalisation for example, noticing the emotional plight but also defensive mechanisms soon put in place by these children (Bowlby, Robertson & Rosenbluth, 1952).

Bowlby (1980, p. 229) also proposed that 'every situation we meet with in life is construed in terms of representational models we have of the world about us and of ourselves.' So not only is the infant and later child adapting to its external environment, at times showing attachment distress in the hope that there will be a more experienced human being available to aid its survival and security, he is also 'busy constructing working models of how the physical world may be expected to behave, how his mother and other significant persons may be expected to behave, and how each interacts with the other' (Bowlby, 1969/1982, p. 354).

Here Bowlby referred to the specificity of the parent-infant relationship and a unique way of relating to one's parent, both cognitively and emotionally, as developed within a dynamic interaction in this couple. Research has confirmed that infants can develop different attachment pattern with either parent (Main & Weston, 1981).

Bowlby further explained:

'In the working model of the world that anyone builds, a key feature is his notion of who his attachment figures are, where they may be found, and how they may be expected to respond. [...] it is on the structure of those models that depends, also, whether he feels confident that his attachment figures are in general readily available or whether he is more or less afraid that they will not be available—occasionally, frequently, or most of the time.'

(Bowlby, 1973, p. 203)

This definition follows infant's proximity seeking behaviour to his parents' availability to him, which in turn sets up a pattern of future seeking behaviours as well as internal thoughts and feelings about it. As this develops, the infant and later child constructs a fairly stable model of what is out there but also inside him, this model being tested and acted out in his future relationships, often outside his awareness and almost automatically (Bowlby, 1980), guiding but also challenging his behaviours, feelings and thoughts.

In other words, what might have started as infant's vague observation of his mother's care and love for him, becomes his internal feeling of being cared for and loved, later seeing himself as worthy of care and love, expecting others both to show him care and love but also to see himself as effective and capable of gaining it from them.

Bowlby (1988) coined the term 'secure base' for the parenting attachment figure that is both available at times of distress but also encouraging of exploration at other times, recognising that infant's individual development relies both on security and independence.

Seeing their infant in distress activates caregiving behaviour in parents as they seek to provide protection and care to their offspring, that way increasing the likelihood of his or her survival and their genes being passed on (George & Solomon, 2008). Bowlby named this adaptive and goal-directed set of parental responses the caregiving behavioural system (Bowlby, 1988).

1.3 First empirical studies of attachment: Strange Situation

Bowlby's concepts needed further empirical support, and this was first provided by Mary Ainsworth and her colleagues (1978). Having systematically observed infants interact with their mothers at home in the first year of their life, Ainsworth devised a brief laboratory separation-and-reunion procedure called the Strange Situation Procedure (SSP), in which attachment behaviour is activated by introducing a stranger to the mother-infant interaction, later separating the infant and mother under various conditions. The infant's behaviour on separating and reunion with the mother is observed, recorded and later coded according to the infant attachment classifications. These have become the benchmark for assessing and validating all future attachment methodology (van Rosmalen, van Ijzendoorn & Bakermans-Kranenburg, 2014).

The attachment classifications identified by Ainsworth and her colleagues (1978) organise infants' reactions into three categories.

The first one termed as *secure* (Group B) shows infants seek proximity of the mother when distressed but otherwise able to play and explore the room, while their mothers show ability to respond sensitively and consistently to attachment distress signals, having interpreted them accurately. These behaviours indicate that these infants have internal working models that they are worthy of care and protection, and know where to seek and gain it, expecting others to give them care and protection, just like they have come to rely on gaining it from their mothers.

Further research has shown that these infants tend to have best outcomes socially and emotionally (Sroufe, 2005), showing good understanding of mixed emotions at the age of 6 for example (Steele, Steele, Croft & Fonagy, 1999). They are less likely to engage in aggressive play and show fewer externalising behavioural problems as toddlers (McElwain et al., 2003, Vondra et al., 2001). They also enjoy more social competence within peer relationships as adolescents (Weinfield, Ogawa & Sroufe, 1997).

Thompson (2016) reviewed many positive outcomes strongly associated with secure attachment, including better emotional regulation and understanding, greater social competence and a stronger sense of self. In terms of family relationships, not only does secure attachment predict more positive parent-child interactions, it also acts as a buffer against negative experiences, for example parental stress (Tharner et al., 2012).

The second category is called *insecure-avoidant* (Group A) and is organised around infants' minimised contact with their mothers when distressed, as shown in their accelerated heart rate (Sroufe & Waters, 1977), refusing to interact on reunion for example, continuing to explore the room as if in no need of proximity from her, although still distressed internally. Mothers of these infants tend to be less affectionate, even rejecting, of close contact in particular, not responding well to infants' attachment distress calls. These infants in turn seem to have learnt that being in distress pushes the mother away, and to maximise her attention, they minimise their distress, keeping up the attachment distance read from her previous behaviour. Their internal

working models indicate that showing distress is undesirable as it will lead to rejection, this way defining that to be worthy of care and protection, they must not make demands on their mothers and others.

The third infant attachment category is termed *insecure- ambivalent* (Group C) and shows infants organising their adaptive strategies around maximising proximity-seeking activities at the expense of exploring the room and their environment. They would be both very distressed and demanding of their mother, whilst simultaneously showing angry and resistant behaviour towards her. Mothers of these infants tend to ignore attachment signals or respond to them in a haphazard way, making their infants wary of their attention, which in turn invites them to either intensify their distress calls or have a very strong reaction following them. Their internal working models suggest to them that they are only worthy of care and protection when really distressed, expecting others to either react to it or not, but not according to their needs.

Both insecure attachment categories are associated with greater risk for poor outcomes socially and emotionally due to children's difficulty to regulate their feelings and sustain positive relationships (Sroufe, 2005). They are more likely to engage in acts of aggression as toddlers (McElwain et al., 2003) and show more externalising behavioural problems at school (Fearon & Belsky, 2011; Guttman-Steinmetz & Crowell, 2006). They are also more likely to develop both internalizing and externalizing emotional and behavioural difficulties later in life (McCartney et al., 2004).

DeKlyen and Greenberg (2016) summarised in their review various poor outcomes for mental health associated with insecure attachment, including greater likelihood for anxiety and obsessive-compulsive disorders, especially when combined with other risks factors.

1.4 Disorganised attachment

All three infant attachment classifications described so far, that is secure, insecure-avoidant and insecure-ambivalent, differ in their presentation of proximity-seeking attachment behaviour but share a consistent strategy of doing so. These infants show an organised way of adapting to their environment, suggestive of an anticipated response and a predictive use of an attachment figure (Main, 1990).

A contrasting group of infants predominantly from high-risk families, often with history and experience of maltreatment and neglect, showed behaviours that were impossible to classify within the attachment classification above. Researchers struggled to do so, at times even assigning a secure category (Carlson et al., 1989), until Main and Solomon (1986, 1990) revisited around 200 videos of these difficult-to-classify infants in the Strange Situation Procedure.

The result of their analysis was a fourth attachment category named *disorganised* (Group D) (Main & Solomon, 1990). They identified these behavioural indicators of disorganised attachment classification: simultaneous

or sequential display of contradictory behaviour, such as approaching the parent whilst walking backwards, misdirected or stereotypical behaviour, freezing and stalling for a substantial period of time and direct apprehension or disoriented behaviour towards the parent (Main & Solomon, 1990).

Disorganised attachment hence refers to the conflict at the level of attachment system, with the infant failing to find a coherent way of responding to the attachment alarm, his or her behaviour manifesting this disruption and inability to adapt to the environment (Duschinsky & Solomon, 2017). These disruptions are suggestive of increased alarm, fear and conflict when making use of and being responded to by an attachment figure.

Research has shown that infants categorised as disorganised are most at risk for developing serious mental health difficulties later on in life (DeKlyen and Greenberg, 2016; Sroufe, 2005). Two recent meta-analytic studies highlighted the increased risk for both internalizing and externalizing problems (Fearon et al., 2010; Groh et al., 2012). Those classified as disorganised show higher levels of aggressive behaviour and dissociative symptomology all throughout their childhood and adolescence (Lyons-Ruth, 2003; Moss, Cyr, & Dubois-Comtois, 2004; Sroufe, 2005). Many of their severe relational difficulties continue into adulthood (Johnson & Greenman, 2006) and parenthood (Main, 1990).

1.5 Parental Behaviour: observational measures and findings

Using both observed parental behaviours at home and infants' laboratory reactions when faced with the loss of attachment figure in the Strange Situation, Ainsworth was able to relate these and devised one of the first observational measures of parent-infant interaction called Maternal Care Scales (Ainsworth, 1969a). The most widely used construct from these is that of Sensitivity- Insensitivity and it rates the parent's availability, responsiveness and ability to adapt to infant's attachment signals (Kobak, Zajac & Madsen, 2016). This scale showed differences between mothers of secure and insecure infants. Research has confirmed positive association between maternal sensitivity and secure attachment in infants (De Wolff & Van Ijzendoorn, 1997).

Further three scales of Cooperation-Interference, Acceptance-Rejection and Accessibility- Ignoring were devised to differentiate between mothers of insecure-avoidant and insecure-ambivalent infants (Bretherton, 2013).

Even though disorganised attachment is strongly associated with maltreatment, Cyr and her colleagues (2010) found that children growing up with at least five parental social-emotional risk factors, such as low income, single mother, adolescent mother, low education, ethnic minority and/or substance abuse, are just as likely to be classified disorganised as those that have suffered abuse and neglect.

Furthermore, the meta-analytic data showed that 15% of infants in low-risk families were also classified as disorganised in the SSP (Van Ijzendoorn, Schuengel, & Bakermans–Kranenburg, 1999).

The correlation between maternal sensitivity and disorganised attachment showed a very small effect size (De Wolff & Van Ijzendoorn, 1997), although clinical interventions aimed at increasing sensitivity in parents proved to be effective in preventing or changing disorganised nature of attachment (Bakermans-Kranenburg, Van IJzendoorn, & Juffer, 2005). This paradoxical finding seems to highlight the importance of sensitive parenting but also suggests that other aspects of parenting play their part in the formation of disorganised attachment.

To explore this, Lyons-Ruth and her colleagues (1999) returned to the videos of infants now classified as disorganised in the SSP, this time paying close attention to parental communication and responses. They identified five dimensions of disrupted maternal affective communication: affective communication errors, role/boundary confusion, fearfulness/disorientation, intrusiveness/negativity and withdrawal, and used them to create a measure called Atypical Maternal Behaviour Instrument for Assessment and Classification (AMBIANCE) (Bronfman, Madigan, & Lyons-Ruth, 1992; 2009).

Tereno and her colleagues (2017) showed that reducing these atypical maternal behaviours in interventions aimed at high-risk population led to

prevention of disorganised attachments, this decrease in disrupted maternal communication partially accounting for the reduction in disorganisation.

Another coding protocol for scoring atypical parental behaviour was previously devised by Main and Hesse (1992; 2005) who identified parents present towards their children as frightened, threatening or dissociative (FR behaviours).

Further research confirmed the association between atypical maternal behaviours and disorganised attachment (Lyons-Ruth et al., 1999; Madigan et al., 2011), one study postulating that infants that have experienced these behaviours are four times more likely to develop disorganised attachment (Madigan et al., 2006).

1.6 Moving to the level of representation: Adult Attachment Interview

In a seminal contribution to the Monograph of the Society for Research and Child Development fittingly called *Growing Points of Attachment Theory and Research*, Main, Kaplan and Cassidy (1985) reported on their empirical study designed to investigate attachment patterns not just in infants but also children and adults, doing so by designing new measures based not just on behaviour but also 'language and structures of mind' (Main et al., 1985, p. 67). These methodological inventions followed their innovative conceptual work in the area of internal working models, which they came to define

‘as a set of conscious and/or unconscious rules for organization of information relevant to attachment and for obtaining or limiting access to that information, that is, to information regarding attachment-related experiences, feelings, and ideations.’

(Main et al., 1985, pp. 66-67)

Both their theoretical and methodological advances widened the scope of research investigations, now not only observing attachment behaviour and feelings of infants as indicators of their internal working models but also examining how these models ‘direct [...] attention, memory, and cognition’ (p. 67).

Having noted that attachment behaviour grows not only out of and within the interaction with the parent, say on reunion, but also in its absence as the infant and later child deals with being separated, both emotionally and cognitively- this after all was Bowlby’s starting point; children’s responses to prolonged institutional separations (see Bowlby, Robertson & Rosenbluth, 1952) - Main and her colleagues (1985) began to note conversations between children and parents around separation and reunion, later asking them directly about these and other hypothetical attachment experiences.

With children, they used a photograph of a parent, or a video recording of a separation to stimulate children’s thoughts around attachment (Main et al., 1985). This technique allowed them to study not only a particular child’s reaction to their parent but also their more generalised idea of attachment

pattern and how they were able to express it. In other words, researchers began to study not only interactions within attachment relationships, inferring internal working models from those, but also how those involved in them were able to communicate with others about their attachment relationships (Bretherton,1990).

Applying the same principles to the assessment of adults, George, Kaplan and Main (1984) devised an hour-long semi-structured interview called the Adult Attachment Interview (AAI), in which they asked interviewees about their childhood attachment experiences and the impact of these on their current life and choices.

The interview begins by asking about interviewee's relationship with their parents as a child in general, followed by a request for five adjectives or phrases best describing their relationship with one parent, later followed by a request to provide some examples of memories or incidents from childhood that illustrate these choices. This is later repeated for the second parent or other important caregivers. The interviewees are then asked about their attachment memories more generally, such as childhood illnesses and separations, and what role their parents played in them as well as their evaluation of all of these on their present life. Another section asks about serious losses and traumas of childhood, again both in terms of memories and present evaluations. The interviews are fully transcribed and coded according to the classification described below (Hesse, 2016).

Just like infants in the Strange Situation Procedure face stress resulting from separation and subsequent reunion with a parent, showing their attachment strategies in coping with it, the AAI has been designed to arouse attachment feelings and memories not only by inviting adults to face their autobiographical past but also to cope with it throughout the interview. The questions change from very specific to more general, asking for brief statements first but soon requiring further evidence and elaboration. This can only be done if the adult has both access to these memories but also a coherent way of presenting them, repeatedly so, mirroring infants' search for attachment figures when distressed, otherwise able to play and explore. In other words, it asks for a mind that is flexible but coherent (Hesse, 2016).

And just like infants' reaction in the Strange Situation Procedure shows what they have made of their carer's responses to their attachment distress, linking these to carers' behaviour, adults' ability not only to describe but also freely and truly reflect on their past attachment experiences, reveals their states of mind with regard to attachment (Mayseless, 2006), showing not only what they have made of their specific past attachment experiences but also what they think about the importance of attachment experience in general.

Main and her colleagues (1985) coded the transcripts into three adult attachment classifications. The first one was termed *secure- autonomous* and showed adults openly discussing their past attachment experiences, both good and bad, having reflected on them over time and seeing them as important. Similarly, these adults valued attachments in general, giving them

some importance in their lives too, and could objectively reflect on their various relationships, showing ease at discussing them.

The second group was called *insecure-dismissing* and showed adults unable to recall their childhood attachment experiences, seeing them as unimportant for their current life. They would often idealise their attachment figures, especially when coming up with adjectives and phrases, but were unable to provide any evidence or in fact contradicted themselves in their later statements or explanations. They found it difficult to take part in the interview, avoiding most questions in various ways, for example by offering very brief answers.

The third adult attachment classification identified was *insecure-preoccupied* (Main et al., 1985). These adults were able to recall childhood attachment experiences but presented them in confusing ways, either as if still happening, becoming very agitated and almost in conversation with their parents, or very passive, or so distracted by their involvement in their memories that they did not answer a particular question but went into detour linked with the emotion aroused. They were involved in the interview but struggled to reflect and focus on the task in hand.

Two other categories were identified later (Hesse, 2016), both the fourth category of *unresolved/disorganised* (U) and the fifth of *cannot classify* (CC) showed adults unable to speak about difficult attachment experiences in coherent ways, often marking instances of unprocessed loss and trauma,

lapsing into non-thinking states of mind that disturbed their speech and discourse (U/d).

Main and Hesse (1990) proposed that it is the parents classified as unresolved (U) that present with FR behaviours- see section 1.5 p. 21 - due to their unprocessed loss and trauma causing them overwhelming feelings and paralyzing states of mind (U/d). Further research confirmed this association between parents' U classification and FR behaviours (Jacobvitz et al., 2006; Schuengel et al., 1999), although the meta-analytic data also showed that 47% of D infants did not have mothers with U classification (van IJzendoorn, 1995).

Lyons-Ruth and colleagues (2003) used a different coding scheme to map out these atypical states of mind, classifying them as *Hostile- Helpless* (HH) and scanning the entire interview for signs of contradictory and unintegrated feelings and thoughts about the attachment figures. They believed that this allowed for capturing instances of past loss and trauma in more detail and throughout the whole interview, even if the interviewees did not disclose past loss and trauma explicitly as required by the previous coding protocol (Lyons-Ruth et al., 2005).

Research showed a strong association between the HH states of mind and personality disorder features, the HH states of mind mediating the effects between the severity of childhood abuse and current personality functioning (Lyons-Ruth et al., 2003; Finger et al., 2015).

Fonagy and his colleagues (1998) devised a protocol to code for Reflective Functioning (RF) on the AAI, mapping out the parents' capacity to mentalise, that is reflect on the mental states and intentions of their parents in the past attachment situations as asked about in the interview (Slade, 2005).

Further studies confirmed the association between parental RF as scored on the AAI and infant classification; the parents capable of reflecting on their past attachment experiences were much more likely to have a securely attached infant, even if they had experienced abuse or trauma (Fonagy et al., 1991), whereas those with lower levels of RF were much more likely to have an infant with disorganised attachment (Ensink et al., 2016). These findings opened up a new area of attachment research; intergenerational transmission of relational trauma.

Since the AAI was a measure developed and used alongside various other measures in the study by Main and her colleagues (1985), they administered these interviews to parents of infants that were classified using the Strange Situation five years previously and found a strong association between the infants' attachment categories in the SSP and their parents' classification on the AAI (Hesse, 2016).

These findings were later confirmed by meta-analytical data (van IJzendoorn, 1995; van IJzendoorn & Bakermans-Kranenburg, 1996), showing that around 58% of mothers can be judged as secure, 24% dismissing, 18% preoccupied; with 19% of these being also unresolved. This meant that the coding and classifications of the AAI had been validated by corresponding to the infant

attachment categories of the SSP and could be used as a valid measure for assessing the internal working models of adults (Hesse, 2016).

More importantly, these correspondences highlighted the fact that there was a close link between the internal working models of adults who became parents and their parenting behaviour, showing in the attachment strategies adopted by their infants and later children (Kobak et al., 2006). This influential study as well as further longitudinal studies showed that the internal working models set up in infancy tend to persist and assert their influence on social and emotional development throughout life span (Carlson, 1998; Sroufe, 2005). It also highlighted the importance of understanding how these internal working models of parents and infants interacted, leading to intergenerational transmission of attachment patterns.

However, the AAI and its results also showed that it was not the actual early attachment experience, nor the presumed quality of the relationship with the early attachment figures as indicated in the interview that asserted most influence on current parental behaviour, but the present emotional and cognitive stance taken by parents towards their past attachment experiences and views (Bretherton & Munholland, 2008).

1.7 Parental representations: coding schemes and findings

Given that it is the current stance taken by parents towards their past attachments experiences that informs their caregiving, and given that attachments appear to be relationship- specific (Van Ijzendoorn, Schuengel, & Bakermans–Kranenburg, 1999), a number of new measures have been designed to assess and identify the internal working models at work in a particular parent-infant or parent-child relationship. These internal working models of parents became known as parental representations.

Parental representations hence refer to parent’s attachment attitudes, their expectations, feelings and thoughts about their child and themselves as a caregiver (George & Solomon, 1996). As described in the section on the internal working models, once established, parental representations operate mostly automatically, outside the parent’s awareness and are composed of both cognitive and affective components, some of them mapping out the inter-related and multivarious aspects of the parent-child relationship. They are relatively stable and help parents interpret their infant’s or child’s attachment behaviour as well as guide their own attachment responses (George & Solomon, 2008b).

1.7.1 Parent Attachment Interview

Bretherton and her colleagues (1989) designed one of the first interviews examining parental representations with a specific child called the Parent

Attachment Interview (PAI). They argued that it is not only infants that show attachment distress and seek proximity from their carers but parents too 'keep a watchful eye on their infant, to intervene when the infant is getting into a potentially painful or harmful situation' (Bretherton et al., 1989, p. 205). Since parents also experience caregiving distress and relief, it seemed important to examine the parental side of the attachment relationship.

In order to do so, their interview begins by discussing the parent's thoughts and feelings before, during pregnancy and after the child's birth. Similar to the AAI, the next section asks the parent to give five adjectives characterising the child and elaborate on these by offering specific situations linked to those. There are also questions about various past emotional situations and how the child and parent acted in them, as well as an intergenerational question, asking the parent to compare and reflect on their relationship with their child and parent (Bretherton, 1990). Finally, the parent is asked to envisage their child as a teenager and adult.

The interviews are coded on a nine-point Sensitivity/Insight Scale (Biringen & Bretherton, 1988); the high scores signifying the parent's ability to respond sensitively to their child as well as offering specific evidence of doing so, hence showing both sensitivity and insight into their actions, not just theoretical knowledge of good parenting.

Bretherton (1990) explained that the PAI aimed to examine all the levels or schemas of internal working models of parents, from the very specific ones,

as described in situations where a child hurt herself and the parent had to deal with it, to more general ones, showing how the parent thought they were able to meet the child's needs, to the very general ones about the parent's representations of themselves as a caregiver. Just like with the AAI, organisation and coherence across these levels would reveal secure attachments, inconsistencies would highlight a particular mechanism of insecurity, such as the inability to generalise from lower schemas shown in the ambivalent and preoccupied adults.

This also highlighted the fact that parents conveying consistent attachment behaviour, as shown in their organised and interconnected schemas of parental representations, communicated not only important information about their specific attachment to the child, but also facilitated a way of organising information and feedback about close relationships in general, allowing their child to use these strategies in other relationships. It also meant that both the child and parent could more easily update the schemas of their relationship as various schemas connected within and across hierarchical levels (Bretherton, 1990).

One study showed that certain aspects of parental representation, such as experience and management of aggressive impulses and capacity for emotional investment, predicted maternal sensitivity (Biringen et al., 2000).

1.7.2 Parent Development Interview

Slade and her colleagues (2004) designed the current version of the Parent Development Interview (PDI-R), although the original measure (PDI) was devised in 1985 (Aber et al., 1985). This interview also taps into parents' autobiographical narratives about their child and their relationship.

The parents are asked about their perceptions of the child, what they like and dislike about him, but also invited to reflect on their relationship, what they enjoy and struggle with. They are asked to consider their strengths and weaknesses as parents, that way examining the more general schema of being a parent. The methodology is similar to the AAI, so parents are asked to give five adjectives describing their relationship with the child and support their choices with some episodic evidence. They are also asked about challenging attachment situations, how their child acted in them and how they responded. This way the interview seeks to examine parental insight into their understanding of the child in terms of attachment behaviour, feelings and thoughts (Slade, 2005).

There are also some AAI-type questions asking the parents about their childhood experiences and how they think these have affected their current parenting, hence exploring both relatively stable representations of past relationships as well as current parental representations still in development and therefore more dynamic.

The most often used coding scheme for analyzing PDI is that based on reflective functioning (RF; Fonagy et al., 1998), coding each question from -1 for bizarre responses signifying an attack on mentalization to 5 for basic capacity for RF to 9 for high RF showing exceptional mental-state thinking and insights (Slade, Bernbach, et al., 2004). Slade (2005) argued that the parent's capacity to consider and attend to their child's mental states impacts on their own feelings and caregiving behaviours, that way guiding their ability to regulate the affective states in their child, including their attachment distress.

Slade and her colleagues (2005) showed that RF was associated with infant attachment, parents with high RF were more likely to have a securely attached infant. Another study showed that parents with higher parental RF were less likely to exhibit significant disrupted communications when faced with their infant's distress (Grienenberger et al., 2005).

The PDI was adapted for use with adoptive parents (Henderson, Steele & Hillman, 2001) as well as parents of older children (George & Solomon, 1996).

The latter modification used a different coding scheme (George & Solomon, 2008a), turning the PDI into the Caregiving Interview.

Based on their elaborate theory of caregiving, George and Solomon (1996, 2008b) analysed their Caregiving Interviews for parenting strategies, that is how willing and competent, both emotionally and cognitively, parents saw themselves in their caregiving roles. Accordingly, they were scored on four scales called secure base, rejection, uncertainty and helplessness, later

renamed 'segregated systems'. These were based on parents' evaluations of feelings, thoughts, and behaviour in situations posing real and psychological threat to their child (George & Solomon, 1996).

Those parents that scored high on secure base scale showed good commitment and ability to provide safety and protection to their children. Those classified as rejecting showed unwillingness to participate in the caregiving relationship, often negatively valuing their children and their caregiving capacities. Those scoring high on the uncertainty scale showed great doubts and confusion about their children, for example their negative emotions, and their own ability to provide and protect them, often questioning and contradicting themselves in the interviews. The helplessness scale showed parents as helpless and out of control, unable to provide protection and care, also seeing their children as beyond help and control, or role reversing the caregiving relationship (George & Solomon, 1996; 2008b).

These caregiving representations showed positive association with the infant attachment categories (George & Solomon, 1996; Solomon & George, 1999); and the segregated systems parental category was predictive of child disorganised attachment at the age of six (Solomon & George, 2006).

1.7.3 Working Model of the Child Interview

Zeanah and his colleagues (1986) designed another semi-structured interview for assessing parental representations in a specific parent-child relationship

called the Working Model of the Child Interview (WMCI). This interview investigates parents' perceptions as well as their thoughts and feelings about their child and relationship. Similar to the previous interviews, it includes both general questions and requests for specific examples and episodes.

The interview is coded on two scales, the primary ones to assess the qualitative and content aspects of the parents' representations, and the secondary scales to assess the affective aspects. The primary scales include richness of perception, openness to change, intensity of involvement, coherence, caregiving sensitivity, acceptance, infant difficulty and fear for safety. The secondary scales include joy, anxiety, pride, anger, guilt, indifference and disappointment (Benoit, Zeanah et al., 1997).

Once scored on these dimensions, the transcripts are categorised into three categories mirroring the infant attachment classifications. These are balanced, disengaged and distorted.

Balanced representations show parents as coherent and involved, accepting of their role and the characteristics of their child. They see the child as separate and value their relationship with her or him, showing joy and pride in them.

Disengaged representations are characteristic of parents who present as distant and cold, indifferent to the child and their relationship, finding it difficult to describe its unique qualities. They seem unable of emotional involvement,

presenting as rigid, their narratives lacking in detail. They minimise their role as a parent, finding it difficult to see the impact of their parenting on the infant.

Distorted representations show parents as confused and internally inconsistent, preoccupied or overly anxious, their narratives showing emotional struggle to feel close to the child, their thoughts and feelings often out of context. These parents score high on intensity of involvement, anxiety and anger as well as infant difficulty and disappointment, while having very low scores on coherence, openness to change and caregiving sensitivity.

More recently, a fourth category of *disrupted* representations was added to the coding scheme of the WMCI (WMCI-D; Benoit & Crawford, 2010), showing parents as incoherent and contradictory, often fearful and helpless, even disorientated and dissociating. Crawford and Benoit (2009) devised this category by turning the observational measure AMBIANCE into a representational one; the five dimensions of disrupted affective communication on the AMBIANCE used for assessing and scoring atypical parental behaviour now mirrored by the categories of WMCI-D scoring these characteristics of disruption in the transcripts of the Working Model of the Child interviews.

Studies showed significant stability in parental WMCI classifications over time (Benoit, Parker et al., 1997) as well as an association between WMCI-D and disorganised attachment (Crawford & Benoit, 2009).

1.8 Theories of disorganised attachment

Bringing together data from observations of parent-infant interactions and assessments of parental representations as described in the previous sections, a number of theories of disorganised attachment have been put forward.

Main and Hesse (1990) proposed that fear is the underlying emotion driving this process, both in parents and infants. They claimed that the parent's unresolved past trauma or loss gets triggered by the infant's attachment behaviour and stops them from offering supportive response, instead parents present as frightened, threatening or dissociative (FR behaviours; Main and Hesse, 1992; 2005). That way the infant's distress cannot be regulated by the parent, and the attachment behaviour terminated in any organised way by the infant as he finds more alarm and anxiety in his parent who is also the source of attachment comfort, hence the description 'fright without solution' (Main & Hesse, 1990).

Importantly, these FR behaviours show that parental caregiving responses are also driven by fright, each form mirroring primitive mammalian reactions to danger: flight in frightened, attack in threatening and freeze in dissociative behaviours (Hesse & Main, 2006). The examples of these behaviours are parents suddenly looming in front of the infant, assuming an 'attack' position; sudden frightened look in the absence of external changes and altered tone of voice with a haunting quality.

Since observations of these FR behaviours were based on the studies of low-risk families, with no direct parental maltreatment or abuse, and given the evidence of parents' unintegrated memories and emotions linked to traumatic experiences of loss or maltreatment shown in the AAI, Hesse and Main (2006) claimed that the infants classified as disorganised showed clear signs of intergenerational transmission of trauma.

Lyons-Ruth, Bronfman and Parsons (1999) suggested that it is not only FR behaviours but also other atypical parental behaviours, such as contradictory and withdrawing caregiving responses, that cause the infant's fearful alarm. They focused on the overall ability of the caregiver to regulate infant's distress and offer comfort, identifying a wider number of disrupted communications (see previous section 1.5, p. 20; Lyons-Ruth et al., 2003). These included affective errors, such as contradictory cues, nonresponse or inappropriate response; role confusion, that is role reversal and sexualisation; and withdrawal.

They also identified two generic profiles of parenting present for D infants. The *hostile/self-referential* regarding attachment subgroup contained mothers that showed intrusive and role-confused expectations, often both making demands and rejecting their infants' call for attention. In contrast, the *helpless/fearful* regarding attachment subgroup were mothers that presented as fearful and withdrawing, often giving in to their infants' demands but also creating distance and removing attention that way (Lyons-Ruth, Bronfman & Atwood, 1999; Lyons-Ruth et al., 2004).

These profiles were linked to different kind of past traumas, the hostile subgroup of mothers more likely to have experienced violence and physical abuse, the helpless subgroup was associated with past sexual abuse (Lyons-Ruth & Block, 1996).

Schuengel and colleagues (1999) found that FR behaviours predicted disorganised infant attachment and were associated with maternal representation on the AAI. More importantly, this study also showed that unresolved parental loss combined with secure representation did not predict disorganised attachment in infants, highlighting the importance of parental security and sensitivity but also suggesting that another source of FR behaviours might be at play, not just U/d as argued by Main and Hesse (1990).

The latter suggestion was confirmed by Lyons-Ruth, Bronfman and Parsons (1999) who showed that atypical parental behaviours predictive of disorganised infant attachment included a wider range of behaviours as described before. In fact, their study found that within their wider coding protocol (AMBIANCE) only 17% were FR behaviours. Another example of wider context for these behaviours, beyond the parent being the primary source of fear, is the association between partner violence and disorganised infant attachment (Zeanah et al., 1999).

Grienenberger and his colleagues (2005) attempted to clarify the relationship between secure parental representations, atypical parental behaviour and disorganised attachment. They argued that the concept of parental sensitivity

did not seem to address those moments of attachment distress when atypical parental behaviours were most likely to occur, hence not addressing the parent's ability to regulate infant's distress as attempted by Lyons-Ruth and others (2003).

Using the AMBIANCE measure in their study, they confirmed that atypical parental behaviours predicted disorganised infant attachment, but they also showed that parental reflective functioning (RF) was negatively associated with atypical parental behaviours. This meant that parents with higher parental RF were less likely to exhibit significant disrupted communications when faced with their infant's distress, with RF acting as a buffer against breakdowns in affect regulation (Grienenberger et al., 2005).

Research has shown that mothers presenting with intense emotions, impulsivity and unstable relationships, in particular those diagnosed with borderline personality disorder, are much more likely to have an infant classified as disorganised (Hobson et al., 2005).

The study by Grienenberger and others (2005) was part of a wider collaboration of the researchers interested in the concept of reflective functioning (RF), claiming that it is this parental RF that underlies sensitive caregiving and infant attachment security (Fonagy et al., 1991; Fonagy & Target, 1997).

RF refers to parent's capacity to reflect on their own mental states and intentions, noticing them in their behaviour, as well as parental capacity to reflect on their child's mental experiences, seeing not just the child's behaviour

but also their desires, feelings and intentions. This capacity is seen as crucial in producing knowledge about internal experience of oneself and others, leading to the development of affect regulation and social skills (Slade, 2005).

It is this capacity to reflect on one's own past and present emotional experiences, including negative experiences and affects, that Grienenberger et al. (2005) explored and measured in the study described above. They argued that parental RF allowed the parent to recognise what was happening inside her, as a result of the present interaction with her infant but also as stemming from the past experiences with her own parents for example, and distinguish this experience from the experience of her infant, as an independent human being with her or his own mind.

Grienenberger et al. (2005) also found that the relationship between the parental RF and infant attachment organization was mediated by atypical parental behaviours, which meant that the lower levels or absence of RF was a contributing factor towards the formation of disorganised attachment (Luyten et al., 2017).

Berthelot and his colleagues (2015) confirmed the association between low RF and attachment disorganisation in a study of mothers that experienced childhood sexual and physical abuse, showing that those with little capacity to consider their traumatic experiences in psychological terms were three times more likely to have infants classified as disorganised (Berthelot et al., 2015).

This study made use of a specific reflective functioning regarding trauma (RF-T), confirming the variability and usefulness of the concept of RF.

A different approach to understanding the aetiology of disorganised attachment was offered by George and Solomon (2008b) who had adapted the PDI to create the Caregiving Interview (George & Solomon, 2008a; see also section Parent Development Interview). This was then coded according to parental responses on four scales, one of them being segregated systems. This category showed parallels with the attachment categories of D and U and was defined as a failure to defend against attachment experiences, thoughts and feelings that are unacceptable, creating a separate system outside consciousness. In the extreme, this system can lead to parental abdication of caregiving role, which can take two forms (George & Solomon, 2008b).

The first is dysregulation and shows mothers flooded by their own fears about themselves and their infants; their interviews full of vulnerability, inadequacy and loss of control.

The second is constriction and relates to mothers removing themselves from caregiving situations, freezing whilst leaving their infant in distress. These interviews show mothers either relegating their caregiving role to their children, considering them precocious and special, or merging with their child and considering their distress as their own, describing a very special relationship between them two: 'Mothers can think of the child only in relation to themselves – the child is invisible.' (George & Solomon, 2008b, p. 31).

1.9 Conclusion

This literature review examined the concepts of parental representation and disorganised attachment. Firstly, Bowlby's concept of the internal working models was explicated and shown as the bedrock of all attachment research. Bowlby's ideas around the children's ties to their parents, as well as their parent's ability and struggle to attend to them continue to inspire contemporary researchers. Solomon and her colleagues (2017) recently returned to Bowlby's theory for clarification and inspiration with their conundrums around disorganised attachment.

Also inspired by Bowlby's attachment theory, Mary Ainsworth conducted the first empirical studies of attachment, observing parent-infant interactions at home but also devising a laboratory measure to assess the quality of early attachment relationships called the Strange Situation. This observational measure led to infant attachment classifications, now the benchmark for assessing and validating all attachment methodology.

One group of infants, however, did not seem to fit the original classifications and continued to puzzle scientists. Since her doctoral study Mary Main (1973) continued to analyse these difficult to classify infants, and in further collaboration with Judith Solomon introduced a new concept of disorganised attachment. Just as the reactions of infants led to puzzlement, further research showed that these confusing behaviours and states of mind had very serious

negative implications for future psychological functioning. This was detailed in this paper.

Since attachments develop within the early parent-infant relationship, this paper next reviewed the parental aspect of the formation of disorganised attachment put forward in the research literature, linking the observational and representational methods and findings.

The observational measures of parent-infant interactions were explained and their importance for studying attachments shown. Since measuring the observations of parental behaviours around the concept of maternal sensitivity seemed to show limited usefulness for studying disorganised attachment, two new coding protocols of FR behaviours and AMBIANCE were introduced. Both measures were explained, and their findings detailed.

In order to map out the findings from the representational measures of studying the parental aspect of the formation of disorganised attachment, the move to the level of representation within the attachment research was charted and detailed, including the Adult Attachment Interview. One important part of this interview was the section on the past loss and trauma. Three different methodologies for coding this section were introduced: U/d, HH and RF. All of these aim to further our understanding of intergenerational transmission of relational trauma.

The AAI paved the way for semi-structured interviews designed to study specific parent-child relationships. The three introduced in this review were PAI, PDI and WMCI. All of these interviews explore the internal working models of parents when providing caregiving to their children, also known as parental representations. The concept of parental representation was introduced and research findings from these interviews detailed.

Bringing together all the methodological advances in the research literature as applied to the study of disorganised attachment, the last section of this paper reviewed the theories of disorganised attachment.

Main and Hesse (1990) argued for the importance of fear and FR parental behaviours. Lyons-Ruth and colleagues (2003) widened the range of atypical parental behaviours (as measured by AMBIANCE), arguing that the absence of parental response can be as confusing and disorganising to the infant as parental fear (Lyons-Ruth, Bronfman and Parsons, 1999). Fonagy and colleagues (1991) revised the importance of maternal sensitivity by introducing a new concept of parental reflective functioning, mapping out the parents' capacity to mentalise their child's mental states as well as their own, at moments of attachment distress too. George and Solomon (2008a) proposed a more generalised approach to caregiving, identifying a whole area of caregiving that is unacceptable to parents but continues to influence their behaviour and parental representations.

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Part 2: Empirical Research Project

Title: Exploring parental representations in mothers
whose infants go on to develop disorganised attachment

Candidate number: FJZM8

Word count: 8450

Abstract

Aim: Research has shown that infants categorised as having a disorganised attachment with a primary caregiver are most at risk for developing serious mental health difficulties later on in life. This study aimed to explore the processes that may contribute towards the formation of disorganised attachment in infants by analysing parental representations, assessed in the first year of the infant's life, in a sample of parents whose infants were classified as disorganised one year later.

Method: The study utilised data collected as part of a randomized controlled trial (RCT) of parent–infant psychotherapy (PIP) for parents with mental health problems and their young infants (<12 months of age). Out of 76 mother-infant dyads that took part in the RCT, 7 mothers were later identified as having an infant with disorganised attachment (when the infants were 12-24 months old). Using purposive sampling, these 7 cases were selected as the sample for the current study. The Parent Development Interview, a semi-structured interview capturing the parents' representations of their infant and their relationship was administered one year prior to the infant attachment classification. A thematic analysis, a flexible yet rigorous way of organising data by identifying, analysing and reporting patterns (themes) within the data set was conducted.

Results: The four key themes that emerged from the interviews were Emotional distress, Enjoyment, Special relationship and Ambivalence. Each theme comprised several subthemes: emotional distress had subthemes of anxiety about baby's health and behaviour, feeling angry, feeling low and feeling helpless; enjoyment had subthemes of mutual enjoyment and

supportive others; special relationship had subthemes of baby as perfect, baby with special skills/interests, baby as a source of comfort/support and special connection; ambivalence had subthemes of ambivalent feelings, ambivalent behaviour and feeling trapped.

Discussion: By using a qualitative exploratory approach, this study analysed parental representations differently from top-down quantitative coding protocols, hence its findings offer a useful insight and comparison with the current theories of disorganised attachment. All the themes identified were discussed and situated within the current literature on disorganised attachment.

2.1 Introduction

Advances in neuroscience and genetic research have revealed the importance of very early relationships and social experiences for healthy infant development (Bokhorst et al., 2003; Lyons-Ruth & Jacobvitz, 2016; Schore, 2010; Strathearn et al., 2009). Since these early biological and psychological developments take place within the early parent-infant relationship, the quality of parent-infant interactions is predictive of a range of psychological and social outcomes for the child later on (Kobak et al., 2016; Schore, 2010; Sroufe, 2005).

Infant attachment security is strongly associated with many positive psychological outcomes, including better emotional regulation and understanding, greater social competence and a stronger sense of self (Thompson, 2016). Secure attachment also predicts more positive parent-child interactions and acts as a buffer against negative family experiences, for example parental stress (Tharner et al., 2012).

In contrast, disorganised attachment has been identified as a key risk factor for developing serious mental health difficulties later on in life (DeKlyen and Greenberg, 2016; Sroufe, 2005). These include internalizing and externalizing problems (Fearon et al., 2010; Groh et al., 2012). Those classified as disorganised show higher levels of aggressive behaviour and dissociative symptomology all throughout their childhood and adolescence (Lyons-Ruth, 2003; Moss, Cyr, & Dubois-Comtois, 2004; Sroufe, 2005). Many of their

severe relational difficulties continue into adulthood (Johnson & Greenman, 2006) and parenthood (Main, 1990).

Disorganised attachment refers to the conflict at the level of attachment system, with the infant failing to find a coherent way of responding to the attachment alarm, his or her behaviour manifesting this disruption and inability to adapt to the environment (Duschinsky & Solomon, 2017). These disruptions are suggestive of increased alarm, fear and conflict when making use of and responding to an attachment figure (Hesse & Main, 2006). They are also indicative of unpredictability and great variance in parental caregiving actions, feelings and thoughts (George & Solomon, 2008b; Lyons-Ruth, 2002).

Given the detrimental effects of disorganised attachment on psychological and social development, it is important to explore and understand the processes underlying it. One area that has been studied extensively is the parental aspect of the formation of disorganised attachment, both the quality of parent-infant interactions and the nature of parental representations.

Parental representations refer to parent's attachment attitudes, their expectations, feelings and thoughts about their child and themselves as a caregiver (George & Solomon, 1996). They are relatively stable and help parents interpret their infant's or child's attachment behaviour as well as guide their own attachment responses (George & Solomon, 2008b).

Based on data from observations of parent-infant interactions and assessments of parental representations, the following theories of disorganised attachment have been put forward.

Main and Hesse (1990) proposed that fear is the underlying emotion driving this process, both in parents and infants. They claimed that the parent's unresolved past trauma or loss (U/d) gets triggered by the infant's attachment behaviour and stops them from offering supportive response, instead parents present as frightened, threatening or dissociative (FR behaviours; Main and Hesse, 1992; 2005).

Since observations of these FR behaviours were based on the studies of low-risk families, with no direct parental maltreatment or abuse, and given the evidence of parents' unintegrated memories and emotions linked to traumatic past experiences of loss or maltreatment shown in the Adult Attachment Interview (AAI), Hesse and Main (2006) claimed that the infants classified as disorganised showed clear signs of intergenerational transmission of trauma.

Lyons-Ruth, Bronfman and Parsons (1999) suggested that it is not only FR behaviours but also other atypical parental behaviours, such as contradictory and withdrawing caregiving responses, that cause the infant's fearful alarm. They focused on the overall ability of the caregiver to regulate the infant's distress, arguing that the absence of parental response could be just as confusing and disorganising to the infant as was parental fear.

In order to evidence this, Lyons-Ruth and her colleagues (1999) returned to the videos of infants classified as disorganised in the Strange Situation Procedure. They identified five dimensions of disrupted maternal affective communication and used them to create a measure called Atypical Maternal Behaviour Instrument for Assessment and Classification (AMBIANCE) (Bronfman, Madigan, & Lyons-Ruth, 1992; 2009).

Schuengel and colleagues (1999) found that FR behaviours predicted disorganised infant attachment and were associated with parental representation on the AAI. This study also showed that unresolved parental loss combined with secure representation did not predict disorganised attachment in infants, highlighting the importance of parental security and sensitivity but also suggesting that another source of FR behaviours might be at play, not just U/d as argued by Main and Hesse (1990).

The latter suggestion was confirmed by Lyons-Ruth, Bronfman and Parsons (1999) who showed that atypical parental behaviours predictive of disorganised infant attachment included a wider range of behaviours as described before. In fact, their study found that within their wider coding protocol (AMBIANCE) only 17% were FR behaviours.

Fonagy and colleagues (1991) revised the importance of parental sensitivity by introducing a new concept of parental reflective functioning (RF), mapping out the parents' capacity to mentalise their child's mental states as well as their own, at moments of attachment distress too. This capacity to reflect on

behaviour as revealing of desires, feelings and intentions is seen as crucial in producing knowledge about internal experience of oneself and others, leading to the development of affect regulation and social skills (Fonagy & Target, 1997; Slade, 2005).

Further studies showed that the lower levels or absence of RF were associated with atypical parental behaviours (Grienenberger et al., 2005) and disorganised attachment (Berthelot et al., 2015).

A different approach to understanding the aetiology of disorganised attachment was offered by George and Solomon (2008b) who had adapted the Parent Development Interview to create the Caregiving Interview (George & Solomon, 2008a). This was then coded according to parental responses on four scales, one of them being segregated systems. This category showed parallels with the attachment categories of disorganised and unresolved and was defined as a failure to defend against attachment experiences, thoughts and feelings that are unacceptable, creating a separate system outside consciousness. In the extreme, this system could lead to parental abdication of caregiving role (George & Solomon, 2008b).

This approach links the attachment theory with psychoanalytic insights and clinical observations. Two important psychoanalytic concepts relevant for early parent-infant communication are those of projection and containment. Klein (1946) described the infant's use of the unconscious mechanisms of splitting and projection to expel unwanted sensations and emotional experiences into

their parents. Bion (1962b) elaborated on the importance of parental minds for processing these early infantile projections by allowing them to be absorbed and digested, only then producing a containing response (Bion, 1962b). They both postulated that the use of these psychological mechanisms continues into childhood and adulthood.

All the theories of disorganised attachment described above are based on data gained from the observational and representational measures. The former are observations of the quality of parent-infant interactions, including the parental behaviour, later usually scored according to a protocol used. Two such examples are coding protocols of FR behaviours and AMBIANCE.

As for the representational measures, these are semi-structured interviews, such as the Parent Development Interview (Slade et al., 2004), designed to elicit parental representations regarding a current parent-infant relationship. The parents are asked about their infant's behaviour and feelings, their relationship and their views of themselves as parents. The answers are usually scored according to a coding protocol used.

This means that both the observational and representational measures tend to be quantitative, applying a prescribed coding protocol to parent-infant interactions or parental interviews. However, even these 'top-down' measures can be revised by using qualitative methodology.

For example, the beforementioned AMBIANCE coding scheme (Bronfman, Madigan, & Lyons-Ruth, 1992; 2009) was devised by examining the Strange

Situation videos of infants already known and classified as disorganised, the researchers later returning to these videos to study each parent-infant interaction, paying close attention to every parental communication and response, hence doing so 'bottom-up.' This is how they revised and extended the previously most widely used observational coding protocol of FR behaviours, identifying a wider range of parental atypical behaviours associated with the development of disorganised attachment in infants (Lyons-Ruth et al., 1999).

The current study aimed to apply the same principle to a representational measure, doing so by analysing the Parent Development Interviews administered to mothers one year prior to their infant's attachment classification, hence purposively returning to the interviews of mothers whose infants became known and classified as disorganised. This data offered a unique opportunity to explore the caregiving representations of mothers in their infants' first year and compare the results with the findings from the quantitative coding protocols as theorised in the current literature on disorganised attachment.

2.2 Method

2.2.1 Context and design

This study is a retrospective secondary qualitative analysis of a subsample of data collected as part of a randomized controlled trial (RCT) of parent-infant psychotherapy (PIP) for parents with mental health problems and their young

infants (<12 months of age). The RCT investigated the outcomes of PIP for parents with mental health problems who were also experiencing high levels of social adversity (Fonagy et al., 2016). Parent-infant dyads were clinically referred and randomly allocated to PIP or a control condition of standard treatment.

All the baseline assessments, including the Parent Development Interviews (PDI) used in the current study, were administered prior to randomisation so the subsample contains data from both treatment groups as these were collected pre-treatment.

2.2.2 Participants

Out of 76 mother-infant dyads that took part in the RCT, 7 mothers were later identified as having an infant with disorganised attachment.

These infants were classified using the Strange Situation (SSP; Ainsworth, Blehar, Waters, & Wall, 1978); a semi-structured laboratory procedure assessing the quality of infants' attachment, that is their ability and confidence to use a primary caregiver as a secure base. The SSP was administered at the final follow-up assessment for the RCT, one year after the baseline assessments when the PDI data was collected.

Using purposive sampling, these 7 cases were selected as the sample for the current study.

All the infants were between 1 and 8 months old at the baseline assessment when the PDI data was collected.

Interestingly, they were all male. The overall sample in the RCT contained 61% of male infants.

All the mothers had mental health difficulties and suffered from social adversity. They all met the inclusion/ exclusion criteria for the wider study (Fonagy et al., 2016).

More specifically, all the mothers were between 24 and 37 years of age at the baseline assessment. Five out of seven mothers scored above the clinical threshold for depression on the CES-D (Centre for Epidemiological Studies Depression Scale; Radloff, 1977). Five mothers were married; and four had another child in the family. Four mothers were educated to the degree level or above, four were unemployed, two relied on support income, two were socially isolated due to the recent relocation and one mother lived in an overcrowded accommodation.

Due to the small sample, all demographic information is presented as a group to protect confidentiality and preserve anonymity of individual participants.

2.2.3 Measures

The Parent Development Interview (PDI; Slade, Aber, Bresgi, Berger & Kaplan, 2004); a semi-structured interview capturing the parents' representations of their infant and their relationship was administered at the baseline assessment when the mother-infant dyads first came into the RCT. All the infants were under 12 months old.

All the interviews were carried out and all the transcription conducted by the researchers and research assistants from the RCT. The anonymised verbatim transcripts of those interviews served as the data for thematic analysis in this study.

2.2.4 Analysis

Data were analysed using thematic analysis, a flexible yet rigorous way of organising data by identifying, analysing and reporting patterns (themes) within the data set (Braun and Clarke, 2006).

All the interviews were coded at four levels. Firstly, all the verbatim transcripts were read in full a number of times to allow for familiarisation and create the initial meaning codes, each sentence given a code. Then all these codes were put in the table and assigned a second-level code, wider and more generalised meanings systematically assigned to all initial codes. Thirdly, all these second level codes were assigned the most generalised description available, these third level codes becoming the subthemes of the data material.

The next stage of analysis involved organising these subthemes into bigger groups, which became the key themes. This four-stage coding and group organising process was repeated in order to check and refine codes and themes, making appropriate links and dispensing with repetition.

To make the results credible and trustworthy two separate processes were used when conducting the analysis. Samples of anonymised interviews were shared with the peer research group, inviting them to code and later compare their results with the author's. This was followed by discussion, in which adjustments and corrections to the codes were agreed.

Similarly, the research supervisor checked the codes in relations to data as well as the validity of the themes to the codes and data. All this was to minimise unconscious bias of the author.

2.2.5 Ethics

The research protocol for the overall study was approved by a National Health Service Research Ethics Committee (Reference 05-Q0511-47).

All the interview transcripts used in the current study were anonymised during the transcription process, giving rise to no confidentiality or consent issues. No identifiable information has been used throughout.

2.3 Results

Analysis resulted in four key themes and thirteen subthemes described below (See Table 1 for summary). Extracts provide evidence for each theme and subtheme.

Table 1. Key themes and subthemes

Key themes	Subthemes	Number of participants contributing to subtheme (N=7)
Emotional distress	Anxiety about baby's health and behaviour	7
	Feeling angry at partner, baby or others	5
	Feeling low about her or their situation	3
	Feelings of helplessness	4
Enjoyment	Mutual enjoyment	5
	Supportive others	4
Special relationship	Baby as perfect	5
	Baby with special skills/interests	2
	Baby as a source of comfort/support	4
	Special connection	4
Ambivalence	Ambivalent feelings	2
	Ambivalent behaviour	2
	Feeling trapped	3

2.3.1 Emotional distress

The first key theme was present in all seven interviews and described mothers as greatly preoccupied with anxieties and negative emotions about the infant, their relationship with the infant or towards others.

The first subtheme was **anxiety about baby's health and behaviour** and appeared in all seven interviews.

This category highlighted mothers' repeated expressions of fears about their infant's health and physical or psychological vulnerability. They would describe being frightened of possible illnesses, even though as one mother put it 'he is very healthy.' Another mother described checking anxiously on her infant at night to see if he was breathing.

Some of the mothers were concerned about the physical impact of not breastfeeding, sharing about their painful anxiety when seeing their infant vomit or struggle to digest:

'Uh, I worry about, he's got a bit of eczema. Like, physical. He had a little colic. So I worry about.. [...] ..maybe [...] he's constipated. And that worries me. Because he isn't enjoying anymore. He just seems to be thinking about his pain.' (P3, p. 4)

'I was feeding him and he just kind of constantly—he wouldn't latch on to my breast, I would say he was kind of stressed out or I don't know, I couldn't seem

to settle him down in any way. [...] you know, the bottle seems to satisfy him more than my breast.' (P4, p. 3)

This anxiety would make mothers question themselves about their past actions and availability to the infant, their poor mental health and its consequences in particular. Some of the mothers would also feel compelled to seek reassurance about their infant's health and development in his positive behaviour. A few of the mothers described difficulties in pregnancy, having to be hospitalised or taking medication.

Many mothers would feel criticised by others when asked about aspects of caregiving, seeking and feeling personal blame for feeding difficulties with their infant for example.

The second subtheme was **feeling angry at partner, baby or others** and it showed mothers greatly preoccupied by anger. This category appeared in five interviews and the mothers reported being angry with professionals, their partner or families.

A few of the mothers expressed anger and resentment towards their partners, feeling either left by them or treated unfairly when it came to caregiving. Some also expressed confusion about their feelings, unsure if some of that anger and resentment was addressed to the infant. One mother felt confused about seeking her partner's attention for her own needs, which made her feel guilty about not doing so for the infant's benefit.

'Well, I try not to, um... rant and rave in front of him, um, but I'm sure he must sense that I'm angry, you know, because it doesn't just last a few minutes, you know, especially, when I'm trying to contact his father all day, and then getting no response [..] I suppose he probably cries more, or is, um, more irritable as a result of it? I would imagine, although I haven't monitored that, I can't say that for sure.' (P1, p. 8)

This shows how the preoccupation with anger made the mother unavailable to the infant and his needs as confirmed by other participants. They described leaving their infant in distress, unable to attend to him, being either paralysed by their own emotions or feeling that the infant was 'in the wrong.'

A few of the mothers described feeling paranoid and overly scrutinised by professionals when hospitalised due to mental health difficulties, which in turn made them very angry and wishing to leave and regain their independence.

The third subtheme was **feeling low about her or their situation** and described mothers preoccupied by low mood and despair, struggling to motivate themselves to offer supportive care to their infants. It was characteristic of three interviews.

One participant spoke of great disappointment at her partner, despairing about her current family situation:

'..he's been through so much and I feel so bad for him. It just shows how difficult life is in general, I think. And how easily it can just be taken away from you. [...] I'm talking about my new life as well, a single parent and as a mother .. and his new life with me, which wasn't meant to be this way [...] it's not what I wanted.' (P1, pp. 2-3)

A few of the mothers described feeling disconnected and exhausted at night, having difficulties to sleep but also struggling to attend to their infants when distressed or hungry:

'You know, the last night I was just kind of lying in bed, just crying. It sort of felt. You know, I just felt that I was just someone bad. [...] Yeah, I guess last night was kind of the lowest point. [...] I just felt kind of very alone.' (P2, pp. 4-5)

The third subtheme was **feelings of helplessness** and showed mothers expressing a strong need to be cared for but also frustration that this was unavailable to them. It was present in four interviews.

The next excerpt offers a striking example of this category:

'Um, again, in the nights, I feel, in the nights, I wish someone could just, and often, you know, if he's crying a lot, or in the night, I just think, "Oh, I wish, someone could care for me, as in could feed him for me and make me a drink." [...] Um, 'cause I have had that feeling, "Oh, I wish I was being cared for like Person 1" [...] more so right at the beginning [...] for the birth, like I just wanted

to lay there and almost be catatonic and just let people, you know, feed and nurse me. I just felt so, so low and just didn't want to let, but did you say in the past week?' (P1, p. 9)

This participant showed how her preoccupation with these feelings took her into a different, perhaps more traumatic past time, making it difficult to sustain answering the question, which was asking about the need to be cared for in the past week.

A few of the mothers described their sense of being helpless when faced with their infant's distress:

'I get quite upset [...] with him. I feel like I'm, how can I say it, like my upset, me being upset can kind of paralyse me with Person 1. [...] For example, when he cries sometimes he tends to choke, you know? That these little things can paralyse me.' (P6, p. 12)

2.3.2 Enjoyment

This second key theme described mothers taking great pleasure in their infant, their relationship and interaction or their role as a mother. It also showed mothers speaking of others as supportive towards their role and relationship with the infant. It was present in six interviews.

The first subtheme was **mutual enjoyment** and relates to mothers' expressing great pleasure in their infant, their relationship and interactions but also their role as a mother. It was present in five interviews.

One participant described a scene of mutual joy between the mother and her infant:

'...he smiles when he sleeps or sometimes like when he wakes up and I change his nappy in bed and he's happy and he's kind of studying your face and sometimes—it just looks like a smile or he looks like he's enjoying being with you and looking at you.' (P4, p. 1)

Other participants described feeling really good about their role as a mother when things went well, after a good feed or having managed to settle their crying infant for example. They spoke of joint interactions of happiness, describing moments of closeness, expressing a lot of care and attention given to their infants at those times.

The second subtheme was **supportive others** and considered how some mothers felt supported by others, their family and friends in particular, but some also by professionals. This category appeared in four interviews.

One participant spoke of her sense of having her family there to support her:

'Sometimes my mum comes over here and he was sleeping, he was fine but I felt like I couldn't breathe, you know, because I was in so much pain and I felt

like I wish somebody could help me. I just wanted somebody to take the pain away and help me to relax.' (P4, p. 6)

Other mothers spoke of the importance of their partners for their caregiving role, be it to share those moments of joy with them or seek their support when in difficulty.

2.3.3 Special relationship

This key theme appeared in six interviews and relates to mothers describing the infant and his abilities or their relationship as very special, unlike that of anyone else or with anyone else; the infant offered special things to them.

The first subtheme was named **baby as perfect** and was present in five interviews. The mothers would express only positive views of their infant, describing their babies as perfect, although finding it difficult to be specific about these good traits and qualities, and even more difficult to express any negative comments about their infant's behaviour or traits. However, there were many hints from mothers about their negativity towards infants. In fact, when the mothers began to speak about their dislikes of their baby, they would become rather overwhelmed by their negative feelings.

The following extract encapsulates this difficulty of mothers to express views about their infant freely, highlighting their own anxieties about things possibly going wrong for their relationship and mothering as well:

'It's when he's vomiting a lot because that just makes me worry even more [...] I guess that's not even his fault but it's... it's something that kind of concerns me and makes me kind of wonder about my ability as a mother who's not feeding him right or you know... I can't think of anything else that I don't... You know, he's just perfect. Everything about him is just perfect.' (P2, p. 4)

This wish for a 'perfect baby' seemed to have been mirrored by an expectation of 'perfect mothering' as shown below. It is worth noting that this same parent expressed her fear of hating the infant during pregnancy later in the interview:

'..if it wasn't for my poorly hands and so on I would just love even if he was to just fall asleep in my hands, I wouldn't mind him staying in my hands all the time.' (P6, p. 3)

These mothers would speak of idealised versions of their caregiving, often denigrating themselves as carers when unable to provide it.

The second subtheme was **baby with special skills/interests** and relates to mothers assigning skills and interests to their infants that are beyond the age and stage of infants' development. This subtheme was present for two mothers.

One described wishing to teach her baby to read at nine months and feeling rather disappointed that she had not managed to do so due to time constraints. She also described an ordinary interaction of her baby reaching out for her face as unique to her baby, no other baby does that according to her.

The other mother assigned a developmentally inappropriate interest to her baby, somewhat mixing emotional needs of infants with sexual interests of adults:

'Um, I was at the—at the swimming pool. He was about two and a half to three months and he kept crying every time I left him alone and the minute I would sit him with us, you know, all girls in bikinis and so on, he would start kind of smiling to everyone and interacting to everyone [...] I've always said that he likes girls. He likes good-looking girls.' (P6, p. 3)

This mother seemed to be suggesting that it was not so much her presence, but her presence as a woman in bikinis together with her friends that had brought calm to this distressed infant.

The third subtheme was **baby as a source of comfort/support** and described mothers assigning emotional capacities to their infants that are beyond the age and stage of infants' development. This was the case for four participants. The following excerpt encapsulates the mothers' wish for that kind of support:

'I just feel that he knows that things are difficult and probably can sense that from me especially when I've sort of cried over him or held him and been crying. It's almost like he gives me comfort. If I, if he's crying, and I start to cry, he stops. It's almost like he's giving me something back, you know. [...] I feel

he's, you know, quite in touch with my feelings and insightful in that way.' (P1, p. 1)

The same mother, however, later qualified her infant's ability to offer this support:

'..in the nights when I feel, "Oh, I wish someone could come and help me out here." [...] Cause you cuddle Person 1, I cuddle Person 1, but it's not like you're getting a cuddle back. You know, you need that. [talks to Person 1, still crying].' (P1, p. 9)

Another participant described her sense of disappointment at what she considered a lack of affection from her infant:

'You know, the last night I was just kind of lying in bed, just crying. It sort of felt. [...] I just felt kind of very alone. [...] And... Kind of not really being... loved. Uhm, I mean I guess he's, you know, he's too small to kind of show any kind of affection at the moment.' (P2, pp. 4-5)

A different kind of feeling was stirred up in another mother disappointed with her infant's inability to offer emotional warmth. This feeling seemed to link with her sense of helplessness when it came to infant's upset:

'Yesterday I blew a little bit because he was a bit... moody. Yes, I think yesterday I was a little bit angry. Because, he gets a little bit... I don't know

what he wants, so I don't know what to do. And I get tired and I don't know what to do.

I: So what was he doing? What was the situation?

P: No, he just... Just wouldn't cuddle.' (P3, p. 4)

The fourth subtheme was a more general sense of a **special connection** between the infant and the mother as described by four participants.

One mother described a sense of knowing her infant before. Another mother described this unique quality of their relationship in these words:

'I would say close, it's a very close relationship, um, there is I'm sure I'm sure there is a secret, you know like a special bond. [...] Um, no, I feel like maybe he does, he does have the same kind of same special bond, um, feeling, like I do.' (P6, p. 3)

This mother seemed to communicate not only great closeness with her infant but also a level of intimacy about their relationship that needed to be kept away from everyone else; a somewhat precious quality about it, perhaps almost forbidden, hence sitting awkwardly in relation to others.

This need for exclusivity and intimacy seemed to have impacted on mothers' ability to let the infant spend time with others, limiting it to minimum:

'And the family wants to spend time with the baby all the time. [...] And suddenly I had that feeling like, "Oh my God, I need to see the baby." And I think he had

the feeling as well. [...] And now, I don't let them take him too much, I think.'

(P3, pp. 5-6)

2.3.4 Ambivalence

The last key theme was very prominent in four interviews and relates to mothers' continued expressions of intense mixed feelings or behaviour towards the infant, their relationship or being a mother.

The first subtheme was **ambivalent feelings** and described mothers' strong mixed feelings about their infant, their relationship or being a mother. It appeared in two interviews.

One participant claimed that she was both very close and distant to her infant, oscillating between intense love and feeling low and lonely:

'At the moment I feel there isn't really much of a relationship between us. You know, that's why I said like it almost feels like anyone can be his mother. Because I feel, even though I love him so much, I don't really feel a connection.' (P2, p. 3)

She also expressed her strong mixed feelings about being a mother due to complications with her partner and family, at times wishing she did not have the baby at all, this thought making her feel very guilty.

Another mother expressed her mixed feelings about being a mother due to feeling overwhelmed by the role:

'I suppose it's also, also guilty that actually I don't want to be with them, I wanna do something for myself and I really don't just want to see them at all and then I feel guilty about it cause I don't have any choice..' (P7, p. 5)

The second subtheme called **ambivalent behaviour** highlighted mothers' strong mixed feelings as shown in their behaviour towards the infant. This was the case for two participants.

One described her interactions with the infant around feeding this way:

'Yea sometimes I spoil too much and um, at the same time [...] I press I think a lot. [...] I think for myself but if I don't push him, he will no eat it and he will not say to me 'mama I'm hungry' [...] so I need to. Uhm.. it's very difficult that because two feelings in myself, so mixed up, yeah.' (P5, pp. 3-4)

This mother seemed aware of the impact of her behaviour on the infant and although wishing not to use force, her anxiety about his health did not allow her to stop:

'Oh when we feed him because he is screaming and he wriggle and he don't want it and yeah so it's very hard, it's very hard for him, it's hard for me and the whole situation is very tensed. [...] 'I think he does not like it, it's not enjoyable you know, he put it back.' (P5, p. 3)

Another mother described her behaviour towards the infant when she was feeling low and emotionally unavailable, holding him even closer physically:

'When I'm feeling low, I feel that's when he might feel rejected. But I'm scared if he does feel rejected because, you know, whether he picks up on that. Uhm... So I kind of try and hold him close.' (P2, p. 11)

The third subtheme was described as **feeling trapped** and relates to mothers' strong sense of loss of agency and autonomy, this sense causing them intense feelings of ambivalence towards their infant, their relationship or being a mother. This category was present in three interviews.

One participant described her sense of having to attend to her infant all the time, hinting at hostile feelings this was stirring up in her:

'He just needs attention all the time, whether it's a system. [...] like his body, or because he's a little bit spoiled. But he needs me all the time. Cry cry cry all the time.'

[..]

'I'm just exhausted. I'm really tired. And a little bit on my patience, not to hurt him or anything. [...] But I still love him, never wanted to hurt him. Just, sometimes, I want to say really hard, "Be quiet." But I'd always hate to do that to him.' (P3, p. 1-5)

Another participant concurred with this feeling of being at the mercy of her infant/children:

'I feel I'm trapped, frustrated, angry. [...] ..you need to pay them attention and think about them all the time, they just demand it, I suppose demanding, really demanding [...] ..like the whole time (laughs). (P7, pp. 1-3)

These mothers seemed unable to affect changes, even when reporting some awareness of their infant not needing them all the time, or even showing signs of discomfort with them, that feeling of being at the mercy of their infant persisted. However, they also wondered if what they considered their infant's constant demand on them was due to their anxiety or as they put it their 'really wanting him.'

All of these mothers also expressed disappointment that their infant was not more independent, confirming the mixed and perhaps confusing nature of their actions and expectations.

2.4 Discussion

This study aimed to explore parental representations in mothers whose infants were younger than one year and went on to develop disorganised attachment; using its results to compare with the findings theorised in the current literature on disorganised attachment.

The first key theme was **Emotional distress**. It was present in every interview and contained a number of important emotional stressors reported by the mothers, including their anxiety and preoccupation with negative emotions.

Many of these anxieties and feelings were very understandable given that all these infants were younger than one, and their mothers were only in the first weeks of parenting as well as suffering from mental health difficulties.

Also, the interview protocol contained a number of questions specifically asking about negative emotions and how the mothers managed them.

However, large sections of the interviews with these subthemes contained numerous expressions of mothers' own anxieties and feelings, their preoccupation also showing in the way they answered the questions, often much less information was offered about their infants' behaviour and states of mind. There were examples of distorted discourse, when the mothers became so preoccupied with their feelings, even disoriented, that they could not answer the question asked (Crawford & Benoit, 2009).

All of the mothers in the sample faced social adversity and mental health difficulties, which would have impacted on their ability to manage maternal stress and relational challenges. Research has shown that mothers presenting with intense emotions, impulsivity and unstable relationships, in particular those diagnosed with borderline personality disorder, are much more likely to have an infant with disorganised attachment (Hobson et al., 2005). Other studies highlighted the association between parental conflict and violence and disorganised attachment (Zeanah et al., 1999).

Cyr and her colleagues (2010) showed how a combination of various parental social-emotional risk factors, such as low income, single mother, adolescent

mother, low education, ethnic minority and/or substance abuse, greatly increased the likelihood of developing infant disorganised attachment.

In terms of the impact of distress on parental representations, George and Solomon (2008b) proposed that parents who became flooded by their fears about themselves, their children or caregiving, even if temporarily, would often end up unable to respond to their children's attachment needs, that way abdicating their caregiving role and leaving the infant or child exposed to his own fears. They linked these dysregulated caregiving states of mind to parents' sense of helplessness and fears about providing safety and protection to their children. These themes seemed to resonate with the findings described in this section of the study,

The second key theme **Enjoyment** showed mothers interacting positively with their infants and others, expressing pleasure at these interactions but also recognising moments of mutual joy.

Even though all the mothers expressed anxieties about their caregiving, as shown in the key theme Emotional distress above, some of the mothers described recovering their sense of maternal agency as their mental health improved, now speaking of moments of closeness but also discovery, expressing a lot of care and attention given to their infants at those times.

Again, the interview protocol prescribed specific questions about the qualities most liked about the infant by the mothers as well as moments of joy and when they felt they clicked as a dyad, so some positive answers and the presence of this theme might have reflected this fact as well.

None of the theories described before claim that infants with disorganised attachment are exclusively and continually exposed to parental behaviours or representations associated with disorganised attachment. In fact, disorganisation suggests unpredictability and great variance in parental caregiving actions, feelings and thoughts (George & Solomon, 2008b; Lyons-Ruth, 2002).

Linking various aspects of the themes of Enjoyment and Emotional stress perhaps highlights a strong sense of maternal ambivalence that was present in the interviews. The clinical literature suggests that maternal ambivalence causes great anxiety, but if worked through, offers mothers further opportunities for learning emotionally about their infants and themselves (Parker, 2005). However, research has also shown that the inability to mitigate negative feelings by the presence of positive ones exposes mothers to defensive processes that can lead to further fear, helplessness and narcissism as they battle to understand their maternal negativity (Lyons-Ruth, 2002; Lyons-Ruth & Spielman, 2004).

The use of defensive mechanisms also limits mothers' ability to see their infant as an agent in his own right, with all his feelings, this leading to further caregiving distortions and unpredictable reactions, which in turn put the infant in an impossible role and situation (George & Solomon, 2008b; Lyons-Ruth, 2002).

In some interviews these aspects of ambivalence had crystallised into a theme of its own, woven through and referred to by the mothers throughout (see the key theme Ambivalence).

The third key theme **Special relationship** highlighted a number of subthemes that seemed particularly relevant to the topic of attachment disorganisation.

Most of the mothers used idealised ways of describing their infants as well as their caregiving, shying away from negative comments, often qualifying and disputing these negative thoughts. At other times, however, they would be rather denigrating of their caregiving and very critical of their infants, hinting at or expressing very strong negative feelings towards them.

Lyons-Ruth and her colleagues (2005) described and studied the precarious nature of these idealised versions of caregiving, highlighting the processes of splitting and dissociation at work. These defensive processes affected the mothers' ability to face their infant's distress and negativity, leading to feelings of helplessness or hostility as manifested in atypical parental behaviour, which in turn was associated with disorganised attachment in infants (Lyons-Ruth, 2003).

Some of the mothers described unrealistic expectations of their infants, either by ascribing adult skills and interests to them, or by seeking adult-like emotional support and understanding from their infants. Similar to the subtheme above, they would blame themselves for not managing to teach their infants these skills.

This subtheme seemed to resonate with the clinical and research findings by Lyons-Ruth and Spielman (2004) who traced these contradictory, role-confused and sexualised parental behaviours in mothers that would both ignore and override their infant's attachment signals, often attributing feelings to the infant with little insight into their developmental needs. These mothers showed a high proportion of self-referential statements, such as the one described in this study when it is difficult to see what infant under one would show preference in good-looking girls.

Further psychoanalytic insight into these behaviours and representations can be offered via the concepts of projection and projective identification (Klein, 1946; Bion, 1962b). Just as infants and very young children use primitive mechanisms of splitting and projection to expel unwanted sensations and internal experiences, adults continue to rely on these mechanisms at times of great distress. Those mothers that continue to project their own fears and desires in excess might expose their children to these unwanted mental states, leading to confusion and enmeshed functioning (Silverman & Lieberman, 1999).

The majority of the mothers described their relationship with their infants as something very special, even a 'secret'. They felt a special bond and speculated about their infants feeling the same.

George and Solomon (2008b) described this way of relating by mothers as caregiver abdication by constriction, showing mothers relegating their role as

a caregiver and merging with their infant to create a very special connection that cannot be disturbed by other views. This seemed to limit the mothers' ability to allow others into this special relationship, but it also seemed to put their infant into a very precarious, albeit glorified position.

The fourth key theme was **Ambivalence** and showed mothers expressing strong mixed feelings or showing strong mixed emotions in their behaviour towards the infant.

Some of the mothers expressed their ambivalence about their infant or being a mother, describing both intense love for their infant and no connection at all, in fact feeling low and lonely or completely swamped by their duties as a mother.

Lyons-Ruth and her colleagues (1999) identified similar kind of caregiving behaviours and representations in mothers that presented as fearful of their ambivalent feelings but also withdrawing, giving in to their infants' demands but also creating distance and removing attention and themselves that way. Interestingly, they found that male infants were more likely to develop disorganised attachment when faced with these kinds of behaviours in their mothers.

This might have been an important factor in this study as well, given that all the infants were male. Tronick (2009) found that male infants were particularly vulnerable to withdrawn behaviours of depressed mothers as they would show high levels of vigilance and emotional reactivity stopping the mother-infant

dyads from interacting and repairing their relational difficulties, hence establishing a negative cycle of communication, which in turn led to greater emotional dysregulation in male infants.

A few of the mothers described their ambivalent behaviour towards the infant, one when feeding, the other when holding the baby. They described wanting to be close to their infant but also feeling a certain distance or tension between them. One could wonder what the infant would make of this kind of behaviour; how confusing it could be to be both fed and forced or held and not seen.

Main and Hesse (1990) proposed that those mothers that were frightened of their own anxieties, which might be rooted in their own histories of being fed or held, would present this fear but also their way of dealing with it to the infant, sending both frightened and frightening responses to them.

Previously, in the clinical domain Bion described a similar state of mind when writing about meaningless fear within the infant whose mother could not take in and process his early anxieties and terrors, that is contain them, calling it 'a nameless dread' (Bion, 1962a, p. 116).

Lyons-Ruth and her colleagues (1999) later identified five dimensions of disrupted maternal affective communication, two of which were affective errors and negative-intrusive behaviour. The first one is characteristic of mothers that give contradictory cues, in this study the example of a mother that holds tighter as she withdraws further, the second means physical intrusion by the mother,

as perhaps exemplified by the mother that forces food into her child as he vomits it.

2.5 Strengths and limitations

Whilst this study has several strengths, such as retrospective design and purposive sampling, allowing it to explore data from the mothers whose infants went on to develop disorganised attachment, its findings need to be seen in the context of some limitations.

Firstly, it was a small qualitative study so none of the findings can be generalised and interpreted as contributing towards our understanding of the causes and precursors of disorganised attachment. Further research employing large quantitative designs might be able to shed light on those.

The themes identified in this study might be due to variables not accounted for in this design, for example be very specific to new mothers or a clinical sample.

This also means that this study cannot compare its findings with those representations of mothers with securely attached infants. It might be that some themes would overlap as certain anxieties about one's infant, their health and distress, are very common for all parents, especially in the early weeks of parenting. The study design does not allow for this kind of comparison, although further research might tease out these distinctions and overlaps.

However, the qualitative design allowed for detailed exploration of the caregiving representations in a small sample of mothers, giving voice to these early parent-infant interactions and parental representations. The themes identified in this study contributed to our understanding of disorganised attachment by situating them in the current literature on disorganisation, that way confirming some of the findings gained from quantitative coding protocols. The themes that overlap highlight the potential areas for identifying the representational precursors of disorganised attachment and indicate useful avenues for further quantitative research.

Also, further qualitative studies using a larger sample size could confirm the findings of this study.

Secondly, this study explored caregiving representations in a clinical sample of mothers that faced social adversity. Some of the themes identified might be specific to this group and would not be replicated with non-clinical groups of mothers or those with mental health difficulties but without social adversity. Further in-depth qualitative analyses could study and identify themes found in those populations, comparing them with the findings of this study.

2.6 Conclusion

This study aimed to explore and examine the caregiving representations of mothers whose infants were younger than one and went on to develop disorganised attachment. All the mothers in the sample suffered from mental health difficulties and faced social adversity. The four key themes identified by

analysing the Parent Development Interviews were Emotional distress, Enjoyment, Special relationship and Ambivalence.

Given its qualitative design, this study could not explore the causal relationship between the themes and precursors of disorganised attachment. However, some of the themes identified matched those elaborated in the current literature on disorganised attachment. This indicates that these themes can be usefully studied to further our understanding of the nature of representational precursors of disorganised attachment.

Overall, it seemed that most of the themes highlighted the mothers' unpredictability and great variance in their caregiving representations and descriptions of parental behaviours. Many of the mothers reported great preoccupations with negative emotions and anxieties, struggling with those in the relationship with their infants as well. They would describe feeling helpless when faced with their infant's distress, removing themselves from these highly charged interactions physically or emotionally.

Some of the mothers showed great difficulty in dealing with their ambivalent feelings, defending against their maternal negativity by idealised caregiving, distorting their infant's needs and capacities whilst reporting how very special that relationship or infant was to them. A few of the mothers described hostile caregiving actions, whilst voicing denigrating representations of themselves as mothers.

These themes linked with the current literature on disorganised attachment, highlighting that idealised caregiving and unreliable parenting put the infant in an impossible role, causing him great deal of confusion and anxiety that can lead to disorganised attachment.

It is therefore very important to pay close attention to these overly positive representations in the clinical context, delving and gaining a fuller picture of the parent-infant relationship, also exploring the parents' way of dealing with distress and negative emotions. The parental sense of agency and availability as well as their capacity to distinguish their own thoughts and desires from those of their child need to be part of a sound parent-infant mental health assessment.

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Part 3: Reflective Commentary

Candidate number: FJZM8

Word count: 3640

3.1 Introduction

This reflective commentary charts my journey through the research component of the UCL Doctorate in Independent Child and Adolescent Psychotherapy at the Anna Freud National Centre for Children and Families (AFNCCF) and the British Psychotherapy Foundation (bpf). This programme was a new collaboration between these institutions, building on the clinical tradition at the bpf, and enriching the professional doctorate with research experience of the AFNCCF/UCL.

As such, I was part of the first cohort of trainee child and adolescent psychotherapists taking part in this newly designed course, integrating both the clinical and research component within the four years of training. This integration posed a number of challenges but offered a new opportunity to learn about and engage in research right from the start of the training, alongside developing clinical skills and practice.

In this commentary, I will first describe the early stages of developing research interests and skills, followed by my experience of choosing the subject, design and method for the empirical study. I highlight the key areas of learning from my clinical audit and literature review here. I will then describe the experience of conducting the empirical study; the difficulties I had encountered when using the method and producing the results as well as my ways of overcoming them. I reflect on the key findings from the empirical study in this section too. Finally, I will sum up the overall experience of taking part in the doctoral training, both its clinical and research component.

3.2 Beginnings

As described above, this newly designed programme integrated the research component alongside the clinical training, which meant that we were given introductory lectures and offered research seminars in the first year of training. I found these very helpful as they allowed for initial immersion in the research methodology and vocabulary. I found the journal club particularly helpful, as we were reading research articles by other psychotherapists conducting their research alongside their clinical work. This felt inspiring as in the early days of training it was easy to get swamped either by clinical demands and anxieties or research tasks and readings.

It seemed that both clinical and research beginnings needed their time and space so to be helped to think about managing them in parallel, or even to imagine using one area to inform the other was an important part of the induction into the training. This was stressed in all the seminars, although at times it felt as though our clinical work was under yet another demand to prove its significance and usefulness. We discussed this openly in the research seminars as well, learning about evidence-based practice and practice-based evidence, to understand these concepts further and situate our profession within the current health care system and its values. This also gave us a sense that taking part in these activities and showing willingness to participate in all aspects of mental health agenda could potentially restore a sense of control and ability to effect changes whilst staying in contact with others and the latest developments in the field.

The research seminars were held in the group format, so we began discussing our potential research topics very early on. We also engaged in a number of practice projects, which allowed for further learning from one another, designing and collaborating on hypothetical study designs. This way of learning was very important for the audit task we were asked to conduct within our clinics at the end of that academic year.

I was able to present the results of my audit to the multidisciplinary team at my child and adolescent mental health service, having benefited from a number of presentations to my colleagues when working on our practice projects. Even though initially very anxious, I came to see how this presentation opened up more communication channels for me within the team, that way installing the feeling of being part of it. I was beginning to reflect on this sense of connection and working together as opposed to somewhat old-fashioned view of psychotherapy as reclusive and unique, even beyond reach.

I believe that these seminars and practical assignments have given me more confidence and freedom to explore how the clinic-based research skills fit in with the clinical aims and tasks of my professional role.

In my clinical audit I researched the topic of self-harm and risk-taking behaviour. More recently, I jointly led and facilitated a workshop for parents whose adolescents present with self-harming and suicidal behaviour. This initiative was part of a quality improvement programme within my NHS Trust, aiming at improving the quality of care and patient outcomes. It linked with other local initiatives and targets, such as that of understanding and devising

efficient ways of addressing adolescent crisis and behaviours without burdening other services, such as the A&E departments. I learnt a lot from this project and have continued to connect my clinical skills with wider professional needs and institutions.

3.3 Choosing the subject, design and method

When it came to choosing the topic for my empirical study, I was drawn to data collected as part of a wider study looking into the effectiveness of parent-infant psychotherapy (Fonagy et al., 2016). I developed my curiosity about clinical training when working in the early years education, at one point as a senior nursery officer with under ones, which meant working closely with parents of these infants, observing and attending to many anxieties these early relationships entailed.

In the clinical component of the training, I had the opportunity to join a senior clinician working in the perinatal service, offering treatment to a mother suffering from post-natal depression. I also worked with a mother of a five-year-old child that suffered from post-natal depression when she gave birth to him. In the treatment I could hear about her very painful and difficult experiences with parenting this boy from very early on. All of this experience informed my interest in infant development and early parent-infant communication, including its disruptions.

The Parent Development Interviews (PDIs; Slade et al., 2004) administered to mothers one year prior to their infant's attachment classification offered a unique opportunity to explore the parental representations captured before it was known that these infants would classify as disorganised. Both the concept of parental representation and disorganised attachment were very relevant to my clinical work, and I decided to organise my literature review around those. I was curious about the measures used to explore these concepts, such as various semi-structured interviews including a PDI, but also theories of disorganised attachment.

As for the measures, I reviewed the methodological development of studying attachment strategies and found the move to the level of representation within attachment theory fascinating. The Adult Attachment Interview (AAI; George et al., 1984) with its clever design invites adults not only to face their autobiographical past but also to cope with it throughout the interview. The way the questions enquire about attachment memories and early relationships, asking for brief statements first but soon requiring further evidence and elaboration, connects strongly with the key psychoanalytic ideas of enquiry, including free association and following a trail of thought to its emotional destiny.

However, the firm structure and holistic approach to the AAI offers a great deal of information to a clinician. The same methodology has been applied to semi-structured interviews designed to study specific parent-child relationship, for example the abovementioned Parent Development Interview. I would like to

explore and find a way of using these interviews or their spirit in my future clinical learning and practice, especially when assessing or initiating treatment with parents.

Reading and reviewing the findings of attachment literature has increased my awareness of early attachment strategies but also how they translate and transform into adult representations, including caregiving representations. I have also become more attuned and observant of ways parents relate to me when describing their children's distress and their way of dealing with it. Of course, this links with my learning about working in the transference and countertransference but I found the concepts and ways of understanding emotional regulation and relationships within attachment theory complementary to my clinical learning.

Improved understanding of attachment patterns has also informed my ways of responding to parents and young people who present with dismissing or preoccupied ways of relating, modulating my presence according to their attachment needs and presentation, that is either allowing for more active stance and understanding of the fears behind avoidance or readiness to hear various complaints, taking these in, before addressing the attitude shown.

Reviewing the key methodological developments in attachment theory has also increased my developmental understanding of these ways of relating as well as ways of studying and addressing them. In particular, I have become more aware of the detrimental effects of disorganised attachment on mental

health and functioning, Again, I am now more cognisant and observant of these kind of behaviours in children and young people, expecting variability in their presentation, but also aware of some of the sources of these presentations as surveyed in my literature review.

The findings from the AAls around parental unprocessed loss and trauma as well as other parental representations and behaviours associated with disorganised attachment linked very much with my clinical experience and learning about Bion's concept of containment (Bion, 1962b). I find his theory of thinking and linking as well as his clinical writing about ways of being in the consulting room of particular importance and it was very good to be reminded of it within the context of research literature on atypical parental behaviours and disrupted caregiving representations.

Bion described the importance of parental mind for processing early infantile fears by allowing these to be absorbed and digested by the parent, this modulating function producing a response that both comforts and informs the infant of his predicament, that way not only containing the present distress but also modelling ways of processing distress in general, hence installing an internal sense of containment (Bion, 1962b).

Interestingly, one of the central ideas in the literature on disorganised attachment is that of fear, both in parents and infants. Main and Hesse (1990) were the first ones to describe how parental unresolved loss or trauma gets triggered by the infant's attachment behaviour and stops them from offering

supportive response, instead parents present as frightened, threatening or dissociative. That way the infant's distress cannot be regulated by the parent, and the attachment behaviour terminated in any organised way, as it is met with more alarm at the source of attachment comfort, hence the description 'fright without solution' (Main & Hesse, 1990).

I believe that Bion described a similar state of mind when writing about meaningless fear within the infant whose mother cannot take in and process his early anxieties and terrors, calling it 'a nameless dread' (Bion, 1962a, p. 116). I found it fascinating to see how different traditions within the fields of research and psychotherapy arrived at a similar way of understanding basic emotional needs of infants and their parents.

In the research literature, I found the writings of Karlen Lyons-Ruth of great inspiration as her work is steeped in the clinical tradition, bringing together findings from clinical and empirical research as well as neuroscience. She shows great understanding of high-risk populations and in collaboration with others has devised various attachment-based assessment tools, including a very influential and popular observational tool called the AMBIANCE scales for atypical parent-infant interaction, which identified five dimensions of disrupted maternal affective communication (Bronfman et al., 1992; 2009).

This coding scheme was devised by Lyons-Ruth and her colleagues (1999) by examining the Strange Situation Procedure videos of infants already known and classified as disorganised, paying close attention to every parental

communication and response. This is how they revised and extended the previously most widely used observational coding protocol for atypical parental behaviours associated with disorganised attachment in infants. One of the core skills in clinical training of psychoanalytic psychotherapists is that of close observation, with every trainee attending families to observe their infant or young child on a long-term weekly basis. Lyons-Ruth's research work shows the importance of holding onto clinical learning and experience, using it to enrich other areas of exploration and knowledge.

In discussions with my supervisor, I became aware that many theories of disorganised attachment were based on top-down coding protocols applied to these interviews. I wondered what it would look like if these interviews were explored using a qualitative approach and decided to do so by using thematic analysis. We wondered how my findings would compare with the theories of disorganised attachment already proposed in the research literature. I also felt that using a qualitative method would allow me to explore these interviews and caregiving representations present within them in some detail, that way perhaps keeping my enquiry and methodology closer to my clinical interests and skills.

However, I was also curious and somewhat anxious about the intersection of my clinical work and this research project. What would it be like to read about these mothers' experiences without being able to respond and understand their thoughts further? Would I be tempted to use my clinical skills when

analysing their words and would that be of hindrance to my research aims and tasks?

3.4 Conducting the study

Having settled on the data, design and method of the study, I proceeded with thematic analysis. We were given research seminars and workshops, in which we learned and practised this method. Some of my colleagues would read parts of my interviews, coding them and then comparing their results with mine. We would then discuss the differences and reasons for them.

It became evident that it was quite natural to have thoughts about the meanings behind the participants' words and offer these very early on. Our seminar leaders and researches helped us understand the difference between analysing and interpreting various statements too hastily as opposed to collecting them patiently and coding them for their meaning using thought-out processes and methodological rigour.

In fact, comparing my learning in both clinical and research seminars, I began to realise that it was not so much what I thought I knew theoretically about others' words and experiences that mattered but finding most appropriate ways of letting them figure out and reveal these meanings for themselves in joint exploration. This was true for my clinical sessions, and the need to learn and wait before offering interpretations in those, as well as for my research analysis where I needed to follow similar procedures to allow for the themes

to emerge from the material. This way the research seminars helped me not only to fine-tune the method of thematic analysis but allowed for further reflection on my clinical skills and ways of using them.

I found the advice of my seminar leaders very helpful and coded all seven interviews for the first-level codes. I also attended a UCL workshop on using a computerised program NVivo to help me with this process. I found myself inputting a lot of data into my computer, having all my first-level codes and their links in the NVivo. However, I could not quite make it work for my second-level codes and began to struggle with progressing into the next stage.

I decided to go back to working in the word document, creating various tables and coding for the first and second levels that way. Again, I could not quite move onto the next stage, finding myself printing out all the interviews, cutting them into chunks to organise my codes that way. Yet again, I became stuck on the first and second-level analysis, despite further attempts to bring these data into more organised and coherent form.

At this point, it began to dawn on me that perhaps it was not the methodology or even technology that was not working for me. I became rather worried about my ability to progress further with this work. In my therapy, I had a chance to think about this block and how it was reminiscent of my previous difficulties to finish academic work. It seemed to me that a certain anxiety about bringing this kind of work to completion resurfaced and I needed more time to process what was going on psychologically for me. I was one of the first children in my

family to enter university, so perhaps this was not only daunting but a rather unexplored journey for me.

I was very lucky to have a very patient supervisor who continued to support and encourage my progress. I also benefited from the support of my service supervisor and overall support at the training school. Yet again, I coded the interviews at the first and second level but this time I was able to sustain my focus and persevere with bringing in all the codes to the next level, eventually coming up with the themes and their description.

Around this time, I was offered the opportunity to present my findings at a psychotherapy research conference. Being able to present one of my themes in a more coherent format was very helpful, although it also made me realise that further refinement was needed on my other themes. It was good to hear from others about their ways of conducting thematic analysis, seeing them present and explicate their concepts and results.

3.5 Reflecting on the findings

Two of the themes that stood out from my literature review and became apparent in the results section of my empirical study, were those of idealisation and helplessness. Many of the mothers would use idealised ways of describing their infants as well as their caregiving, shying away from negative comments, often qualifying and disputing these negative thoughts. They would

be describing what they considered special qualities in their infants, seeing their relationship as a very special one.

These mothers would also report great fears about their infants and caregiving, describing their inability to respond to their children's attachment needs, that way communicating a great sense of helplessness and fears about providing safety and protection to their children.

This made me more aware of my clinical practice, especially the initial assessment aspect of it. All the mothers in my study suffered from mental health difficulties and would have been referred for support from mental health services. I wondered whether as a clinician assessing the relational risk for parent- infant dyads with similar presentation, I would be able to observe and consider the very positive statements by these mothers about their infants and relationship as worrying, especially if combined with the mothers' fragility and sense of helplessness. Also, these idealised parental representations would not be immediately obviously worrying due to the very young age of these children.

However, as highlighted in my literature review and study, these overly positive representations often lead to distortions in parental perceptions and behaviours, causing their infants confusion and alarm that can lead to attachment disorganisation. This finding brought home the previous clinical learning about idealisation and denigration, and the importance of paying close attention to these helpless and idealised versions of caregiving in my assessments and ongoing treatment with parents and their children.

Another area of learning that stood out for me from conducting the study and reviewing the literature as part of it was that of parental reflective functioning (Slade, 2005). This concept links strongly with the clinical tradition of psychoanalytic psychotherapy with its aim to understand the internal world of others, including their ways of defending against anxiety and other internal processes, doing so by engaging in a therapeutic relationship that values greatly curiosity about internal states and their containment.

Similarly, Fonagy and his colleagues (1991) revised and unified these psychoanalytic ideas into the concept of parental reflective functioning, mapping out the parents' capacity to reflect on their own mental states and intentions, noticing them in their behaviour, as well as their capacity to reflect on their child's mental experiences, seeing not just the child's behaviour but also their desires, feelings and intentions.

This capacity allows the parent to recognise what is happening inside her or him, as a result of the present interaction with their infant but also their past experiences with their own parents, and distinguish this experience from the experience of their infant, as an independent human being with her or his own mind. Again, there is a link here with the ideas of containment described before.

One recent innovation in this area is that of a specific reflective functioning regarding trauma (RF-T) that shows that parents who experienced childhood sexual and physical abuse can still have infants with organised attachment if

they are able to consider their traumatic experiences in psychological terms (Berthelot et al., 2015).

Various mentalisation-based therapy treatments offer another way of installing containing capacities in parents and I have been learning about these treatments whilst being trained in them as part of my continued professional development.

3.6 Conclusion

I have described my experience of conducting the empirical study and other research tasks as part of the doctoral training in child and adolescent psychotherapy. It was rather daunting to begin and study both clinical and research domain at once, learning about and practising two sets of skills simultaneously. However, as shown throughout my reflective commentary, this challenge offered various opportunities for enriching my learning in both areas, highlighting the need for evidence and rigour within clinical setting whilst seeking a balanced and sensitive way of collecting data and information for research analysis and purposes.

Even though not without some struggle and pain, I have learnt a great deal from engaging in both clinical and research activities, some of the skills clearly transferable between the two worlds of knowledge and experience, other activities allowing me to understand and participate in wider professional environment. I believe that modern child and adolescent psychotherapy

should aim to engage and communicate with wide range of audiences and institutions, which is facilitated and supported by the kind of training programme I have been privileged to partake in.

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