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A qualitative exploration of parenting representations and experiences amongst mothers at risk of parenting difficulties and care proceedings

Literature Review

Empirical Research Project

Reflective Commentary

University College London

Submitted in partial requirement for the Doctorate in Psychotherapy (Child and Adolescent)

DECLARATION

I declare that the material submitted for examination is my own work. The ideas and findings of others have been referenced in accordance with the guidelines provided and any work by others has been acknowledged.

I understand that anti-plagiarism software may be used to check for appropriate use of referencing.

Date: 11/12/22

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Impact Statement

I hope to disseminate this research as widely as possible, in order that it may have a broad impact for future research, theory and clinical practice. I have presented my research to my team in my clinical placement as well as my academic peers and tutors and will continue to share and discuss my research with colleagues. A shortened version of this manuscript has been submitted for publication in a scientific journal with a primary audience of those interested in child and family social care.

Research impact

A review of the literature exploring parenting representations amongst parents with children on the edge of care highlights a dearth of qualitative research in this field and a predominance of quantitative studies which tend to reduce parent's experiences into researcher-defined measurements or categorisations. Evidence suggests this can contribute to a bleak picture of poor parenting as an unbreakable cycle and parents' feelings of stigmatisation and judgement, which also acts as barrier to their engaging with support. While this underlines the value of expanding qualitative explorations of these parents' experiences to help them feel heard, findings from the empirical study emphasise the further potential of such research to inform deeper theoretical understandings of these parents' struggles, and thereby guide intervention strategies. It is therefore strongly recommended that future research adopts qualitative and mixed-methods strategies.

Theoretical impact

Both the literature review and empirical project provide support for the hypothesis that disturbed parenting representations and experiences amongst mothers with children on the edge of care are highly influenced by parents' own

experiences of relational trauma, and the extent to which these have been emotionally ‘processed’ or ‘worked through’ in subsequent supportive relationships. It is proposed that mothers in this population are likely to have developed a range of psychological coping mechanisms in response to their trauma; some of these are touched upon. Furthermore, it is indicated that in the context of living under the threat of child removal, they are likely to be experiencing heightened feelings of shame, anxiety, fear, hostility and helplessness; it is suggested that all of these are likely to bear considerable influence in their approaches to parenting as well as their ways of engaging with support.

Clinical impact

By offering in-depth insights into the parenting experiences of mothers with children on the edge of care, pointing towards possible psychological coping mechanisms they may have developed in the context of their own relational trauma, and highlighting their emotional struggles, it is hoped that this thesis may be informative in considering intervention strategies with this population. It is suggested that establishing relational trust between parents and their key professionals may be vital for successful interventions, and that this is likely to require the dedication of considerable time and sensitivity on the part of professionals. I have found the insights gained from this research significantly informative for my own approaches in clinical work with mothers involved with the child protection system and/or with histories of relational trauma.

Part 1: Literature Review

Title: Exploring parenting representations amongst mothers at risk of parenting difficulties

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Abstract

The study of a mother's mental representations of her child and the caregiving relationship has become increasingly of interest to researchers wishing to explore the psychological underpinnings of mother-infant attachment and relational difficulties. This narrative literature review aims to explore empirical knowledge regarding the qualitative appearance of parenting representations amongst mothers identified to be at risk of parenting difficulties, with a focus on understanding these mothers' experiences of parenting. Findings across studies which have explored parenting representations amongst socioeconomically disadvantaged mothers, mothers abused by a partner or in childhood, mothers with depression, and mothers in prison are considered. From this review it appears that disturbances in these mothers' parenting representations are often intricately linked with their personal experiences of relational trauma. The presentation of these disturbances and their meanings can vary considerably, and some may be more resistant to change than others. However, not all mothers who have experienced such trauma show concerning narratives, suggesting it is possible to process traumatic experiences sufficiently to hold balanced and caring parenting representations. The limitations of existing studies, and measures of parenting representations, are discussed and the implications of the findings for clinical practice are considered.

Introduction

The notion that the relationship between a parent and their child can be considered at the level of mental representations has its roots both in early psychoanalysis and attachment theory. Freud (1905; 1914; 1920) drew attention to the way in which early experiences of relationships may be internalised and influence subsequent patterns of relating and understanding the world. Bowlby's (1969/1982; 1973; 1980) theory of 'internal working models' (IWMs) proposed that every individual has a cognitive framework for understanding the world and the self within it, at the centre of which lies representational models of one's attachment figures and relationships. It was suggested that the infant's innate drive to seek protection from their mother – conceptualised within an 'attachment behavioural system' – is guided by the infant's representations of the reliability of the mother, shaped by their early interactional experiences (Bowlby, 1969/1982). The mother's reciprocal drive to offer protection – conceptualised within a 'caregiving behavioural system' – is guided by the mother's representations of caregiving; these may be influenced by their own early attachment experiences, as well as their subjective experiences of their capacity to meet their child's needs (Bowlby, 1969/1982; George & Solomon, 1999; Solomon & George, 1962;).

Research in this field evolved from the study of infants' behavioural patterns towards their caregiver, from which their attachment representations were inferred (Ainsworth & Bell, 1970; Ainsworth et al., 1978), to the use of interviews to assess parents' representations of attachment (Main et al., 1985), of themselves as a caregiver (George & Solomon, 1989), and of a particular child and the relationship with them (Bretherton et al., 1989). Associations were found between parents' attachment representations (as related to their own parents), their representations of

caregiving, their caregiving behaviour, and their infant's attachment behaviour (George & Solomon, 1996; Slade et al., 1999; van Izjendoorn, 1995). It has since been increasingly recognised that the exploration of 'parenting representations' (or 'maternal representations' in the case of mothers specifically; Stern, 1991) – defined here as encompassing a parent's representations regarding parenting, their child and the relationship with them – may be valuably informative for our understandings of the psychological underpinnings of parenting behaviour, and the 'intergenerational transmission' of relational patterns (Crawford & Benoit, 2009; Mayseless, 2006; Kelly et al., 2005, Slade et al., 2005).

The exploration of parenting representations amongst mothers seen to be at risk of parenting difficulties and, at worst, care removal, is valuable for multiple reasons. It can improve our understanding of the mechanisms underlying the intergenerational transmission of relational difficulties and maladaptive parenting, it can highlight the kinds of support that may be most useful to different mothers, and it can highlight features which may be indicative of greater or less capacity to change (Baradon et al., 2008; Crawford & Benoit, 2009; Fraiberg, 1980; Fraiberg et al., 1975; Lyons-Ruth & Jacobvitz, 2016; Sleed, 2013). A qualitative approach to this exploration can also help us to hear the voices of these mothers, which are often lost. Increasing empathic understanding of these mothers' struggles may be essential in combatting the marginalisation and stigmatisation which are typically central barriers to their engagement with support (Broadhurst & Mason, 2013; Cox, 2012; Gillies, 2007). While the current literature base in this field is predominantly quantitative, numerical or categorical findings are sometimes elaborated on with qualitative detail such as descriptive examples and interview extracts; a drawing together of these may help us to make valuable inferences. Such is the aim of the

current review: to explore and synthesise our current empirical knowledge regarding the question, 'What do parenting representations amongst 'at-risk' mothers look like, and what may we learn from such findings about their parenting experiences?'

Literature for this review was compiled primarily through advanced database searches on 'PsycINFO', 'Wiley Online Library' and 'Taylor and Francis Online'. The keywords 'parenting/caregiving/maternal/mothers', 'representations' and 'risk' were used to search journal articles, followed by forward/backward citation searching of included articles. Initially, it was hoped to find predominantly qualitative research, thus the keyword 'qualitative' was used, however this yielded few results and therefore was dropped, broadening the search to include quantitative studies which offered at least some qualitative elaborations on quantitative findings. Little research was found on fathers' parenting representations; for this reason and the possibility of differences between paternal and maternal representations – the exploration of which was beyond the scope of this review – it was decided to focus solely on maternal representations. Given emphasis on the formative impact of the earliest mother-child relationship, most research has focused on representations of infants, toddlers, or the foetus; this focus was also retained here. Studies were only included if they (1) explicitly examined maternal representations and (2) reported on the content or style of representations beyond numericized scores. Focus was then narrowed on studies where mothers were identified by the authors to be at risk of maladaptive parenting. As a narrative literature review, this review does not aim to be exhaustive, but rather to describe and synthesise an overview of key research in this area.

The review begins by offering a summary of foundational research regarding infant and adult attachment classifications, followed by summative descriptions of the

main research tools used to examine parenting representations in the reviewed literature and key quantitative findings using these tools. These sections may be used for reference regarding later-presented findings. The search strategy revealed studies exploring parenting representations among five main 'at-risk' populations, findings amongst each of which are considered in turn: 1) socioeconomically disadvantaged mothers, 2) domestically abused mothers, 3) mothers exposed to violence in childhood, 4) mothers experiencing depression and related mental health problems, and 5) mothers in prison. Findings across these populations are then summarised and implications considered.

Infant attachment styles and adult attachment representations

Research using the 'Strange Situation Procedure' (SSP), whereby infants are separated from their caregiver in the presence of a stranger and then reunited, identified four main infant attachment styles based on behavioural patterns (Ainsworth et al., 1978; Main & Solomon, 1986; 1990). Infants who approach their caregiver for comfort and can be soothed by the caregiver at reunion, suggesting a representation of the caregiver as a reliable source of comfort, are classified as 'secure', while those who do not are seen as 'insecure'. Within the insecure category, infants who show minimal affect, for example ignoring the separation or reunion moments, attending to objects rather than the caregiver, and looking away rather than seeking contact, are classified as 'avoidant'. Those who mix proximity and contact-seeking with angry behaviour and continued distress on reunion are classified 'ambivalent'. Those who show disoriented behaviours such as wandering, confused expressions, freezing or disjointed sounds or movements, indicating a lack of any organised strategy for dealing with separation and reunion, are classified as 'disorganised' (this classification is given with a secondary 'best-fitting' assignment

from the other classifications). Disorganised attachment is typically seen as the most concerning of attachment styles, indicating significant difficulties in the caregiver-child relationship, and risk of ongoing relational difficulties and psychological disorder (Lyons-Ruth & Jacobowitz, 2016).

The Adult Attachment Interview (AAI; George et al., 1985) was designed to explore adults' representations of attachment in relation to their relationships and experiences with their own parents; research using this tool identified four adult attachment style classifications seen to broadly correspond with the infant classifications (Main et al., 1985; Main & Goldwyn, 1991). Parents who express a sense of valuing attachment relationships and can describe them and recall memories with ease, while also demonstrating objectivity, are classified as 'secure-autonomous' and may be most likely to have secure infants. Parents who show a lack of emotion and/or dismissal towards attachment relationships, with limited detail and memories described, are classified 'dismissive' and may be most likely to have avoidant infants. Those who seem stuck in dependency or concern regarding past attachment relationships, often giving extensive responses which may lose focus on the context, are classified 'preoccupied' and may be most likely to have ambivalent infants. Those who have experienced loss or trauma which appears insufficiently processed, as indicated by lapses of metacognition or reasoning when describing these events, are classified as 'unresolved' and may be most likely to have disorganised infants (this classification is also given alongside a best-fitting secondary assignment). While broad associations of these adult-infant attachment styles were found, it was recognised that they were not unanimous, and that these methods alone left a 'transmission gap' in explaining how attachment representations were transmitted (van Ijzendoorn, 1995).

Research tools for exploring parenting representations

Partly due to interest in further understanding the 'transmission gap', several structured interview schedules and accompanying coding systems have now been developed to facilitate exploration of parent's representations of themselves as a parent, their infant, toddler or unborn baby, and the relationship with them. The most commonly used or adapted are the Working Model of the Child Interview (WMCI: Zeanah et al., 1994; 1995-2000), the Parent Development Interview (PDI: Aber et al., 1985; PDI-R: Slade et al., 2004) and the Pregnancy Interview (PI: Slade, 2003; PI-R: Slade, 2011). All have similarities in content and structure: parents are asked to speak in detail about their child or unborn baby and the relationship with them, with a focus on responses to emotionally-charged interactions, awareness of the child's experiences, and understanding of these interactions (Slade et al., 1999). One difference is that the WMCI contains more prompts to elicit the parent's representations of the child or unborn baby, while the PDI and PI have more focus on representations of the relationship with them[1]. The PI also has an adapted focus from the experience of mothering to the experience of pregnancy.

The WMCI typologies

Research using the WMCI typically uses the original coding system (Zeanah et al., 1995-2000). Representations are first coded on 5-point scales for the presence of six qualitative features ('richness of perceptions', 'openness to change', 'intensity of involvement', 'coherence', 'caregiving sensitivity' and 'acceptance') and two content features ('infant difficulty' and 'fear for safety'). Secondly, emotional tones regarding representations are scored (such as joy, pride, anger,

[1] George and Solomon (1989; 1996) also developed adaptations of the PDI with a greater focus on mother's representations of the self-as-caregiver – the Caregiving Interview – however, since research using this interview within the search criteria was not found, it is not discussed in detail here.

disappointment, indifference). Finally, representations are classified into one of three main categories: ‘balanced’, ‘disengaged’ or ‘distorted’. Balanced narratives give a reasonably rich and full description of the baby’s personality and the relationship with them, are relatively straightforward to follow, suggest the caregiver is involved in and values the relationship, and indicate openness to new information about the child. Disengaged narratives are characterised by a sense of indifference, detachment or emotional distance from the relationship, which may be seen in lacking detail and/or emotional involvement, excessively cognitive or intellectualised descriptions, or indications of aversion to the child. Distorted narratives are characterised by confused, inconsistent or incoherent descriptions; emotional involvement may be present but the parent may seem preoccupied, anxious and overwhelmed, or self-involved, and show insensitivity to the child. The parent may struggle to stay focused on the child and relationship during the interview.

A systematic review of 14 studies using the WMCI found that amongst 513 mothers from low-risk samples, 53% had balanced representations, 21% disengaged and 26% distorted (Vreeswijk et al., 2012). Research exploring associations between these typologies and other measures of the parent-infant relationship suggests that mothers with balanced representations are more likely than those with non-balanced representations to have securely attached infants (Benoit et al., 1997; Madigan et al., 2015; Huth-Bocks et al., 2004a; Zeanah et al.,1994); one study also found that mothers of infants with clinical problems were more likely to have un-balanced representations (Benoit et al., 1997). Balanced representations have also been associated with more maternal positive affect and soothing caregiving behaviour, and better infant emotional regulation (Korja et al., 2010; Rosenblum et al., 2002). One study in a low-risk community sample reported that balanced vs non-balanced

prenatal classifications fully accounted for the relationship between adult attachment and infant attachment at 11 months, with postnatal classifications not adding to this prediction (Madigan, 2015). All these studies report the strongest associations and predictive validity for the balanced category.

Associations between the two non-balanced typologies and other measures of the mother-infant relationship appear less straightforward. While evidence supports an association between disengaged representations and avoidant infant attachment, weaker or non-significant associations have been reported between the distorted and ambivalent classifications (Benoit et al., 1997; Cox et al., 2000; Zeanah et al.,1994). In Benoit and colleagues' (1997) study, 56% of mothers with distorted representations had infants classified as secure. One study found that the infants of mothers with disengaged representations showed more negative affect in a play task, and that mothers showed more rejection; however, no clear patterns were found for the distorted classification (Rosenblum et al., 2002). Conversely, another study reported that distorted representations were more strongly related to 'non-optimal' mother-infant interaction than were disengaged (Korja et al., 2010); these findings highlight the need to consider more subtle differences within broader categorical associations.

Although not used in the presently described literature, it is relevant to note that a 'WMCI-Disrupted' coding system (WMCI-D; Crawford & Benoit, 2009), has been more recently developed given the authors' recognition that the original system lacked a clearly corresponding classification for unresolved or disorganised attachment classifications. The WMCI-D system classifies narratives as 'disrupted' based on high scores on five dimensions: 'affective communication errors' (eg. reported discordance in emotional responses to the child); 'role-boundary confusion'

(eg. repeated self-references, role-reversal with the child); 'fearfulness/dissociation/disorientation' (eg. using frightened voices, episodes of trancelike behaviour); 'intrusiveness/negativity' (eg. reported intrusive or attacking behaviours towards the child; and 'withdrawal (eg. described avoidance of close/affectionate engagement with the child). Disrupted narratives have been found to be significantly associated with mothers' unresolved attachment, infant disorganised attachment and disrupted parenting behaviours (Crawford & Benoit, 2009). It is perhaps because the WMCI-D does not also account for the other typologies that the original system is still more widely used; however, it is likely this classification may capture some of the issues not captured by the distorted or disengaged categories, thus addressing some of the methodological limitations of these noted in the present review.

Reflective Functioning on the PDI and PI

Research exploring parenting representations using the PDI or the PI has typically coded narratives for 'reflective functioning' (RF: Fonagy et al., 1991; Fonagy et al., 1998; Slade, 2005), defined as the parent's capacity to reflect on their own internal experiences and to acknowledge and reflect on the child or foetus's subjective experiences (Slade & Sadler, 2018). Using the RF coding system adapted for this interview, 'demand' questions, which push the parent to consider and describe theirs and/or their child's thoughts and feelings, are scored on the RF scale, which are then considered alongside the whole interview when determining an overall RF score. The typical RF scale ranges from -1 to 9, with higher scores denoting better RF. Scores at the lowest end of the scale (-1 to 0) are very rare and indicate the parent's complete rejection of RF, characterised by incongruent responses that lack credibility, or inappropriate, highly distorted or bizarre reflections.

Parents with low RF (1 to 2) generally deny or block recognition of their own and their child or foetus's mental states, focusing rather on behaviour or physical reality. Those with moderate to low RF (3-4) may show some recognition of mental states but struggle to link them to behaviour or other internal states, or this ability may be inconsistent. A score of 5 indicates average RF, meaning the parent is consistently able to link mental states and behaviours. Parents with high RF (6-9) show acknowledgment of mental states and their dynamic nature, for example by offering detailed narratives of interactions between theirs and their child's mental states and behaviours (Slade, 2005).

Evidence suggests that amongst low-risk samples, scores of around 5 are the average, while this may be lower in high-risk samples. Smaling and colleagues (2015) found the average score among 79 mothers with no financial problems, reasonable social support and education and no alcohol or substance use was 4.28, compared with 3.36 among 83 mothers with difficulties in at least one of these areas. A slightly higher but comparable mean of 5.08 was found for postnatal RF by Slade and colleagues (2005) in a sample of 40 well-educated, stable middle-class mothers. These authors also found that higher RF scores were associated with autonomous parental attachment classifications, and secure infant attachment classifications; lower scores were found for mothers with ambivalent and disorganised children, but not avoidant. Maternal RF largely accounted for the link between adult attachment and infant attachment, however, contrary to previous findings (van Ijzendoorn 1995) this adult-infant attachment link was relatively weak and not clinically significant. In another study with a similar low-risk sample, associations were found between maternal RF, infant attachment, and disruption in mothers' affective communication (Kelly et al., 2005). These authors found that the relationship between RF and infant

attachment was mediated by mothers' capacity to regulate her baby's fear and distress without disrupting them. Overall, while evidence suggests that mentalising capacity is likely to be related to quality of parenting and the relationship with the child, the usefulness of the single-score RF measure as a determinative assessment of a parent's state of mind regarding caregiving has been questioned, with the suggestion that it may capture only one characteristic of parenting representations (Fonagy et al., 2016; Sleed, 2013).

Identifying 'Hostile/Helpless' and other 'relational risk' features in the PDI and PI

The Hostile/Helpless coding system for the PI (HHPI: Terry, 2018) and the Assessment of Relational Risk (ARR: Sleed, 2013) coding system for the PDI are two additional coding systems used in the presently described literature. Both are informed by important work exploring possible representational models associated with the intergenerational transmission of relational difficulties. Main & Hesse (1990) proposed that for parents with unresolved loss or trauma, the intensity of the attachment relationship may trigger overwhelming emotions which were previously dissociated from; this may explain empirically observed maladaptive caregiving behaviours including frightened, frightening, or dissociative responses to the infant, and lapses of reasoning in AAI narratives. Lyons-Ruth and colleagues (2003; 2005) expanded this work and the concept of 'unintegrated' states of mind, proposing that early relational trauma (which may encompass chronic experiences of deviant child-caregiver interactions, as well as specific instances of loss or abuse), may elicit an unconscious psychological defence mechanism whereby good and bad aspects of the other and the self are 'split'. Caregivers may therefore be represented as either malevolent ('Hostile') or victimised ('Helpless'); individuals may shift between both

representational stances and show identification with these positions. Under this Hostile/Helpless (HH) model, representations of the other as hostile and the self as helpless, or the opposite, may then also be elicited in a parent's relationship with their own child, leading to behaviours such as unresponsive withdrawal or aggressive intrusion, or shifts between the two.

The original HH coding system, developed for the AAI, (Lyons-Ruth et al., 2003) rates narratives on a 9-point scale (1-9), with a score of 6 or above resulting in a HH classification (5 leaves the decision 'open to coder's judgement'). Two key features are reported to characterise HH narratives: the representation of at least one caregiver as hostile and/or helpless, and apparent efforts to cope with overwhelming attachment and trauma-related affects. Using this system, it was found that HH states of mind regarding attachment were associated with mothers' own experiences of relational trauma, as well as attachment disorganisation in their child (Lyons-Ruth et al., 2005).The adapted HHPI coding system (Terry, 2018), has a similar 9-point scale and classification structure, adapted to focus on the expectant mother's evolving caregiving representational system, and identify features of hostility or helplessness within representations of herself as a caregiver, her unborn baby, the father of the baby and her own caregivers (representations of which are specifically elicited by the PI). In the HHPI, narratives scored 5 and above receive a HH classification. A recent synthesis of studies using the original HH coding system and including Terry's (2018) adaptation shows good empirical support for associations between parental HH states of mind and mothers' own experiences of relational trauma, attachment disorganisation in their child, disruptions in parent-child interactions, and parent maltreating behaviours (Turgeon et al., 2022).

The development of the ARR coding system for the PDI (Sleed, 2013) was also informed by the work of Main & Hesse and Lyons-Ruth and colleagues but draws further on the wider literature exploring potential risk indicators in mother-infant behavioural interactions. This system codes narratives on 5-point scales for ten key narrative features of 'representational risk' that have been identified across this literature: 'hostile behaviour'; 'hostile parental experiences'; 'fearful affect'; 'helplessness'; 'emotional distress'; 'enmeshment'; 'incoherence'; 'idealisation'; 'mutual enjoyment' (reversed); and 'supportive presence' (reversed). Scores are then calculated for three subscales: 'ARR Hostile' (sum of hostile experience, hostile behaviour, mutual enjoyment reversed score and supportive presence reversed score); 'ARR Helpless' (sum of fearful affect, helplessness and emotional distress); and 'ARR Narcissistic' (sum of enmeshment and idealisation). A total 'ARR Risk' score out of 50 is also calculated (sum of all items). The ARR measure has been found to be associated with parental psychopathology and the quality of mother-infant interaction (Sleed et al., 2021).

Parenting representations of socioeconomically disadvantaged mothers

Several studies have explored parenting representations in samples of mothers considered at-risk principally due to financial deprivation. Sokolowski and colleagues (2007) and Rosenblum and colleagues (2018) used the WMCI with mothers of toddlers living in impoverished communities of Midwestern USA: in both samples the majority were from ethnic minorities (predominantly African-American), were single, poorly educated and dependent on state support. The distribution of representational typologies was similar across the studies: amongst Sokolowski's sample of 100 and Rosenblum's sample of 75 mothers, 38% and 31% had balanced representations, 36% and 39% disengaged, and 26% and 30% distorted,

respectively. This is a notable difference from the distribution reported by Vreeswijk and colleagues (2012; see above) across low-risk samples. It could be hypothesised that the more external stressors a mother faces, the harder it is for her to hold balanced and warm parenting representations. However, other findings suggest that the link is more complex.

Sokolowski and colleagues' (2007) found while mothers with disengaged representations were slightly less educated than those with balanced representations on average, there were no other associations between demographic factors and parenting representations; instead, relational conflict was the most important predictor of non-balanced representations. Mothers who reported high conflict with their own mothers (mostly verbal) were most likely to have 'disengaged' representations. Their narratives tended to be characterised by resentment of the child, and a lack of expressed joy, sensitivity and involvement with their child. Mothers who reported high conflict with their child's father (violent and verbal) were more likely to have 'distorted' representations; their narratives also showed more expressions of guilt and less openness to change. The authors suggest that conflict with one's own mother could be experienced as a rejection, leading to a defensive tendency to dismiss attachment and thus appear disengaged (Main & Goldwyn, 1984). Conflict with a romantic partner, however, may be associated with a more present and active internal dilemma (as indicated by expressions of guilt alongside resistance to change) which could lead to representational distortion. These interpretations are speculative; however, they highlight the likelihood that multiple mechanisms underlie the varying imbalances in mothers' representations.

Rosenblum and colleagues' (2018) findings also support this view of multiple pathways underlying representational imbalances. These authors conducted the

WMCI with mothers before and after a 13-session reflective-functioning informed multi-family group intervention or control procedure. They found a significant increase in balanced representations (39.4% to 52.4%) in the intervention group alone, alongside a significant increase in scores for 'Parenting Reflectivity'; however, this difference was almost entirely explained by disengaged representations shifting to balanced (nine of 16), with very little change in distorted representations (one of 14). While the authors suggest that the intervention helped to 'enhance parental awareness and responsiveness to child emotional needs' (p.381) particularly for disengaged mothers, we might also wonder what was different for the disengaged mothers for whom change was not recorded. The authors' interpretations are limited by the fact that linked data was not presented (ie. it is not possible to see if mothers whose representations became balanced were also those whose reflectivity increased); it is also difficult to gauge the valence of reflectivity scores, given the small scale (1-5) and lack of comparable normative scores. Overall, the study is limited by the lack of any in-depth or qualitative investigation of the data, which might have offered insight into differences between individual mothers.

Terry's (2018) exploration of prenatal representations amongst young, medically underserved and socioeconomically disadvantaged mothers-to-be offers a more in-depth exploration of representational imbalances. This mixed-methods study, which looked at the PI narratives of 26 young mothers receiving a home-visiting intervention (Sadler et al., 2013), found that 11 of 13 mothers who lost custody of their child within the first two years of life had narratives classified as 'Hostile/Helpless' (H/H), compared to only two of 13 mothers who retained custody. Qualitative findings illustrate how mothers' representations might be understood further in the context of their personal histories. For example, we are given an in-

depth analysis of a H/H narrative from 23-year-old ‘Mary’, who suffered childhood neglect and abuse, had a history of multiple miscarriages and now lived alone in assisted housing with little relational support. Prevalent features of Mary’s narrative are expressed resentment about the pregnancy and detachment from the imagined baby (for example, using the term ‘it’); Terry (2018) suggests these could be understood as Mary defending herself from the pain of further loss. We also see striking self-contradictions and inconsistencies in Mary’s views of caregiving; one moment she speaks of coping well with pregnancy and feeling ‘on top of the world’ (p.90), and another she describes herself as desperately struggling, ‘a stupid hormonal cow’ with a strong desire to ‘get rid of it’ (p.89-91). Mary expresses a firm desire to ‘never, ever turn out like (her mum)’, alongside worries that she will do just this (p.95). Terry suggests these might be linked to Mary’s avoidance of integrating and processing emotionally uncomfortable experiences.

Overall, these findings seem to support previously discussed evidence that relational difficulties play a greater role in representational distortions than socioeconomic adversity alone; this can be said also of Terry’s (2018) comparative analysis of a non-H/H narrative. We are told that ‘Jane’, a teenage mother who was still in school and lived with her father and sister, came across as mature and realistic in her interview, with a hopeful attitude that seemed linked with her strong attachments to her family. Terry highlights how Jane acknowledges her sadness at losing her adolescence while seeming reassured by her father’s ongoing support (p.84) and suggests that Jane seems to be working through her complex feelings about the pregnancy. While Terry notes elements of concern in Jane’s representations, such as her avoidance of thinking about her ruptured relationship with her mother and her inability to form an imagined notion of the baby, she

illustrates how Jane's ready access to relational support from family, alongside her own internal resources, appeared to help her to retain otherwise mostly integrated and coherent representations. While we know the family was living under severe socioeconomic constraints, interestingly, this does not feature in Terry's presentation of the narrative.

Parenting representations of domestically abused mothers

Research into the parenting representations of mothers exposed to domestic violence (DV) during pregnancy shows that this risk factor is also associated with a higher prevalence of non-balanced prenatal parenting representations as measured by the WMCI. In a community-based, predominantly Caucasian (63%) and African American (25%) sample, Huth-Bocks and colleagues (2004b) found that amongst 89 pregnant women who reported at least one recent incident of DV, 67% had unbalanced narratives (41% disengaged and 26% distorted); amongst 113 comparison mothers who reported no DV, only 40% had unbalanced narratives (23% disengaged and 17% distorted). Based on analysis of the same sample, Theran and colleagues (2005) also found that although most mothers with balanced prenatal representations continued to have balanced representations one-year post-partum, those whose representations became unbalanced were likely to have experienced DV during pregnancy, to have lower income, and/or to be single.

While these findings support the general theory that DV can disrupt a mother's representations, particularly when combined with additional risk factors, a comparison of case examples across these papers also reveals that such disruptions can be qualitatively different between individuals even within the same WMCI classifications. For example, Huth-Bocks and colleagues' (2004b) extract from a disengaged narrative illustrates a mother whose representations seem filled with

hostility and resentment towards her baby, whom she experiences as violent; she says, ‘he beats me up all the time’, ‘kicks me in the ribs’ and ‘kicks my butt’ (p.89). She also expresses a dismissive helplessness, saying ‘can’t do nothing about it’ and laughing each time she references her abusive partner. While Theran and colleagues’ (2005) extract from a disengaged narrative also conveys a disconnection between the mother and her imagined baby, it is much less hostile and more passively distant; as the authors describe, ‘striking in the lack of detail, affect and engagement’ (p.258). This mother drifts from vague hopes for her child’s distant future to memories of not being ready for pregnancy, and admits even in her third trimester she is ‘just now getting used to the idea I’m gonna have a baby’ (p.258).

Unfortunately, these authors do not give any individual background information for the mothers they quote; however, we might still speculate about how certain features of the narratives could be understood in context of these mothers’ experiences of relational trauma and their psychological responses. For example, the mother quoted by Huth-Bocks and colleagues (2004b) could be seen to be unconsciously ‘transferring’ her experiences of her violent partner into her relationship with her unborn baby; indeed, when asked how she imagines him to be she says ‘bad, like his father’ (p.89). She seems to see herself in this relationship also as a helpless victim, who can only laugh about the situation to reduce the pain of it (Lyons-Ruth et al., 2005). The mother quoted by Theran and colleagues (2005) might be seen to be avoiding, rather than reliving, painful emotions associated with relational struggles, bringing herself into a dreamy, distant state of mind as a way of managing overwhelming anxieties. While these interpretations are theoretical, they nonetheless highlight the limitations of a broad categorical system for exploring more subtle differences between mothers’ representations. The distorted narrative extracts

in these papers are also qualitatively distinct; although both show disjointed streams of consciousness around pregnancy and the baby, lacking a coherent representation of the infant, Huth-Bocks and colleagues' (2004) extract reveals expressions of panic, helplessness and overwhelm, while Theran and colleagues' (2005) is filled with brash exclamations, laughter, and dismissiveness. Again, while it is not noted by the authors, we might wonder if these mothers' representations could be best understood in the context of their relational histories.

Despite their limitations, a strength of these papers (Huth-Bocks et al., 2004b; Theran et al., 2005) is that they remind the reader not all mothers who experience DV during pregnancy have disrupted parenting representations; both authors present extracts from domestically abused mothers with balanced narratives. Interestingly, these are qualitatively more similar; both mothers speak with warmth and sensitivity about their child and express excitement about meeting the child and being a mother, alongside acknowledging difficulties they have had in pregnancy. Huth-Bocks and colleagues (2004b) speculate that their quoted mother, who speaks with awareness and concern about the impact on her baby of her own stress, was able to do so partly because she had left the abusive relationship; though one might also wonder about the contribution of the internal and external resources that helped her do this. Theran and colleagues' (2005) finding that over a third of mothers with disengaged or distorted prenatal representations (37% and 40%, respectively) had balanced representations one-year post-partum supports the notion that some mothers may galvanise such resources during pregnancy. Compared with those whose representations remained non-balanced, these mothers had fewer depressive symptoms, were more likely to have higher income, and to report being in a stable

relationship; these findings therefore also suggest the importance of protective factors in helping mothers to regain balance after periods of struggle.

Parenting representations of mothers exposed to violence in childhood

The relationship between past exposure to inter-personal violence (IPV) and maternal representations elicited by the WMCI was explored by Schechter and colleagues (2005; 2006), with a sample of 41 mothers at or close to clinical criteria for IPV-related posttraumatic stress disorder (IPV-PTSD). These mothers of young toddlers (8-50 months) were enrolled at a hospital-based mental health clinic in a predominantly Hispanic community specialising in at-risk families. All reported having been exposed to IPV in childhood as a victim or witness; over half had experienced two or more forms of childhood maltreatment and 71% also reported IPV trauma during adulthood (Schechter et al., 2005). Most (83%) had unbalanced representations; however, it was notable that the most common classification was distorted (59%) rather than disengaged (24%). This might support the theory that unresolved relational trauma can lead to fragmented and disorganised mental representations (Fraiberg et al., 1975; Hesse & Main, 2006; Lyons-Ruth et al., 2005; Main & Hesse, 1990). The finding that mothers with distorted representations showed a higher mean PTSD severity than those with disengaged or balanced representations also perhaps accords with the theory that trauma related to violence is especially predictive of disorganisation, while that related to passive maltreatment (such as neglect or rejection) may be more predictive of avoidance (Lyons-Ruth & Block, 1996).

Similarly to Rosenblum and colleagues' (2018) findings described earlier, Schechter and colleagues (2005) found that IPV-exposed mothers with disengaged representations showed lower RF than those with balanced representations, while

this was not the case for distorted representations. The authors suggest that the low RF-disengaged association is perhaps unsurprising given that this classification incorporates aspects of poor reflectivity. However, the finding that several distorted narratives had median or above-median RF levels implies that RF does not always capture the concerning features of these representations. The authors explain that although these mothers were ‘able to understand (their child) is an individual with a separate mind’, their perceptions were ‘psychologically skewed by past-trauma associated anger, fear and helplessness’ (Schechter et al., 2005, p.326). They offer a case example of a mother with an average-RF but distorted narrative, who had experienced early abuse from her father and a male family friend; the authors link this to the way in which, despite showing reflectiveness about her son’s subjective experiences and feelings, she characteristically saw him as angry, violent and controlling. These findings suggest that the association between IPV and a mother’s RF may be determined by her ongoing psychological responses to her trauma. Avoidance or denial of painful memories or feelings may be associated with lower RF, while more complex processes, such as ‘transference’ of past relational experiences into the mother-infant relationship, may be less so.

There is evidence, however, to suggest that a history of IPV may impact a mother’s reflective capacity if they are experiencing ongoing violence with a partner. Using the same sample as Huth-Bocks and colleagues (2004b), Malone and colleagues (2010) explored the relationships between childhood maltreatment, prenatal representations and DV during pregnancy. In accordance with Schechter and colleagues’ (2005) findings, women with distorted representations were most likely to report the highest levels of childhood physical and sexual abuse, *provided* they did not experience DV during pregnancy (Malone et al., 2010). Women with

distorted representations who did experience DV during pregnancy were *less* likely to report histories of physical and sexual abuse than women with disengaged or balanced representations. The authors highlight that self-report measures are often used to assess histories of abuse; however, when such experiences are also current, mothers with distorted representations may be defended against remembering or admitting them (Malone et al., 2010). The recent findings of Suardi and colleagues (2020) suggest that this kind of denial or dissociation may also come across as lower RF. These authors found in another sample of IPV-PTSD mothers that IPV-PTSD was not significantly associated with RF overall, but it *was* predictive of lower RF if the mother reported violence perpetrated by the child's father (Suardi et al., 2020).

These studies also show that the experience of childhood physical abuse does not definitively lead to disrupted maternal representations; some women seem to have processed these experiences in a way that leads to balanced or secure representations (Malone et al., 2010). An example of how therapeutic intervention may facilitate this is offered in Schechter and colleagues' (2006) study reporting on a pilot Clinician-Assisted Videofeedback Exposure Session (CAVES). The authors found that after mothers watched videos of their interactions with their children with a clinician who helped them reflect on the child's thoughts and feelings, mothers were significantly less negative when describing their child's personality. They offer a case example of 'Mrs A' who complained that her 40-month-old daughter was 'out of control', 'demanding', and 'fat' (Schechter et al., 2006, p.442). Mrs A had lost her father young and been physically and emotionally abused throughout childhood by her mother; the authors report that it became increasingly clear through the intervention that Mrs A's parenting representations carried echoes of her

experiences of her own mother. Following the intervention, Mrs A. was able to observe her daughter having a tantrum and instead see an echo of herself: ‘she reminds me of me when I was little with my mother and I wanted something. I’d cry and cry’ (p.443). The fact that this intervention consisted of only one session supports the view that the parenting representations of traumatised mothers can be malleable to positive change.

Parenting representations of mothers experiencing depression and related mental health difficulties

Several studies were found that explored maternal representations in clinical samples, with some common themes across findings. These studies tended to focus on mothers with depressive symptoms, perhaps surprisingly, given the body of literature around personality disorders (PDs) and parenting difficulties (Newman & Stevenson, 2005); however, PD diagnoses can be contentious and low mood, depression and anxiety are still recognised as the most common maternal mental health problems (Russell et al., 2017). In a sample of 34 predominantly White British mothers involved in a randomized-controlled trial (RCT) of parent-infant psychotherapy and 42 controls, Sockett (2011) looked at associations between maternal psychopathology and the 10 Assessment of Relational Risk features (ARR; described earlier) in PDI narratives. Narratives of mothers with higher levels of depression and psychological distress were characterised by more expressions of hostility towards the child, less descriptions of being a supportive parental presence, more feelings of helplessness and a greater sense of enmeshment with the child. The author noted that overall, these mothers’ representations were less joyful and communicated more distress than non-depressed mothers. This can be compared to the findings of Trapolini and colleagues (2008) who used the PDI with 80 mothers,

59 of whom were depressed; here also, depressed mothers spoke with less positive affect and more expressions of sadness or distress regarding their child and caregiving.

The above findings are also comparable to those of Sleed (2013), who looked at PDI narratives of 118 clinically referred mothers and 56 controls. Sleed found that mothers' depressive and psychological distress symptoms were related to higher ARR Hostile and ARR Helpless scores. Her example extract from an interview with a high ARR Hostile score helps us understand what this looks like, as the mother describes her baby as 'angry' and 'never patient' and talks about wanting to 'bite him in the face' or 'throw him out' (Sleed, 2013, p.214). However, it also alludes to the impact of her depression on her parenting experiences. She describes a time when, with her first son, she 'forgot all his food… his nappy, everything' (p.214) yet his lack of protest felt relieving, in contrast to her new baby whom she experiences as demanding. There is a sense this mother feels constantly confronted by her parental inadequacies as she describes him repeatedly rejecting her attempts to soothe him and imagines him criticising her. The way she seamlessly transitions from talking about her baby's anger and her own also gives a sense of the 'enmeshed' feature captured on the ARR.

The association between psychopathology and expressed helplessness in maternal representations was also found by Røhder and colleagues (2019) in a sample of 53 pregnant mothers with serious mental illness, 23 of whom had major depressive disorder. Since this sample also included 12 mothers with psychosis and 12 with bipolar disorder (plus 14 controls), it is not possible to attribute the association to depressive symptomatology alone, yet it may suggest that the relationship is more generalisable across pathologies that impact a mother's

emotional coping capacity. Interestingly, these authors also found that helplessness was especially prevalent in mothers who had experienced DV, and those who felt unsupported by their own mothers. Sleed's (2013) example of a narrative with a high ARR Helpless score, from a mother whose baby was conceived by rape, helps us to understand these more generalised findings. This mother's responses are filled with fear of threats, including paedophiles, freak accidents, crime, trusted people turning against her and the future risks of adolescence. She moves from one fear to the next and admits 'I worry about everything I can't control' (p.215). While one might understand the anxiety in this mother's representations in terms of her mental health difficulties, we might also again wonder about the links with her own past trauma, especially given that her expressed fears for her child include sexual attack, sexual maturation, betrayal and abandonment.

A recent study by Isosävi and colleagues (2019) also illustrates how maternal representations can be understood in terms of a mothers' relational history with her parents, as well as her clinical symptomatology. This study is unique in that it analysed one mother's parenting representations through deductive content analysis of a year's psychotherapy notes. 'Kati' is frequently judgemental and critical of herself as a mother and often also adopts this attitude towards her son. The authors show how this judgementalism often gives way to feelings of helplessness and intense concern about things being wrong with her or her son. Again, while one might understand these aspects of her representations in relation to her depression and anxiety, the information that Kati experienced her own father as angry and critical, and her mother as fearful and helpless, helps to elaborate on this understanding. The authors highlight that Kati's criticisms of her son seem comparable to the criticisms she received from her father, for example for being

socially cautious and negatively emotional; in these moments it is as if she is identifying with her father. Yet other times she views her son as critical and judgmental, as if she is identifying the baby with her father. Her feelings of helplessness in the caregiving role frequently echo her views of her mother. Interestingly, the authors report that Kati showed an advanced ability to reflect on complex and painful relational experiences with her parents, signified by an RF score of 7. However, as described previously in relation to distorted narratives, her parenting representations appeared psychologically skewed by previous relational experiences.

There is some evidence for the effectiveness of interventions in reducing symptoms of depression and representational disturbances amongst clinical samples, although some aspects of representational difficulties may be more resistant to change than others. Sockett (2011) found in her clinical sample that a year from baseline, having received various support, mothers had significantly lower mean scores of depression and, concordantly, significantly lower levels of representational hostility, helplessness, emotional distress and fearful affect. Fonagy and colleagues (2016) similarly found that, amongst 76 clinically-referred mothers, levels of depression were lower following a year of parent-infant psychotherapy, as were ARR Hostile and ARR Helpless scores on mothers' PDI interviews. (Interestingly, no significant change was found in RF scores, which again indicates the importance of not relying on this measure as a sole indicator of representational quality. Sockett (2011) also found, however, that idealisation, enmeshment and role-reversal in narratives were especially resistant to change. Sleed (2013) notes that these features, classified under the ARR Narcissistic subscale, are most common amongst mothers with more severe pathology, as may be seen in prison samples,

where psychological defensiveness is extremely high. Her example of a narrative with a high ARR Narcissistic score, from a mother who had suffered a stillbirth and was in a violent relationship at the time of interview, is helpfully illustrative. This mother's idealised descriptions of her son as 'the boy that I lost… a special blessing that God gave me' and the suggestion 'maybe he feels he needs to protect me' (p.219-220) indicate how her representations of him are entwined with memories of her lost child and fantasies of a protector from her partner. She denies any difficulties with her son, prompting the consideration of how challenging it may be to acknowledge her caregiving struggles, especially if she fears losing him. Overall, there is a sense that these representations are holding her together, which perhaps foretells their resistance to change.

Parenting representations of mothers in prison

While few studies have explored maternal representations amongst mothers in prison, these offer valuable insight into the psychological struggles of this population. These mothers are typically very traumatised, with limited emotional resources and high rates of mental health difficulties; they are also continuously facing the possibility of their child being removed (Corston, 2007). In a study of mother-infant dyads involved in a pilot intervention for mothers and babies in prison, Baradon and colleagues (2008) analysed 15 mothers' PDI transcripts using a grounded theory approach, finding five main themes. The first of these, *idealisation of baby and self-as-mother*, captures mothers' romanticized descriptions of their babies – such as 'cute, 'funny' 'happy' and 'lovely' – and themselves – such as 'good mothers', 'caring' or 'understanding' – despite being unable to elaborate much on these categorical terms (p.247). Much like in Sleed's (2013) high ARR Narcissism narrative described above, and in accordance with her findings also amongst a

prison sample, mothers typically denied difficulties in the relationship, saying they liked ‘everything’ about their baby, and when asked what they liked least, often replied ‘there isn’t anything’ (Baradon et al., 2008, p.247). One may understand such idealisation in several ways: for example, as a wish to convince the interviewer of being a capable mother, or a wish to believe this themselves, or perhaps a wish to feel more in control under such challenging circumstances. Whatever the precise motivations, it is possible that these mothers were unconsciously protecting themselves from the discomfort of seeing themselves as an inadequate mother.

The remaining themes elaborate further on these struggles, helping the reader to understand some of the painful emotions these mothers may have been trying to avoid. For example, *guilt about bringing the baby into prison* reveals an emotional battle these mothers may face frequently, while also suggesting how they might psychologically defend themselves by asserting that the baby ‘doesn’t know any different’ or that they could hide their feelings from the child (Baradon et al., 2008, p.248). *Role of the infant in the mother’s mind* shows how these mothers may consciously or unconsciously ascribe a role of ‘rescuer’ or ‘comforter’ to their baby, also supporting Sleed’s (2013) findings that ‘role-reversal’ and ‘enmeshment’ were common representational features among this population. *Expression of anger and hostility* captures the sense in which mothers’ narratives communicated anger against their circumstances or people felt to have done them injustice (such as prison officers or family members); however, the authors highlight how anger was rarely expressed openly towards the child. Rather, covert hostility was often conveyed, for example in mothers’ descriptions of their baby’s behaviour in negative terms, such as ‘lazy’ or ‘attacking’, at the same time as calling them ‘cute and lovely’ (Baradon and colleagues, 2008, p.250). Although this is not acknowledged by the

authors, we may wonder whether mothers did not feel safe enough – either with the interviewer or within themselves – to admit feelings of resentment towards their child. *The mothers' wish for their baby to have different, better experiences than their own* underlines the pain of these mothers' pasts, while offering a sense of hope that some mothers were able to acknowledge damage and the need for repair within themselves – a perspective seen by Baradon and colleagues (1999; 2008) as fundamental to breaking the cycle of intergenerational risk.

Together, these findings suggest that the parenting representations of imprisoned mothers have quite particular features; however, they could also highlight difficulties for these mothers in communicating their representations. In both Baradon and colleagues' (2008) and Sleed's (2013) samples, mothers' idealisation and reluctance to acknowledge struggles between themselves and their babies were quantified in low RF scores (means of 2.7 and 3.4, respectively). We may wonder if it is unconsciously desirable for these women not to mentalise their children, since doing so might feel too painful. Yet it is also likely that they are reluctant to admit difficulties for fear of child removal – a theory supported by research with mothers involved in the wider child protection system (Dumbrill, 2006; Darlington et al., 2010). Sleed's (2013) finding that mothers in her sample tended to report surprisingly low levels of depression – despite behavioural evidence to the contrary – might also be explained by either of these perspectives. Overall, such evidence emphasises the challenges of relying on self-report assessment methods for mothers who are consciously or unconsciously motivated by fear of critical judgment. It may also highlight the challenges of working therapeutically with such a population. Baradon and colleagues' (2008) paper offers some hope that intervention may have the potential to elicit some positive change: a small but significant increase in RF and a

qualitative decrease in idealisation was found amongst mothers following the programme. Nevertheless, further exploratory research would be greatly warranted amongst this population.

Summary of findings

This review explored research findings regarding the parenting representations of mothers identified to be at risk of maladaptive parenting; the search strategy yielded studies that systematically explored representations amongst five main 'at-risk' populations. There was a notable lack of qualitative research in this area; most of these studies described findings primarily in terms of the classifications or scores of mothers' representations, as defined by coding systems designed for use with the WMCI and PDI interviews. However, since a particular aim of this review was to better understand the experiences of these mothers, and therefore the underlying influences in their parenting representations, studies were only included that reported further on the content or quality of representations beyond numericized scores, and particular attention was paid to secondary findings which elaborated on quantitative results.

As might be expected, an overall finding was that high proportions of mothers in these populations had disrupted parenting representations. Studies using the WMCI have found that in normative samples, over half of mothers typically have representations classified as 'balanced' (Vreeswijk et al., 2012); this review showed that amongst socioeconomically disadvantaged mothers and mothers experiencing domestic abuse, around two-thirds were found to have 'unbalanced' representations (Rosenblum et al., 2018; Sokolowski et al, 2007; Huth-Bocks et al., 2004b). An even higher proportion of mothers with unbalanced representations, 83%, was reported amongst mothers exposed to interpersonal violence in childhood (Schechter et al.,

2005). Representations amongst mothers experiencing mental health difficulties and those in prison have more commonly been explored with the PDI; representational disturbances amongst these samples were described in terms of greater risk features such as hostility, helplessness, enmeshment, distress, and less positive affect and engagement with the child (Baradon et al., 2008; Røhder et al., 2019; Sleed, 2013; Sockett, 2011; Trapolini et al., 2008). Interestingly, poor RF – a measure which has been previously considered a useful indicator of parenting difficulties – was only characteristic of samples in two studies (Baradon et al., 2008; Sleed 2013); it seemed this measure was not sensitive to all important aspects of representational disturbances (Fonagy et al., 2016; Isosavi et al., 2019; Rosenblum et al., 2018; Schechter et al., 2005; Suardi et al., 2020).

Another key finding is that mothers' experiences of relational trauma, and their psychological responses to these experiences, seemed the most important predictor of the extent and presentation of representational disturbances; links between demographic risk factors and these disturbances may therefore be mediated by the association of these risk factors with higher relational conflict. Reported experiences of relational conflict were the most significant predictor of unbalanced representations in the two studies that analysed the data for such associations (Huth-Bocks et al., 2004b; Sokolowski et al., 2007) while lower education levels (Sokolowski et al., 2007), lower income and single status (Huth-Bocks et al., 2004b) were cumulative risk factors. Extracts of mothers' narratives across all papers helped illustrate possible ways in which experienced relational trauma, in combination with challenging living circumstances and poor current relational support, might underlie representational disturbances. Some narratives suggested that a mother may be reliving aspects of her past relational experiences in the relationship with her baby,

or experiencing a disorganised state of mind regarding the relational experience altogether; others suggested that the mother may have learned ways to psychically distance herself from close relational experiences. When authors provided details about mothers' backgrounds, it was often possible to draw links between the content of mothers' representations and their relational histories.

An equally important finding was that not all traumatised mothers have disturbed maternal representations, and furthermore that disturbed representations can change. It seemed that balanced representations were possible particularly for mothers who had successfully moved away from abusive relationships (Huth-Bocks et al., 2004b) and found support in healthy relationships (Terry, 2018; Theran et al., 2005), as well as mothers who seemed able to be in touch with painful emotions regarding the past (Terry, 2018; Schechter et al., 2006). Greater concern was conveyed for mothers who seemed to be strongly psychologically defended against processing painful emotions and perhaps lacked sufficient stability in current circumstances and relationships to help them engage in this process (Baradon, 2008; Terry, 2018). Some evidence was given for ways in which therapeutic intervention might help mothers to process their past trauma sufficiently to hold more balanced maternal representations (Baradon et al., 2008; Schechter et al., 2006).

Limitations

Several limitations of the reviewed literature must be acknowledged. Firstly, the lack of qualitative research in this area is striking: while a quantitative focus may be useful for developing assessment or outcome measures, it can also draw attention away from understanding the experiences and struggles of individuals. Secondly, since most studies reviewed analysed representations with semi-structured interviews and predefined coding or classification systems; the findings

reported are largely framed by the structure and content of these, including the underlying assumptions they make about what constitutes a ‘balanced’ or ‘unbalanced’ narrative. However, the validity of such assumptions may be open to challenge. For example, none of the presented studies examined the relationship between ethnicity or culture and maternal representations; the possibility that some qualitative differences in maternal representations are influenced by cultural norms is therefore unaccounted for. Thirdly, almost all studies relied primarily on self-report data, from interviews and questionnaires. Especially given that this population typically feel judged, stigmatised and wary of professionals (Dumbrill, 2006; Darlington et al., 2010), the reliability of responses may be questioned and the data might only be usefully considered holding this context in mind. Likewise, some degree of background information about individual participants seems important when interview extracts are presented, but several studies were limited by a lack of such contextual information. Finally, the lack of research regarding fathers' parenting representations, which influenced the decision to focus solely on maternal representations in this review, must be acknowledged as a broader limitation; further research in this area is much needed.

The review itself also has its limitations. While it was structurally useful to consider findings in relation to the primary risk factors identified by authors, these populations are by no means distinct, since these risk factors frequently overlap and appear to intersect in complex ways. It is hoped that this was communicated sufficiently to the reader, alongside an emphasis on the importance of considering the individual, as well as the collective, experiences of participants. It is also acknowledged that, while focussing only on studies that explicitly explored maternal representations facilitated a systematic search strategy, it may have limited the

scope of the review to include more theoretically oriented papers, such as psychoanalytic case studies, which explored the topic without clearly stating this aim. It is hoped that some references to such writings (such as Fraiberg et al.,1975), which were previously known by the author and referenced within reviewed papers, indicates their equal value for our understanding of this topic. Further exploration of the literature might benefit from a broader synthesis of systematic research and clinical papers.

Conclusions

Together, the findings of this review support the perspective that disturbed parenting representations amongst mothers at risk of maladaptive parenting may be powerfully influenced by these mothers' experiences of relational trauma, and particularly the extent to which these experiences have been emotionally 'worked through' (Fraiberg, 1980; Fraiberg et al., 1975). One clinical implication is that interventions for this population might most usefully be focused on therapeutically exploring mothers' experiences of relational trauma and helping them to process painful emotions linked to the past, to help them find stability in the present. For some mothers, however, this may firstly require practical support; mothers who are still in abusive relationships, have little or no social support, or are living in extreme deprivation, may not yet have the external or internal resources to do this emotional work. Given that a history of relational difficulties often lies at the heart of these mothers' struggles, building trusting relationships with them may be the most essential first step towards engaging them with support.

This review also highlights the pressing need for improved and more widespread understanding of the difficulties facing mothers at risk of maladaptive parenting, amongst professionals and society in general. Preliminary findings that

certain features of maternal representations may indicate greater or less capacity for change, or the need for certain technical approaches, suggest the value of further systematic research in this area to inform clinical interventions. Such research might also be usefully integrated into practice, for example, the routine use of interviews designed to elicit parenting representations at the start of interventions might help foster therapeutic relationships, as well as informing clinicians' understanding of their clients and therefore their approaches. What seems essential in future research is that the significance of individual experiences is not missed; the lack of qualitative literature in this domain reflects a tendency for these women's experiences to be reduced to statistics, which can suggest a bleak picture of poor parenting as an unbreakable cycle. This can fuel the stigmatisation and judgement of these women, which often acts as a barrier to their engaging with support. There is therefore also strong argument for additional, more exploratory and qualitative research, which raises the profile of these women and helps people understand that, with the right support, change can be possible.

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Part 2: Empirical research project

Title: A qualitative exploration of parenting representations amongst mothers with young children on the edge of care

Word count: 7871

Abstract

Mothers who are at risk of losing custody of their children represent a vulnerable and stigmatised population, whose voices are seldom heard. Exploring their perspectives of parenting, their child and the relationship with their child – their 'parenting representations' – can improve our understandings of their struggles and inform interventions seeking to interrupt cycles of transgenerational trauma. Research in this area so far has been predominantly quantitative, meaning valuable information about subjective experiences is often lost. The present study sought to address this gap by thematically analysing interviews with eight mothers with under-3-year-olds on the edge of Local Authority care, completed at the beginning of a specialist therapeutic intervention. Results are reported around five themes: 'Idealistic portrayal of the child and relationship', 'Struggling as a parent', 'Shadows of the past', 'The child and motherhood as comfort' and 'Anxiety about loss and fighting for the child'. The parenting struggles of mothers in this population are complex and multi-faceted, fuelled by ongoing relational trauma, fears of further pain, adversity, and difficulties in accessing and trusting support. Successful interventions are likely to require comprehensive, long-term approaches which holistically address mothers' unmet physical and emotional needs, and begin with building relational trust.

Introduction

The study of parenting or caregiving representations – a parent's subjective conceptualisations of parenting, their child, and their relationship with the child – has recently gained momentum, with a growing appreciation that it can offer important insights into the psychological underpinnings of parenting behaviour (Mayseless, 2006; Rosenblum et al., 2018). In the field of attachment research from the 1980s, growing interest in the parent's attachment relationship with their child and their 'Internal Working Models' (IWMs; Bowlby, 1969/1982; 1973; 1980) of parenting eventually led to the development of interviews to examine parenting representations, such as the Working Model of the Child Interview (WMCI: Zeanah et al., 1995-2000) and the Parent Development Interview (PDI: Aber et al., 1985; PDI-R: Slade et al., 2004). Within the field of psychoanalysis, theoretical interest in parenting representations also increased following Fraiberg and colleagues' (1975) seminal paper illustrating, through a case study, how the 'ghosts' of a mother's past might colour her parenting experiences. There is now an expanding body of evidence to indicate that parenting representations can provide a window into the complex interplay between a parent's early experiences, their parenting behaviour, and the nature of the relationship with their child (Mayseless, 2006; Rosenblum et al., 2018). While the underrepresentation of fathers in paediatric and parenting research is contentious (Davison et al., 2017; Cabrera et al., 2018), factors such as the historical view of mothers as primary caregivers and challenges in recruiting fathers to research (Mitchell et al., 2007) mean that most literature in this area to date has focused on the parenting representations of mothers, also termed 'maternal representations' (Stern, 1991).

Exploring parenting representations amongst mothers with children at risk of

being removed from their custody, termed ‘on the edge of care’, is especially valuable for multiple reasons. It has been increasingly highlighted that birth mothers involved with the child protection system typically have their own histories of ‘relational trauma’ – that is, consistent disruptions to their sense of being safe and loved within significant relationships – which bears impact on their parenting (Daum & Labuschagne, 2018). If parents struggle to attune and respond to their child’s needs, perhaps because their own are unmet, the child is also more likely to perpetuate this cycle and struggle later as a parent (Daum & Labuschagne, 2018; World Health Organisation, 2020). While there is considerable quantitative research examining the links between mothers’ unresolved relational trauma and maladaptive parenting, which tends to highlight risk to the child (Lyons-Ruth & Jacobovitz, 1999; Lyons-Ruth et al., 2005; Madigan et al., 2006; Main & Hesse, 1990), there is far less research focusing on these mothers’ perspectives and experiences; this may be crucial given that a central barrier to the success of clinical interventions is poor engagement (Daum, 2009), often fuelled by mothers feeling blamed and marginalised (Broadhurst & Mason, 2013; Siverns & Morgan, 2019). Indeed, a small body of qualitative research exploring experiences of parents with childhood trauma suggests that they typically live in fear of repeating their own pasts, and often acknowledge a need for support but experience this support as unsafe (Siverns & Morgan, 2019). Further qualitative research in this area is much needed to improve our understanding of these mothers’ struggles, to help them feel heard, and to inform clinical interventions including approaches to engagement.

At present, there is little research explicitly exploring the parenting representations of mothers with young children on the edge of care, although there is an expanding body of (predominantly quantitative) research regarding representations of mothers identified to be ‘at-risk’ of parenting difficulties – mostly due to adverse

circumstances such as socioeconomic deprivation, experiences of abuse and mental health difficulties. Quantitative evidence suggests that high proportions of these populations show ‘disrupted’ maternal representations. For example, amongst mothers who are socioeconomically deprived, experiencing domestic abuse, or who were exposed to violence in childhood, typically 60-80% have representations classified as ‘disengaged’, meaning lacking in detail and emotional involvement with the child, or ‘distorted’, meaning confused and inconsistent (Huth-Bocks et al., 2004; Rosenblum et al., 2018; Schechter et al., 2005; Sokolowski et al, 2007); this compares with the ‘normative’ average of 47% (Vreeswik et al., 2012). Disengaged representations have been linked with dismissive and rejecting parenting behaviour (Rosenblum et al., 2002; Sokolowski et al., 2007), while distorted representations have been linked with hostile-intrusive and disoriented-frightening behaviour (Korja et al., 2010; Schechter et al., 2008). Other studies have identified representational features that indicate ‘relational risk’, such as expressions of helplessness or hostility, and idealisation, enmeshment or role-reversal; these are all more prevalent amongst traumatised mothers (Sleed, 2013; Sockett, 2011; Terry, 2018).

A key limitation of this literature is the dominance of quantitative research, which typically constrains mothers’ representations into researcher-defined categories or measurements, and the lack of qualitative research, which can help us understand mothers’ own perspectives and the subjective experiences which underlie their representations. While quantitative evidence indicates that relational trauma is the most significant predictor of representational disturbances (Huth-Bocks et al., 2004; Sokolowski et al., 2007), qualitative evidence seems to support Fraiberg and colleagues’ (1975) view that disturbances are shaped more specifically by the extent to which this trauma remains ‘unresolved’ – meaning that the painful experiences have

not been emotionally processed and integrated, usually within supportive relationships. For example, in a study exploring the prenatal representations of young, underprivileged mothers-to-be, Terry (2018) illustrates how one mother's frequent expressions of hostility and helplessness may be understood in relation to her ongoing estrangement from friends and family combined with her traumatic history, while the comparative cohesion and balance in another traumatised mother's representations might be understood in the context of her strong familial support. This and a small number of other studies also indicate how deeper exploration of mothers' representational disturbances can support clinical intervention, by leading to a processing of trauma within a safe therapeutic relationship. These studies highlight that representational disturbances and difficulties in the parent-child relationship can be amenable to change (Isosävi et al., 2019; Rosenblum et al., 2018; Schechter et al., 2006, Sockett, 2011).

The present study seeks to expand on the small body of qualitative research exploring maternal representations amongst mothers with young children on the edge of care, by thematically analysing PDI transcripts of eight women enrolled in a therapeutic intervention. Although commonly used in clinical interventions, PDI data is typically used in primarily quantitative analysis; most commonly it is coded for the mother's ability to reflect on her and her child's internal experiences, termed 'Reflective Functioning' and captured as a single numerical score (Fonagy et al., 1991; Fonagy et al., 1998; Slade, 2005). The loss of data incurred by this coding process has been highlighted (Fonagy et al., 2016; Sleed, 2013), yet currently there are few published studies which involve qualitative analysis of PDI transcripts. One exception is Baradon and colleagues' (2008) study which qualitatively analysed PDI transcripts of 15 mothers in a mother and baby prison unit and identified themes illustrating prominent

aspects of these mother's representations and experiences of parenting in highly adverse circumstances. These include 'Idealisation of baby and self-as-mother' and 'The mothers' wish for their baby to have different, better experiences than their own'. The present study aims, similarly, to use a qualitative, exploratory approach to gain a deeper understanding of maternal representations amongst a sample of mothers with complex difficulties who are at risk of losing custody of their child.

Methods

Context

This study was conducted as part of a wider evaluation of a specialist intervention designed to support parents with complex difficulties who have under-5-year-olds on the edge of care. This programme, which ran from 2011-2020, offered 18 months of intensive (two full days per week) mentalisation-based treatment, working with parents and children directly as well as the surrounding professional network. Families were referred by Social Services and assessment of their engagement and progress also informed subsequent decision-making as to whether it was in the child's best interests to remain in the parent's custody. Alongside other assessment and evaluation measures, clinical interviews using the revised version of the Parent Development Interview (PDI-R; Slade et al., 2004) were administered to parents by a keyworker or research assistant at the beginning, middle and end (where possible) of the intervention; these were audio-recorded and periodically transcribed. The present study used baseline (pre-intervention) interview data from this dataset. Ethics approval for the overall evaluation project was granted by the University College London Ethics Committee (*6821/001)* All participants provided written consent for their interview data to be used in the evaluation. To protect confidentiality of individuals, all data presented

in this study has been pseudonymised, and identifying details altered.

The Parent Development Interview-Revised (PDI-R)

The PDI-R (Slade et al., 2004) is a 45-item semi-structured clinical interview designed to examine parents' representations of their children, themselves as parents, and their relationships with their children. In addition to initial descriptive questions (for example, 'could you choose three adjectives to describe your child/yourself as a parent?') parents are asked to consider their child's feelings and thoughts in various situations, and their own feelings and responses towards the child; interviewers prompt for examples to illustrate their answers. Parents are also asked to speak about their own parents, and think about similarities between themselves and their parents, as well as experiences of separation and loss with their child. The PDI-R was adapted from the original PDI (Aber et al., 1985) to be best suited to coding for Reflective Functioning (RF) with the PDI-RF coding system (Slade et al., 2004); this was the primary use of interview data within the wider evaluation project, which aimed to compare parents' RF scores before, during and after the intervention.

Design

This is a qualitative study, in which Thematic Analysis (TA) was used to analyse the pre-intervention PDI-R transcripts of eight mothers participating in the programme. TA was chosen because it enables the researcher to systematically identify and examine patterns of meaning in the data without being tied to a particular theoretical or epistemological position (Joffe, 2012). It therefore allowed me to be led primarily by the data (an inductive approach) while following a rigorous systematic process. The method was compatible with my critical realist assumption that participants' responses would not represent a direct mirroring of 'reality' but could offer insight into the ways they made meaning of their experiences, with the understanding that the broader

context (including, for example, the interview situation and their current circumstances) would influence these meanings.

Participants

A sample size of eight was chosen to allow in-depth analysis while also allowing for comparisons across individuals; this number is considered appropriate for qualitative research when the researcher is interested in the exploration of individual experiences (Robinson, 2014). To ensure a balanced sample, I chose to include four mothers who completed the programme and retained custody of their child at 18-month follow-up, and four who dropped out and lost custody, as well as ensuring a range of ages, ethnicities and primiparity. Participants were therefore purposively sampled. Mothers were excluded if they did not have a completed and transcribed PDI, if demographic data was missing, or custody or drop-out status was not known; this resulted in using PDI data collected between 2011-2017. All mothers in the present sample had children aged under 3. Since it was felt that knowing which mothers retained or lost custody might influence my thinking in the analysis process, the sample was selected by my research supervisor and retained/lost custody status of participants was only revealed to me once primary analysis was complete.

Data Analysis

Interview data was analysed using the six stages of thematic analysis outlined by Braun and Clarke (2006; see Table 1), using digital documents.

Phases of thematic analysis
1. Familiarizing yourself with your data
2. Generating initial codes
3. Searching for themes
4. Reviewing themes
5. Defining and naming themes
6. Producing the report

Table 1. *Phases of thematic analysis: from Braun & Clarke, 2006*

Audio-recordings were pre-transcribed, however, in Phase 1, I listened and re-listened to the recordings, refining and annotating the transcriptions and familiarising myself with participants' voices. I examined each interview in detail, annotating all thoughts and ideas, then writing summaries of initial impressions of each mother. I then more actively considered comparisons across the data, observing notable similarities or differences between narratives. In Phase 2, where I began identifying significant segments of meaning (codes) within the data, I held in mind the research question of exploring parenting representations (for example, 'child as perfect' was an especially relevant code); however, I also coded aspects of the data which seemed meaningful and did not have immediate semantic relevance to the research question (for example 'avoidance/rejection of question').

In Phases 3 and 4, I arranged and re-arranged associated codes under candidate themes which I felt captured patterns of significant meaning. I tried, tested and revised various coding frames, reviewed regularly by my supervisor. Validation checks were carried out by one peer student, who carried out their own 'blind' coding of one interview which was then compared with my coding frames. We found a high

level of agreement; slight points of disagreement were explored further, brought to group supervision, and coding frames adjusted appropriately. In Phases 4 and 5, candidate themes were refined and reworked until we felt satisfied that the data was sufficiently and meaningfully represented. In Phase 6, I wrote and prepared the manuscript, which was reviewed by my supervisor.

Reflexivity

As a trainee Child and Adolescent Psychotherapist, I have a particular interest in psychoanalytic theory; I also have an interest in and experience of working with children and parents involved with the child protection system, though I am not a parent myself and have no lived personal experience in this area. My theoretical and professional background will inevitably have influenced my understanding and interpretation of the data. For example, I often think about psychological 'defence mechanisms' (Freud, 1966) in my clinical practice; I would therefore naturally have been more alert to the ways in which participants' narratives might indicate their protecting themselves from psychological discomfort. My supervisor, an experienced qualitative researcher, psychologist and parent, helped me throughout the project to consider my findings from multiple perspectives.

Results

Results are reported around five central themes found in the data: 'Idealistic portrayal of the child and the relationship', 'Struggling as a parent', 'Shadows of the past', 'The child and motherhood as comfort', and 'Anxiety about loss and fighting for the child'. These were felt to capture prominent features of maternal representations across the sample, though there were important differences between mothers within each theme. Demographic information is presented in Table 2, which highlights the

challenging circumstances of all mothers. Themes are then described in detail and summarised in Table 3.

Pseudonym	Age	Ethnicity	Single	Prev. Children (removed/ live with)	Current child: baby (≤1)/ toddler (>1–3)	Retained/lost custody at 18m follow up
Kayla	18-25	W British	Y	Y (removed)	Baby	Lost
Amber	18-25	Mixed B African/WB	Y	Y (live with)	Baby	Lost
Sherene	26-35	Mixed B African/W British	N	Y (removed)	Toddler	Lost
Alice	18-25	Mixed B African/W British	N	N	Toddler	Retained
Rachel	18-25	W British	Y	N	Baby	Retained
Ruby	26-35	B Caribbean	Y	N	Baby	Retained
Louise	26-35	W British	Y	Y (removed	Toddler	Retained
Alison	>40	W British	N	Y (removed)	Toddler	Lost

Table 2. *Demographic information for participants*

1) 'I love everything about my child, he's perfect': Idealistic portrayal of the child and the relationship

A striking feature across the transcripts was mothers' idealistic descriptions of their child and the relationship with them. 'Happy', 'loving', 'perfect' and 'amazing' were the most common adjectives used to describe the child. Several mothers said their child was 'always' or 'constantly' happy, smiling, or loving, and 'never' crying or

unhappy. Rachel, a young, single White British mother who lived with her baby in a foster placement, said her daughter was only ever sad when tired or teething:

> *Otherwise, all you get is smiles. She even wakes up and she's non-stop smiles!*

Five mothers, including Rachel, said they loved 'everything' about their child, and most expressed joy or excitement about the child. This was especially so for Ruby, Amber and Sherene, who all seemed elated at several points in their interviews. For example, Amber, a single Mixed-Race mother living with her three children, said about her baby:

> *Just like talking about him… I just feel all bubbly inside and I want to explode like you know when you shake a can of coke, I'm just like [pshhhh]! Aww I just love it!*

Mothers also emphasised the strength of their relationship with the child: 'loving' and 'close' were the most common adjectives in this regard, although the nature of the closeness described varied. For example, Amber and Sherene spoke often about 'kisses and cuddles'; these mothers and Louise, all third-time parents, also emphasised 'fun and games'. Ruby, a single Black Caribbean first-time mother, spoke about 'chatting away' and 'face-to-face time' with her baby. Alice, Rachel and Kayla, the three youngest mothers, spoke more softly and romantically about closeness with their child; for example, Alice said:

> *When we're sitting together watching telly, or in the bath together playing… he's just like he's got his mum and "mum loves me".*

Alison, a White British mother who was the eldest by several years, was the only mother not to show these kinds of idealisation; her responses were typically problem-focussed and often long and verbose.

Another aspect of this theme, common to all mothers (including Alison), was a denial that their own struggles significantly affected the child. Many said they successfully hid their difficult emotions or that their child was ‘too young to understand’; some denied experiencing or expressing difficult feelings altogether, for example, ‘I don’t get angry’. ‘No’ was the most typical response to whether the child had ever felt rejected or experienced setbacks. Amber emphasised her child’s advanced abilities for his age as evidence of his having ‘no problems’, and Kayla, a young White British mother who had lost custody of one child and was currently living temporarily apart from her youngest, said:

Yeah, I went through domestic violence but… I mean, it could have affected her, but from what I see now it doesn’t look like it… she’s a happy little girl who loves everyone.

2) ‘It’s a hard job being a parent, to be honest’: Struggling as a parent

Despite the idealistic representations, all mothers also described their struggles with parenting, often increasingly as interviews progressed. Mothers often described their child as troublesome or difficult to manage; for example Sherene, a middle-aged, Mixed-Race mother who had lost two children to care and often came across as overwhelmed, described her daughter as ‘hyper’ and ‘manipulative’ and said:

She’s just doing everything all day, from taking my phone to wrecking the house!

Alice, a Mixed-Race, first-time mother who spoke in quiet, subdued tones, described her son throwing things and laughing at her, while Ruby said her son was ‘stubborn’ and Kayla said her daughter was ‘temperamental’. Most mothers also admitted they struggled to set boundaries, although only Sherene spoke of this as contributing to

her child's unruly behaviour. Nearly all mothers described their dislike of seeing their child upset. Amber said saying 'no' to her children would 'kill' her, while Louise, a single, White British mother who had lost two children to care, said:

> *What I like least is when I hear my child cry. I don't like it. I can't stand it and I don't listen to it because it hurts me and I don't like to know that my child's distressed.*

For every mother, it seemed there was an ongoing juggle between their needs and the child's: struggles with their own emotions, lack of sleep or insufficient time to themselves were referred to unanimously. Expressions of desperation, overwhelm and helplessness were common; Sherene described pleading with her daughter to listen, and needing 'just that *little* bit of time where she's asleep and I can relax', while Alison described often feeling 'really unwell' and 'just want(ing) to shut the whole world out'. Amber described smoking weed to self-soothe, and Ruby spoke of using alcohol to cope:

> *After about an hour I just went, "[growls] Oh my god child, just stop now, stop!" And then… [giggles] I had a drink – just a little one, cause seriously- I was like, "I wanna shoot myself in the face right now."*

Interestingly, while strong reactions to emotional discomfort and expressions of hostility stood out in Ruby's representations, she was one of the four mothers to complete the intervention and retain custody at follow-up. It is perhaps notable that, although a single mother, she had the most present and supportive wider family network of all participants and, from her interview, seemed to have a good rapport with her keyworker.

Overall, all narratives conveyed a sense of mothers struggling against the odds – with financial constraints and insufficient relational support, but also with an internal

feeling of continuously unmet needs. Nearly all mothers referred to the difficulties of parenting with little money, which left them living in cramped conditions (Louise and Alison), struggling to make ends meet (Kayla) and feeling guilty for not providing for the child (Amber and Sherene). Kayla and Amber, both single mothers with little family support, described having ‘nobody there for me’ and Ruby, also single, said ‘it would just be easier if there was two parents in this house’. Those who had partners, however, spoke about problems in their relationships. Sherene said her arguments with her boyfriend were ‘kind of why I’m here’ and Alison said that if she had foreseen how her partner would parent, ‘I would be like no way I’m not having a child with that man.’. Similarly, while several mothers spoke about the challenges of having no family support, Ruby expressed resentment about her family’s active involvement, since it made her feel inadequate. Generally, it seemed that mothers felt constrained at every turn; Alison named this as ‘feeling trapped’.

3) ‘That hurt feeling like someone’s scooping a bit of your soul out… I never wanted that for my child’: Shadows of the past

While some mothers were more open about their histories than others, it was evident that all had experienced considerable relational trauma and it seemed their present lives were still powerfully coloured by their pasts. Every mother spoke of feeling unloved and abused, abandoned or rejected by one or both parents. Alison and Kayla made explicit links between this and their own parenting (interestingly, while this could be seen to demonstrate good reflective capacity, both later dropped out of the programme and lost custody of their babies): Alison linked her own ‘abandonment issues’ to her ‘trouble bonding’ with her children and Kayla said:

I never felt truly loved by anyone, so it’s hard with my kids, to show the affection.

Other mothers made indirect links, alluding to how their experiences had shaped aspects of their character, which in turn shaped characteristics of their parenting and often their experiences of their child. For example, Ruby said:

> *My dad's got anger problems, so, so have I, so my child's bound to be aggressive.*

There was a general impression that relational difficulties experienced or witnessed in childhood had followed mothers throughout their lives; this was especially prevalent in some mothers' references to abusive relationships with partners and with themselves (for example, self-harm). Sherene, who mentioned she was receiving support with her current partner 'for anger management', gave a summary of her traumatic journey:

> *My dad raped my mum. And then we was abused by her other partner for years… she threw me out and I grew up in care… Then I was in a violent relationship myself and ended up on the streets, drugs, prostitution. Now I'm here.*

For all mothers, speaking about their own parents seemed to stir powerful feelings. In some cases, this was directly expressed with emotional language and swearing, while in others, responses were short and dismissive. Such strong feelings often appeared to lead to self-contradictions or inconsistencies in mothers' narratives. For example, when asked to describe her early relationship with her mother, Kayla replied firmly, 'I don't remember any memory with my mum', yet shortly after she described in detail being physically abused and rejected by her mother. Most mothers also showed notable polarisation in their views: their representations of their 'bad' caregiver (often their mother) were fixed and unforgiving, while 'good' was often ascribed to an idealised, rescuing alternative caregiver such as a grandmother (Amber, Ruby, Alice) or father (Kayla, Rachel, Alison). For example, Amber said of her mother:

*See where I've been through so much s*** because of her, it's hard to think of good things. She's selfish. The only word for it.*

Contrastingly, she described her nan as 'amazing, loving, caring' and 'a fantastic woman who has done so much for me'. However, she also mentioned she was taken into care after a year of living with her nan, prompting questions around this idyllic representation.

It was especially striking that all mothers expressed an adamant desire to be 'nothing like' or 'the complete opposite to' these 'bad' caregiver(s), yet often only a few sentences apart acknowledged similarities to their parents; these admissions were often accompanied by expressions of shame or guilt. Ruby said firmly 'I avoid all the things my parents did', yet she also said she was aggressive like her father. Amber said her parents 'showed (her) exactly what and how (she) didn't want to be as a parent'; yet shortly after said:

I am like my mum in the fact that I shout a lot. I shout a hell of a lot. And I don't want to.

Rachel emphasised throughout her interview that she was 'loyal', would 'always put family first' and would 'never walk out on (her) children' like her mother. However, when asked what she would change about her parenting, she admitted that she had left her daughter a few times and wished she hadn't. There was a sense in which mothers seemed to be helplessly repeating the behaviours they wished to avoid.

4) 'It makes me feel like I'm worth something': The child and motherhood as comfort

For nearly all mothers, the child and motherhood seemed an important source of comfort. With the exception only of Alison, who appeared preoccupied with her

struggles and a view of herself as ‘not cut out to be a mum’, all spoke in some way about their child relieving them of uncomfortable feelings. Kayla, the only mother who didn’t live with her child currently, said she was ‘too busy to feel depressed’ when she was with her daughter, adding ‘I like having her around ‘cos she keeps my mind off other things’. Rachel, Alice and Amber described their children physically comforting them when they felt low; for example, Rachel said when she was ‘feeling down’ her daughter would cuddle her and lay on her chest, ‘like she’s trying to comfort me’, and Alice said:

If I’m feeling a bit down, or upset, I’ll ask (child) for a kiss and he just comes and kisses me.

In other cases, comfort seemed to be found in the child as a buddy. Kayla and Rachel spoke of being ‘best friends’ with their children and Ruby and Amber described them as playmates: Ruby said her child had been ‘boring’ as a baby but ‘now it’s like, yay, you’re playing with me!’ while Amber called her youngest her ‘little sidekick’ and said ‘it should be the other way round, but my kids push *me* on the swing!’. Some mothers also spoke of the loneliness they felt when apart from the child; for example, Amber continued:

When they're all sleeping and I can’t go wake them up go give mum cuddles… It’s just like (exhales) here it is, here’s reality. It’s just me.

This sense of role-reversal or confusion was complex since often there was a recognition of the child’s neediness, yet this was framed in terms of meeting the mother’s needs; every mother spoke about how good it felt to be wanted and needed by their child, or how being a mum gave them purpose or value. Rachel said that when her daughter was tired, ‘all she wants is me’ and continued:

It just makes you feel wanted. And that makes you feel like you're doing a good job after all… like you're doing ok.

Similarly, Amber said what gave her most joy in parenting was 'knowing I'm their main security' and later added, 'it's like I'm actually here for a reason 'cos my baby needs me'. For most participants, being 'a mum' seemed a defining part of their identity: Alice chose 'mum' to describe herself when asked for three adjectives, Louise chose 'loving, caring and hardworking' and spoke proudly about the self-sacrifices she made for her child, and Rachel said, 'if I had a day off, I'd rather spend it with my baby than go out'. Kayla also described her joy in motherhood and said:

The proudest moment of my life was holding her for the first time ever and it was just that she is mine, you know, she's mine.

For Ruby, Amber and Sherene, motherhood could also be seen as a saving grace, and the child as a rescuer. Ruby, having had three miscarriages and two terminations, called her son 'my little miracle baby', and also described how his presence sometimes helped her resist buying alcohol. Amber, who spoke about struggling to control her temper, said when she was wound up and angry, her baby would 'bring her out of it… cause he's so little and innocent'. Sherene, whose history of prostitution and drug-taking was touched on earlier, said her daughter 'saved my life, to be honest' and elaborated:

I lost everything and I was nothing… maybe if I weren't pregnant I would still have been smoking crack and ended up dead or gotten AIDS or something.

5) 'I will never be separated from them again because it killed me from the inside out': Anxiety about loss and fighting for the child

In some way, all mothers' representations encompassed very real anxieties about losing or being separated from their child. Legal separation was referred to in nearly all narratives; Sherene and Amber both named 'the thought of losing (their child)' as what they found most difficult as a parent and described the anguish of having previous children 'taken away' (Sherene) or placed in temporary care (Amber). Louise, who had lost two children to care, said she found most difficult 'when I'm with my son and I think about my other sons', and Kayla described the pain of living apart from her daughter:

> *It's the worst feeling ever not to go to sleep knowing your baby's in the bed next to you, not knowing what they're wearing that night or what time they've had their bottle.*

Rachel said 'Social Services' was what she found most difficult as a parent, and others spoke similarly with expressions of hostility or helplessness about dealing with social care. Ruby imagined she might 'kick off' in an upcoming review and said 'I'm so tired, I'm so shattered, why is my child on a protection plan?', while Alison described an argument with her social worker 'bringing up all the trauma' from her previous custody loss and thinking 'I just can't do this again'.

Several mothers also expressed anxieties about the child's health or safety. Louise described worrying her child would 'hurt himself in any way' and Alison and Ruby described worrying about death when their child was unwell. Ruby, who had suffered three miscarriages, said she managed her anxieties by continuously cleaning the house and sterilising toys. Sherene, who had recently suffered a stillbirth, cried as she said:

I fear all these things like is she gonna fall out the window or I have a bad dream about falling out the window… I just want my daughter to be safe.

Sometimes, fears around loss of custody and the child's health and safety were brought together; for example, Ruby later said:

To be honest I'm just very anxious about something happening to him. Child Protection plan or not, I'm just anxious.

There was clearly a limit to how directly mothers could think about the possibility of losing their child, however; six of eight mothers responded to the question 'have you ever felt like you were losing your child a little bit?' with 'no' or a misunderstanding of the question.

In some cases, mothers spoke with a more active sense of determination to protect their child. Amber described herself as a 'mother lion' whenever she had an 'instinct' that anyone might be unkind to her child, and Alice similarly described her defensiveness of her son. Ruby spoke about becoming irate with people wanting to hold her son and said:

Before I didn't care who I had around, if they were junkies or… but now, nuh-uh. I am very protective over my child.

Some mothers emphasised working hard on their maternal capacities; for example, Sherene and Ruby both spoke about working on their difficulties with anger and how much they had improved, while Louise said she had 'reflected from my other children on the things I wanted to change and changed them' – she gave examples of breastfeeding and giving her son more attention. Kayla explained how her mother had supported her with her first child, but this time:

I’ve done it all on my own, you know and I didn’t ask for a penny… It all come from my pocket.

Overall, it seemed that mothers typically saw themselves to be fighting against the odds for their child. This was well captured by Rachel, who described how ‘depressing’ it was when Social Services visited, which could ‘forever put you on a downer’. Yet she also described holding on to hope:

You’d see her little smiles and you’d think, ‘What you’re fighting for is worth it, because you’re fighting to keep your little girl.’

Theme	Subthemes
Idealistic portrayal of the child and the relationship	Idealistic descriptions of child, denial of difficulties Excited expressions of love for child Idealistic descriptions of relationship, denial of difficulties Denial of own struggles affecting the child
Struggling as a parent	Child as troublesome Pain at child's distress/ struggle to set boundaries Juggling personal needs vs the child's Helplessness and overwhelm Using chemicals to cope Struggling against the odds – under-resourced and under-supported
Shadows of the past	Feeling unloved/abused/abandoned/rejected by own parents Influence of being parented on parenting today (direct and indirect links) Repetition of early relational patterns in later relationships Powerful emotional responses to speaking about childhood and past (eg. swearing, defensiveness, inconsistencies in narrative, splitting good v bad) Wish to be nothing like parents but admissions of repeating their mistakes
The child and motherhood as comfort	Child as distraction Child as comforter Child as buddy Importance of being wanted and needed Importance of motherhood as identity Motherhood and/or child as saving grace
Anxiety about loss and fighting for the child	Anxiety about loss of custody and Social Services/ resentment of SS Pain and trauma of previous separation Anxiety about child's health or safety Denial/avoidance of possibility of loss Protectiveness over child Working hard to be a better parent Fighting for the child

Table 3. *Summary of themes and subthemes*

Discussion

This was a qualitative exploratory study, aiming to further our understanding of the parenting representations and subjective experiences of mothers with under-3-year-old children on the edge of care, through an in-depth thematic analysis of interviews with eight mothers referred by Social Services to a specialist therapeutic intervention. Overall, while mothers often gave idealistic portrayals of the child and motherhood, their narratives also illustrated the depths of their struggles with parenting. Alongside unanimous experiences of social and financial adversity, these struggles could often be understood in the context of past relational traumas; narratives indicated various ways in which the legacy of these traumas had profoundly impacted mothers' lives and bore ongoing influences on their parenting representations and experiences. Amidst feelings of depression or loneliness, the child and motherhood could be experienced as primary sources of comfort, while anxieties around losing the child and protectiveness were also often prevalent.

The findings of the first theme, concerning the 'idealisation' observed in the narratives, were reported similarly by Baradon and colleagues (2008) and Sleed (2013) amongst imprisoned mothers. One plausible explanation is that these findings reflect a social desirability bias; it seems understandable that, facing the threat of child removal, mothers may wish to emphasise positive portrayals of the child and parenting in a recorded interview. This interpretation would be supported by Sleed's (2013) additional finding that mothers often reported low rates of depression despite other evidence to the contrary, and similar findings of under-reported parenting stress amongst mothers in prison (Goshin, 2010). This perhaps highlights the importance of not relying solely on self-report measures in these circumstances. It is important to note, however, that one mother in the present sample showed very little

idealisation: ‘Alison’ came across rather as preoccupied with her struggles and a view of herself as incompetent. It is possible that, as an older mother who already had an adult son, she did not ascribe the same levels of hope to this period of motherhood as others appeared to, and therefore felt less motivated to persuade the interviewer of her being a ‘good’ mother; however, other interpretations may also be considered.

Significantly, other mothers went on to show similar expressions of defeat and helplessness later in their interviews. While this may suggest that mothers became gradually more comfortable with their interviewers over time and therefore more honest, it seems important also to consider the meaning of their views being so polarised; things were generally portrayed as either all good, or all bad. In psychoanalytic theory, this is termed ‘splitting’ and is understood as unconscious means of reducing psychological discomfort which might be faced by integrating the two positions (Brenner, 1979). Particularly for mothers with heightened insecurity and shame, negative feelings towards the child may be very uncomfortable and difficult to integrate with positive feelings; this would be supported by the finding, also noted by Baradon and colleagues (2008), that mothers rarely openly expressed anger towards the child, despite alluding to it. Perhaps, there may be tendencies for these mothers to either avoid negative feelings altogether, or adopt a position of helplessness in the face of them (Lyons-Ruth et al., 2003). For Alison, who also seemed highly preoccupied with her family relationships and her past, this sense of being anxiously ‘flooded’ in her representations was predominant, while other mothers tended to shift between idealistic representations at some points and helpless representations at others. Broadly, it may be hypothesised that mothers in this population are likely to have developed a range of psychological coping

mechanisms in response to trauma; they are therefore likely to require therapeutic approaches which are flexible and sensitive to these coping mechanisms.

The finding that mothers' representations often seemed intricately linked with past traumatic relational experiences supports previous qualitative findings (Fraiberg et al., 1975; Isosavi et al., 2019; Schechter et al., 2006; Siverns & Morgan, 2019; Sockett, 2011; Terry, 2018) and highlights the value of exploring mothers' relational histories within interventions. As observed by Baradon and colleagues (2008) and amongst other mothers with childhood trauma (Siverns & Morgan, 2019), all mothers expressed a strong desire to give their child different experiences to their own. While this has been seen as crucial in breaking intergenerational cycles of trauma (Baradon et al., 1999; Fraiberg et al., 1975), the finding that they also described repeating their parents' behaviours suggests that this desire alone was not enough. Fraiberg and colleagues (1975) hypothesised that to move on from such repetition, a mother must have processed the painful emotions associated with her past experiences – usually within the safety of a supportive relationship – else her child's emotional cues will continue to trigger her unmet needs and distress. The inconsistencies and high emotionality in mothers' narratives would suggest that their traumas remained largely unprocessed or 'unresolved' (Hesse & Main, 2000; Main & Hesse, 1990) and indeed, many mothers described their pain at their child's distress as a central source of parenting struggles. It seems likely that these struggles were compounded by a lack of consistent relational support, described by most mothers as an ongoing experience. 'Ruby' was the only mother who referred to recent support from loved ones, which seems significant given that she went on to complete the programme and retain custody of her child, despite showing particularly concerning representations at times.

The finding that the child and motherhood were often seen as a source of comfort similarly accords with previous findings amongst traumatised mothers (Siverns & Morgan, 2019), and might also be understood in the context of mothers feeling under-supported, lonely, and mistrusting of adults in their lives (Alexander et al., 2000). As discussed by others (Alexander et al., 2000; Baradon et al., 2008; Burkett, 1991; Macfie et al., 2005; Sleed, 2013), it seemed that the child could be seen by mothers as carrying different supporting roles, such as 'distraction', 'comforter' or 'buddy'. It has also been suggested that this feature of representations comes from parents having themselves been required to provide emotional support to adults during their childhoods, and therefore having unconsciously internalised an understanding that this can be expected of children (Burkett, 1991; Macfie et al., 2005). Given the complex relational histories of all mothers here, both explanations seem plausible; for all except Alison, it seemed that the child and being 'a mum' were seen as principal sources of security amidst a lonely and unsafe world. For the younger mothers in particular ('Kayla', 'Rachel' and 'Alice'), who often gave romanticised representations of the child and motherhood, these could be seen to offer the love and feelings of being wanted which they had previously longed for, as well as hope for a new beginning; a finding observed previously amongst fostered teenage mothers (Aparicio et al., 2005). For all mothers, motherhood in some way gave feelings of self-worth.

Given the weight of these emotional ascriptions to the child and motherhood, mothers' resounding histories of loss, and their current context, it is perhaps unsurprising that anxieties about loss were also prevalent. The fierce protectiveness expressed by several mothers, and a heightened alertness to threat, have been observed in previous studies with mothers with a history of trauma (Siverns &

Morgan, 2019), while the desire to resist a narrative of ‘maternal failure’ has also been found amongst other mothers in stigmatised minorities (Abrams & Curran, 2011; Mantovani & Thomas, 2014). Together, this underlines the challenges of offering professional support to these mothers, which may easily be experienced as an intrusion, or confirmation of ‘failure’. The stark emotional language with which mothers described previous child protection proceedings and separations from the child is another common finding (O’Neill, 2005; Schofield & Ward, 2011), highlighting that these events can be experienced as further trauma. The fact that most mothers refuted whether they had ever felt they were losing the child further emphasises this point and suggests that professionals must be sensitive to powerful threat responses triggered by anxieties around loss. While previous studies have found that some parents can experience Social Services as supportive (Dumbrill, 2006), here, they were only referred to with resentment. It has been suggested that professionals should address power imbalances and acknowledge the anxieties mothers may be experiencing to help build trust (Dumbrill, 2006); however, negative perceptions of professionals may be resistant to change and it seems likely that trust-building will take considerable time and sensitivity.

Strengths and limitations

This study involved an in-depth analysis of rich qualitative data, collected from mothers of varying ages and ethnicities before they began a clinical intervention; I was able to include mothers who later dropped out of the intervention and lost custody of their child as well as mothers who completed and retained custody at 18-month follow-up. This is a population whose voices are not often heard, and a purely qualitative approach to analysis allowed me to retain a focus on exploring participants’ subjective experiences.

Despite these strengths, the study also has its limitations. The PDI was not primarily designed for qualitative analysis, and the specificity of its questions may mean that some findings are partly reflective of their content; further qualitative research using less structured interviews may be useful. Additionally, the findings here can only be said to reflect mothers' views at one point in time, thus future studies exploring qualitative changes over time in representations would also be valuable. As previously mentioned, fathers are frequently underrepresented in research related to parenting experiences; while this study was usefully able to build on and draw comparisons with previous literature regarding maternal representations, future research which focuses on engaging fathers and exploring paternal representations seems important. The same may also be argued for other caregiving family members. Future research may also benefit from including the perspectives of professionals working with these parents, and other qualitative data such as observational reports, to deepen our understandings.

It seems important that these findings are understood in context, rather than as a direct reflection of mothers' subjective or private representations. Interviewers were professionals who may have been perceived by mothers to influence whether they retained custody of their child; in some cases, a keyworker whom mothers had met a few times, in others a research assistant whom they had only briefly met. While this variability perhaps presents another limitation, in all cases there had been little time for trust to be established. The interview scenario itself and an awareness of being recorded is also likely to have influenced the way mothers expressed their views. We should also remain cautious when considering the generalisability of these findings, especially as this was a specific group of mothers who had all been

referred to a therapeutic intervention. Further research across other clinical or community settings is recommended.

Conclusions and implications

The present findings suggest that mothers with complex trauma may have developed various ways of coping with emotional pain that affect their ability to manage conflicting thoughts and feelings; their feelings of guilt and fear of judgement are also likely to affect their ability to communicate about these struggles. Treatment approaches therefore need to be trauma-informed and consider how to help mothers to feel safer in speaking about the whole range of their affective experiences regarding parenthood (Lyons-Ruth & Spielman, 2004). It was also evident, however, that mothers were under considerable ongoing stress, and greatly lacking in the external as well as the internal resources to manage the challenges of parenting. Treatment approaches must therefore also consider holistic, multi-faceted approaches which involve professional networking to ensure basic needs are met sufficiently for such emotional work to take place (Daum & Labuschagne, 2009).

These findings also indicate that while mothers who have experienced trauma may wish to be different from their own parents, they may find themselves stuck in patterns of repetition, which are likely to be fuelled by their ongoing unmet emotional needs. Effective therapeutic treatment is therefore likely to require a delicately balanced approach whereby the mother is helped to explore her own distressing past experiences and express painful emotions within a safe relationship and setting, while also being helped her to feel empowered that change is possible and gently guided in this (Fraiberg et al., 1975). Given evidence that professionals may easily be experienced by these mothers as intruders or threats, the establishment of trust

and safety in the therapeutic relationship seems an essential prerequisite of any such work becoming possible.

The level and multiplicity of these mothers' needs mean that interventions with this population are likely to be time and resource intensive; a considerable challenge in a climate where faster and simpler solutions are continuously being sought. The present findings support the view that without appropriate intervention, cycles of trauma are likely only to continue repeating; however, service provisions for these vulnerable parents and their children remain inadequate – a situation which has only worsened due to staff shortages (Macdonald, 2020) and the Covid-19 pandemic, with reductions in face-to-face contacts, service restructuring and staff redeployments (Bear et al., 2020; Conti & Dow, 2020a; 2020b). Further research raising the profile of these women and highlighting the ongoing need for appropriate support therefore seems timely, and of great importance.

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Part 3: Reflective Commentary

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The experience of completing a clinical Doctorate as part of my training as a Child and Adolescent Psychotherapist (CAP) has been immensely challenging yet rewarding; it has shaped me in ways I did not anticipate. In this paper I will offer a summative narrative of this journey, reflecting on what I brought to my experiences and what they brought to me at each stage in the training process. In particular, I will highlight the way in which learning to conduct academic work alongside emotional and psychic work has been fundamental for me in finding a greater sense of personal integration as both a researcher and therapist.

Beginning the journey

When I first began this training, my analyst pointed out that I would interchangeably use the terms 'Doctorate' and 'therapy training' depending on my state of mind; we came to understand that this reflected my struggle to integrate the academic and emotional parts of myself. I had studied psychology in university and enjoyed completing quantitative research, finding comfort in systematic processes and categorical answers; at this time, I had imagined myself to train as a Clinical Psychologist, liking the idea of carrying out doctoral-level research alongside a professional training. Though my hobbies and personal interests centred around more creative and spiritual pursuits, such as the performing arts and yoga, there was typically a split in the way I saw these interests in relation to my psychology studies; the former being more aligned with my emotional and creative self, and the latter being more aligned with my identity as an academic. This shifted considerably when, having become increasingly interested in working with children, I embarked on a MSc in Developmental and Clinical Psychology at the Anna Freud National Centre for Children and Families (AFNCCF) and discovered psychoanalytic theory for first time. I fell in love with this different way of thinking and writing which seemed to offer

the integration of psychology, science, the arts, mind-body theories and spirituality that I had been unconsciously yearning for, and at this point I decided I wanted to begin my own psychoanalysis and apply to train as a CAP. Yet bringing together my wish to be structured, formulaic and goal-oriented in my work, and my wish to allow for free association, creativity and fluidity, was a far greater struggle in practice than in principle; I felt this keenly as I wrote my Infant Observation and Work Discussion papers and completed my first exploratory, qualitative research project on the MSc. While I had begun considering the role of my psychological defences in these struggles through my analysis, they were nonetheless relatively intact when I started my CAP training.

First Year: Clinical Audit

When we began discussing the clinical audit in our first year, I recall having mixed feelings. In one sense, amidst the anxieties of finding my feet in a new role, I felt comforted by the idea of a quantitative research task with clearly defined remits. In another sense, I felt resentful that the assignment seemed to be at odds with the psychoanalytic thinking in which I was trying to immerse myself; we were being asked to look at possibly very rich information about some aspect our service, but *only* to measure it against a predefined clinical standard. As I approached the task, however, enquiring amongst colleagues how I could make this most useful to our team, I began to realise that this was also an opportunity to build relationships with them, and improve my understanding of the pressures we were under as a service. My manager had just decided to launch a Quality Improvement (QI) project on reducing our treatment wait-times, so it was conveniently agreed that I would complete a wait-time audit to inform this. I enjoyed carrying out the audit and seeing the value of my findings; we learned we were consistently in breach of our service

standard and, since I could not resist exploring the data further, that there were significant inconsistencies in our system of allocating cases for treatment. I was asked to present my findings to the service Clinical Effectiveness Group and to attend a national NHS QI awards ceremony when our project won an award; I therefore gained invaluable experience of carrying out and presenting research to inform clinical practice within the NHS, as well as building professional relationships across the service. I also gained valuable insight into the impact on patients and clinicians of long waiting times for therapy, which increased my sensitivity to this issue in my work. This said, the project still felt somewhat at odds with our more psychoanalytically-oriented work and remained, for me, somewhat separate to my own emotional and psychic development. In hindsight, I wonder how much this was related to my anxieties about establishing myself in a new peer group and a new team, and my needing to hold on to familiar defences in the face of this.

Second Year: Proposal and Literature Review

At the end of our first year, we were introduced to possible topic areas for our main empirical project; I felt excited and began to foresee how the research could complement my theoretical and clinical development, though I also felt nervous about how I would manage my time. I was drawn to the group using data from the AFNCCF Early Years Parenting Unit (EYPU; Daum & Labuschagne, 2018), since I'd learned about this programme while studying at the AFNCCF and was keen to understand more about their work supporting parents at risk of losing custody of their children. In fact, I had unsuccessfully applied for a research assistant position on the unit a few years previously. On reflection, I wonder if this felt like a kind of second chance. My interest in this field had also been stimulated by beginning to work with looked-after children and families in my clinic. Working with traumatised parents was

often where I felt most out of my depth, so the opportunity to immerse myself in research on this topic felt very attractive. I was delighted to be allocated to this project and, as we began our second year discussing possible research questions in group supervisions, I decided quite quickly on the idea of conducting a qualitative study exploring Parent Development Interviews (PDIs) of mothers on the programme.

As I designed my proposal, my struggles between a desire for open exploration, and a desire for structure, formula and more concrete 'answers' came again to the fore. As I did some initial background reading about the PDI and parenting representations, and noticed the lack of qualitative research which might capture the nuances of parents' subjective perspectives and experiences, I felt resolute in my decision to explore the data qualitatively. However, I was also drawn to some of the quantitative findings I encountered – particularly those linking features of parenting representations with difficulties in the parent-child relationship and suggesting such features might be used to 'predict' relational difficulties. I wanted to do both: I wondered about the possibility of retaining the richness of a qualitative analysis while also capturing something predictive. In the context of our data, I wondered if one might observe qualitative differences between the interviews of mothers who went on to successfully complete the intervention and retain custody of their child, versus those who did not. These thoughts largely guided my proposal to thematically analyse the pre-intervention interviews of a sample of mothers amongst whom half had later dropped out of the programme and lost custody of their child and half had completed and retained custody.

I think my fantasies at this time about finding concrete answers and predictions in qualitative data were largely underpinned by my unconscious anxieties

about uncertainty. Despite moving into the third year of my personal analysis in which I was often thinking about these anxieties, and increasingly practicing a position of 'not-knowing' in my clinical work, my defences were still easily activated, especially once I put my 'academic' hat on. This was highlighted to me when I presented my proposal to the year-group; I was strongly encouraged by one of our course leads to step back from thinking about comparisons between 'custody-lost' and 'custody-retained' mothers while analysing the data, as this might detract from my aim of seeking a deeper understanding of these mothers' subjective perspectives of parenting. This made sense, and my supervisor and I decided that while it may still be helpful to have a sample balanced between mothers who completed the programme and those who dropped out, I should be 'blind' to this information so as not to influence my analysis. After these meetings, as I wrote my research diary, it dawned on me that I had followed a similar pattern in my MSc research of trying to incorporate a predictive element to a qualitative analysis, which was in fact the reason my paper had been rejected from publication by the journal I submitted to. While I moved swiftly on to thinking about the literature review, I believe the seeds were planted here for crucial further self-reflection.

The literature review was probably the most challenging part of the research journey for me. This is not least because of the difficulties of the task itself and my struggles previously described, but also because at this stage in the training we were greatly affected by the Covid-19 pandemic. We were just in the process of brainstorming our literature review questions when all teaching, clinical work and personal analysis moved online. Over the next few months, my enthusiasm to continue thinking and reading around my research topic was lost. I felt drained of my usual resources due to the challenges of trying to contain the suffering of my patients

in this ‘remote’ way, alongside the impact on my own personal life; I also struggled to meet the deadline for a case report paper at this time. It helped that I was not alone in these feelings, however, and despite being online, our group research supervisions became increasingly valuable to me. We shared our struggles while our supervisor held the space and offered suggestions for making the work more digestible, but also reassurance that we must allow leeway for these exceptional circumstances. At this point, I became more consciously aware of some of the parallels between my experiences of research and clinical supervision, specifically in terms of feeling ‘contained’ (Bion, 1962) or ‘held’ (Winnicott, 1965; 1989). As the lockdown eased towards summer and I returned to my clinic in-person part-time, to my relief I felt motivated to begin reading more again. Just as I had begun reading more about service engagement experiences of mothers with children on the edge of care, I was asked to join a colleague in some parent work with a mother whose child had recently been taken off a Child Protection Plan; I was therefore also reminded how research could complement and inform my clinical practice. This said, I struggled to refine the focus of my reading to a clear literature review question while clinical work was at the forefront of my mind, and I looked forward to our summer workshop week when I could explicitly focus on the research.

On reflection, I think I idealised the opportunity to immerse myself in the literature review in a time when I was not seeing patients, possibly imagining the engagement in a more academic task to offer some respite from the emotional challenges of clinical work. In fact, compiling and writing the review was equally emotionally challenging. Since I had felt great interest in reading about traumatised mothers’ experiences of engaging with professionals, it felt hard to accept that this was peripheral to my primary research question and to let go of several studies I had

read. I grappled with refining my question, though eventually managed with my supervisor's guidance, settling on an exploration of our current understandings of the parenting representations of mothers at risk of parenting difficulties. However, given the dearth of qualitative research in this area, I found myself drawn again into quantitative findings. These studies were intellectually engaging, yet I felt I had somehow again lost a more emotional connection to my initial interest in subjective experiences. Struggling to synthesise the eighty-plus papers I had collected, I created a spreadsheet categorising and summarising findings; everything had begun to feel mechanical. At this point my research supervision and personal analysis were essential in helping me re-discover my creativity. I took several days away from my work and returned to it with fresh eyes, asking myself what *emotionally* resonated with me most from the papers I had read. I realised this was the extracts from mothers, in which I could hear the truth and pain of their stories and recognise links between their past traumas and their current experiences of parenting. I remembered the paper which had been central to my initial interest in this topic – Fraiberg and colleagues' (1975) 'Ghosts in the Nursery' – and, at last, it became possible to use emotional intuition and creativity to guide my writing, as well as cognitive thinking.

Third year: Empirical project

With a sense of having achieved an important 'working through' process with the literature review, I was excited to begin looking at and analysing my research data. I had chosen Thematic Analysis (Braun & Clarke, 2006) primarily based on its suitability for my research aims and its compatibility with psychoanalytic thinking, but also because I was familiar and comfortable with it having used it in my MSc research; it was therefore less daunting for me as I entered the data analysis phase.

Though my interviews were pre-transcribed, I chose to begin by listening and re-listening to the audio recordings; I enjoyed this process as it gave me a more ‘alive’ sense of my participants. Initially, I felt sometimes preoccupied by trying to guess whether a mother might have later lost custody, or what categorisation or score her interview might be given on coding frameworks I had learned about. Reflecting on this in supervision and my personal analysis was helpful, however, and once I allowed myself to become more attuned to my emotional responses to the material, it was possible to adopt a more free-associative stance in listening and annotating. I felt moved by the hardship and trauma of these mothers and was also struck by the prevalence of ‘idealised’ representations in nearly all narratives, comparable to previous findings amongst mothers with babies in prison. These early stages of analysis, complemented by our theoretical seminars on attachment and complex developmental trauma, informed my clinical practice as I found myself thinking more actively in my work with parents about how to be more sensitive to the powerful psychological defence mechanisms they perhaps required to protect themselves from unbearable pain. Our group research supervisions at this time sometimes bore similarities to clinical seminars, as we shared observations of and responses to our interview data, considering participants’ experiences and thinking about themes in the material. I noticed that, in my time management, it felt easier at this point to weave in and out of my clinical work and my data analysis since the processes felt complementary.

In our spring research workshops, I felt proud of my progress as I presented my preliminary data analysis to the year-group; however, I was taken by surprise when asked by one of our tutors when I would be ‘un-blinded’ to which of my participants had later retained custody of their child and which had not. I realised that

having made such efforts to immerse myself in the ‘here and now’ of the data, I had quite forgotten about this part of my project. I wondered about the unconscious function of this forgetting; it had allowed me to openly explore my participants’ narratives without trying to judge or predict their parenting capacity, yet it had also perhaps defended me from thinking about the painful reality that half of these women were not able to keep their children. On my supervisor’s suggestion, I gave her my predictions about who might have lost or retained custody before she revealed the true outcomes. This was much harder than I had previously imagined; I was now more in touch with an awareness that the narratives might only be seen as truly representative of these mothers’ perspectives as shaped by the specific interview context in which they were elicited. This said, there were three mothers whose outcomes I felt relatively certain about: two whose parenting capacity I had felt very concerned about and imagined would certainly have lost custody, and another whom I had seen as earnestly making all efforts to reflectively improve her parenting and imagined would surely have completed the programme and retained custody. When I learned that in fact two of these three predictions were incorrect, as well as three of my other (more hesitant) predictions, I was shocked. The process was eye-opening and humbling; as well as bringing me into closer contact with my emotional responses towards my participants, it also made me more aware of the limitations of the data, and my own limitations as a researcher and therapist. Thinking about the countless internal and external variables that may have influenced whether these mothers were able to remain in the programme and retain custody of their child or not – which would not have been fully captured in one interview – reminded me of the importance in my clinical work of taking time to understand the context of my patients and not leaping to premature assumptions or interpretations. It also

prompted me to reflect further about the immense complexity, and the emotional weight, of the ultimate decision to remove a child from their parent.

Moving into the final phase of writing up my report, I faced familiar struggles with perfectionism, however, these felt somehow less overwhelming than earlier in the training; it seemed more possible now to balance my time between my research and clinical work. While this may reflect a general maturation that I experienced throughout the training, I also wonder if I was able to make better use of my research supervision, as well as my personal analysis, to work through various sticking points. At this stage we were often having individual research supervisions, having agreed as a group that this would be most useful due to being in different phases of our work. I found this very helpful and, having built a strong relationship with my supervisor, felt able to speak openly about my struggles with the writing up process; her understanding and supportive approach helped contain my anxieties on an emotional level while, on a practical level, we also made plans and interim deadlines to help me manage the workload. In this procedural sense, these supervisions now felt very similar to my clinical supervisions. As I prepared my manuscript and received my supervisor's feedback on my initial drafts, I also found myself frequently learning from the alternative or additional perspectives she offered. These were often influenced by her personal experiences of motherhood as well as her professional experience – for example, she often pointed out to me when a more psychoanalytically interpretative comment I had made might have, for a mother, come across as presumptuous or judgemental. This was, again, valuably informative for my clinical practice as much as for my research; I became increasingly sensitive in my use of language with my patients and in writing my clinical notes, and also in the way I framed offers of support or advice to parents. When my supervisor

suggested that we aim to prepare and submit a refined version of my report for publication in the next few months, before I finished the training, I was thrilled at the idea and, now that I felt more on top of my work, it felt achievable.

Final year: Bringing it all together and looking back

As I now approach the end of my clinical training, with the research volume of my dissertation complete and having recently submitted a manuscript for publication, I feel grateful for the opportunity to digest and reflect on this journey; at the centre of which for me has been a progressive experience of integration. My memory takes me back to a visit I made, prior to applying for this training, to another school which did not offer the Doctorate alongside the clinical training; I recall being told they felt this was ‘simply too much to ask of trainees’ given the already immense emotional, psychological and practical challenges involved in training as a CAP. I remember holding on to a conviction that this was not necessarily the case when applying to IPCAPA, yet frequently thinking back to these words in my earlier years of the training. Indeed, finding a way of balancing the different components of the training has been an immense challenge; however, I now believe that this challenge has been fundamental to my personal and emotional growth, giving me a framework within which to learn to access and use different parts of my mind and personality in synchrony. I have come to understand, and *feel,* that I can be both ‘an academic’ and ‘a creative’ at once, and also to recognise that the integration of these different parts of me is essential for my working fluently and effectively as both a therapist and a researcher. Recognising the value in thinking about my struggles with my research in my personal analysis – rather than seeing these parts of the training as entirely discrete – was crucial to this learning experience.

As well as learning and growing from the research process, I have also learned a great deal from its content; this has influenced me personally and professionally. I now have a deeper understanding of the complex interplay between mothers' traumatic early relational experiences and their later representations and experiences of parenting, and the potential significance of reparative relational experiences in ameliorating detrimental outcomes. I have a better understanding of some of the subjective experiences of traumatised mothers with children on the edge of care, and the importance of holding in mind their internal *and* external worlds when making sense of these; all this informs my current approaches in my clinical work. I have been deeply moved by my participants' stories and, when I finished writing my report, I experienced great sadness thinking about the recent closure of the EYPU, and the general lack of specialist support available to these mothers. These feelings have inspired my wish to continue working in this field longer term. I recently interviewed, successfully, for a post-qualification role in a Looked-After-Children's CAMHS team and felt proud to be able to speak about my research during the interview. In further discussion with my service and research supervisors, I have also realised my interest in conducting further research in this field, that may serve as evidence for commissioners and funding bodies to support the need for increased specialist services for parents with complex trauma.

Conclusion

I began this training with a belief that the research component would be formative for me, but also something which I would probably leave behind once qualified. I could not imagine myself finding a way to sustain a balance, in the long-term, between working as both a clinician and a researcher, since I saw these practices as making use of different parts of me. Perhaps the most valuable aspect

of this journey for me has been my embodied experience of discovering that, even in an ‘academic’ piece of work, I can write from my heart and use my emotional intuition. In fact, my work is all the richer when I do, much like my work as a therapist. I hope that, as part of a new generation of dual-trained CAPs, I can continue to hold on to this feeling of integration, and engage further with research as something which informs and enhances my clinical practice not only theoretically, but also psychically and emotionally.

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