Maternal Depression, Reflective Functioning and Toddler Play in the Anna Freud Centre's Parent-Toddler Groups: A Mixed Methods Study

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Submitted for the
Degree of Doctor of Philosophy
2023

I, Fernanda P. Ruiz-Tagle G. confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

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Date: 5th October 2023

Acknowledgements

Firstly, I would like to thank my supervisor Dr Inge-Martine Pretorius. You have been a constant supportive and caring figure throughout this process and for that I am forever grateful. Thank you for showing me the wonderful world of early years and toddlerhood. You are truly an exceptional teacher.

I would also like to extend my gratitude to my supervisors Dr Liz Allison and Dr Patrick Luyten who guided me and shared their knowledge on both research in psychoanalysis. You both have been very patient and have allowed me to write a thesis worth submitting. I have learned very much from the both of you.

I am grateful to the UCL Unit of Psychoanalysis for allowing me to experience this journey, to ANID Chile for funding my project and to Dr Jo Russell for her support and advice.

To my UK-based friends, thank you for the encouragement and the containment, especially in difficult times: Eftychia, Victoria, Catalina, Andrea and so many other lovely people I encountered during these years. A very big acknowledgment to my UK-based home: my sisters Ximena, Ashley and Paula who always had the right word and the right kind of chocolate. To Conor Morgan, boyfriend extraordinaire, thank you so much for never giving up on me, for loving me and caring for me. I love you.

To the three people who are a big part of every single one of my accomplishments: My incredibly loving parents and my amazingly kind sister. I could never accurately state in such a short amount of space everything I am grateful to you for, so I will just say thank you for loving me the way you do and for being there every step of the way as if these 7,205 miles between us did not exist. Infinitas gracias, los amo.

Lastly, I would like to thank the families who selflessly allowed their experience to be recorded, as they made this project possible. I truly hope my work can contribute to the wellbeing of many other families like them.

Abstract

This research project explores the impact of maternal depression on toddler play using data from the Parent-Toddler Groups (PTG) Service at the Anna Freud Centre in London, United Kingdom. The literature review of this project offers a review of the concept of toddlerhood and maternal depression mainly from a psychoanalytic perspective as well as a review of the evidence for different models of parent-child interventions. Two studies were conducted. Study One is a statistical analysis of maternal reflective functioning in the presence of depression, with a sample of 28 mothers. Study Two offers a qualitative multiple case study of toddler play in relation to maternal depression including 10 participant dyads. Results suggest that mothers without depression showed improvements in their reflective functioning when attending the PTG, whereas mothers with depression did not show any changes pre- to post-attendance at the PTG. Possible explanations for these findings are explored. Furthermore, results also suggest that children of depressed mothers in this study can present a decreased capacity to play, where the most affected areas are symbolic and social play. Limitations of this study and its clinical implications are discussed and suggestions for further research are proposed.

Impact statement

Postnatal depression is a multifactorial phenomenon where biological, psychological, and social factors are involved. It affects between 10% and 20% of women, however, not only does it leave these women vulnerable, but also their young children, as it is likely they will see their own development impaired due to their mother's symptoms. This means the percentage of people who are affected by maternal depression can become significantly higher. Maternal depression consequently should be approached as a public health issue, especially when many of its risk factors are related to social vulnerability.

This research project explores the impact of maternal depression on toddler play in the context of a psychoanalytically informed parent-child intervention that aims to support child development by facilitating attunement in the mother-child relationship. It is hoped that this piece of research can become a contribution to the current knowledge on maternal depression and its impact on child development, in order to bridge the gap in social care for this population, through the generation of evidence for future policies and health services.

It is also hoped that this project can contribute to the practice of thorough psychoanalytic research where theory can be assessed and improved in order to offer the best possible clinical practice to others.

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Introduction

The present research project aims at exploring the influence of the Anna Freud Centre's Parent-Toddler Groups on the Reflective Functioning of mothers with depression, as well at the impact of maternal depression on the toddler's capacity to play.

In the UK, between 10% and 15% of new mothers may develop Postnatal Depression (RCPsych, 2018). Similar numbers are found in the United States (15%) (National Institute of Mental Health, n.d.) and a slightly higher average in some countries of Latin-America (20%-30%) (Aramburu et al, 2004: Moreno, Domingues & Sergio, 2004; Dois, 2012). Some of the main risk-factors for the development of postnatal depression include a previous history of psychopathology and psychological disturbance during pregnancy, poor marital relationship, low social support, stressful life events and low social status (O'Hara & Swaine, 2009; Ghaedrahmati et al., 2017; Silverman et al., 2017; Hutchens & Keraney, 2020). Research on the effects of maternal stress and depression on children's development suggests that children of depressed mothers are at higher risk of developing emotional, behavioural and cognitive impairments (Goodman et al, 2011; Liu et al, 2017: Madigan et al, 2018) and the role the mother-child relationship plays in this phenomenon has been well established (Fraiberg, Adelson & Shapiro, 1975; Fonagy et al 1991; Zeegers et al, 2017). In order to promote the dyad's attunement and support the child's development, the Anna Freud Centre's Parent-Toddler Groups provide a preventative and therapeutic space that is psychoanalytically informed.

Psychoanalytic theory has devoted a great deal of attention to the importance of the early years and the affective environment surrounding a child, as well as the influence of early experiences in the emergence of psychopathology. From his early work, Freud theorised around the early origins of his patients' current adult symptoms as a way to treat them (Freud 1905, 1909). Later his daughter, Anna Freud, through direct observations and a psychoanalytic lens, sought to test her father's theories on infancy and childhood, not only in order to clarify what could lead to pathology but also to determine what was expected as healthy and normal

development, as well as to elaborate a method to support children's wellbeing (Midgley, 2007). Melanie Klein (1935) would also elaborate on the early experiences of babies and their relational objects, but it would be Winnicott who would pay particular attention within psychoanalysis, to the importance of a child's environment. Winnicott stated 'there is no such thing as an infant' (1960), underlining that the young child cannot exist without the care of his environment. In this sense, psychoanalysis has built a theory of developmental psychopathology with a thorough theorisation of intrapsychic processes, intersubjectivity and mechanisms of change (Fonagy & Target, 2003).

In most psychoanalytic thinking, the role of the mother-infant relationship is considered as pivotal. This is an aspect that contemporary psychoanalysis has in common with other theories of child development such as attachment theory (Fonagy, 2018), where concordances in terms of the therapeutic work carried out with mother-child dyads and some conceptions of what is considered a 'good enough' or 'sensitive' mother, as well as what constitutes healthy development can be found.

This study focuses on how maternal depression presents in the context of a parent-child intervention such as the Anna Freud Centre's Parent-Toddler Groups, its relation to mentalisation and its potential effects in the development of child's play. Mentalisation is defined as the ability to understand one's own behaviours and the actions of others in terms of underlying mental states, such as thoughts, feelings and wishes (Fonagy & Target, 1997) and an optimal parental capacity to mentalise has been associated with healthy child development (Slade et al., 2005). Depression could hinder a mother's capacity to mentalise for herself and her child (Murray and Cooper, 1997; Murray, 2003; Alto et al., 2021; Georg et al., 2023) and maternal depression has been associated with socio-emotional impairments during toddlerhood (Valla et al., 2016; Granat et al., 2017; Camisasca et al., 2017).

Several authors believe in the relevance of supporting a mother suffering with depression given that it is not just her who is impacted by this presentation but also her developing young child (e.g. Nylen et al., 2006; Forman et al., 2007; Stein et al., 2018). Different models have been developed to treat mothers with

depression, whether it is in an individual therapeutic setting, groups or with their child present. As the literature review of this project will show, most approaches have some benefits, but as yet there is no agreement on what modalities yield the greatest benefits not only for maternal mentalisation and mood but also for child development.

Furthermore, this study explores the impact of maternal depression on toddlerhood, which is a pivotal stage in human development where important developmental milestones take place. During toddlerhood, a child takes his first steps towards autonomy, affect regulation, empathy, language, etc. However, for healthy development, an appropriate material and emotional environment is required (Winnicott, 1971) and an indicator of a toddler's progression in development is their capacity to play. Theory and research suggest that children of mothers with depression present a decreased capacity to play (Greenspan & Lieberman, 1994; Tingley, 1994; Lous et al., 2000; Emanuel, 2006; Halfon, 2017; Chazan & Kuchirko, 2019), However research in this area is still limited.

The Anna Freud Centre's Parent-Toddler Groups have been under-used as a setting for formal research studies and relatively little large-scale, systematic research has been conducted of the AFC PTGs (Woods & Pretorius, 2011), therefore an opportunity is found in this service's database for research on parent-toddler relationships and toddler development.

This research project uses mixed methods to approach the subject of maternal depression, its relation to mentalisation and its influence on toddler play. The theoretical sections. The theoretical section of this project includes three chapters. The first one focuses on understanding maternal depression, its risk factors, psychoanalytic conceptualisations about it, and its relationship to mentalisation and its impact on the Young child. The second chapter addresses the developmental stage of toddlerhood, its definition and main milestones in relation to the toddler's affective environment and the potential impact of maternal depression on these developmental achievements, considering the pivotal role of play during this stage. Thirdly, the last theoretical chapter consists on a review of the existing models of intervention to support the mother-toddler dyad in the presence of maternal depression, the contributions of psychoanalysis to these

models and how these interact with outcomes such as maternal symptoms, mentalisation and the mother-child relationship. Furthermore, the first study in this project uses quantitative methods to explore the mentalising capacity of mothers with depression in the AFC parent-toddler groups and whether their use of the groups enhances this capacity, while the second study uses qualitative methods to investigate play variations in toddlers of depressed mothers as opposed to typical play presentations.

The contribution this research projects aims at providing is of both theoretical and empirical nature, as psychoanalytic theory is applied and tested, allowing some bridging of the gap in current knowledge where questions around the effect of depression on child development as well as the efficacy of different treatment models still arise. Similarly, children's play during infancy and toddlerhood remains to be further explored and studied. It is also hoped that this research can contribute to the practice of rigorous research in the discipline of psychoanalysis.

Chapter 1. Maternal depression

This chapter will review the concept of maternal depression, its symptoms, risk factors, and impact on the developing child. Different theoretical perspectives are considered where the psychoanalytic lens plays an important part. Later, links between maternal depression, intergenerational trauma and mentalisation are drawn.

1.1. Definition

Postnatal Depression (PND) is defined as a major depressive episode with onset during pregnancy, or within 4 weeks or 1 year postpartum (American Psychiatric Association, 2013). A consensus regarding the onset of this mood disorder is not clear as it shares a similar overall symptom profile with major depression disorder (MDD), including anhedonia, feelings of guilt, appetite and weight changes, impaired concentration, irritability, lethargy, persistent sadness, sleep disturbances, and thoughts of self-harm or suicide. Common PND symptoms can also include crying more often than usual, doubting one's ability to care for the baby, feeling angry, feeling guilty about not being a good mother, feeling disconnected from one's baby, feeling numb, withdrawing from loved ones and worrying about hurting the baby.

Postnatal depression (PND) occurs at a critical time in the developing relationship between mother and baby, when the infant is very receptive to the subtlest movements of feelings and expressions communicated between mother and child (Cooper & Murray, 1997). Furthermore, it has been associated with pre-term birth and low weight at birth (Davalos et al., 2012), motility difficulties in the first month (Smith et al., 2012) and socio-emotional impairments during toddlerhood, such as poor socio-communicational skills, poor or increased self-regulation as well as externalising and internalising behaviours, amongst other difficulties (Valla et al., 2016; Granat et al., 2017; Camisasca et al., 2017; Alto et al., 2021). Depression with onset during pregnancy is also associated with a heightened risk of maternal substance abuse, pre-eclampsia, preterm delivery and low infant birth weight (Zar et al., 2019). It is also important to note that the leading cause of

direct maternal mortality during the first postpartum year is maternal suicide, accounting for 1 in 7 deaths (Adis Medical Writers, 2019).

1.2. Risk factors

The origins of postnatal depression have been studied, although research is still limited and not entirely conclusive. A history of anxiety and mood problems, especially anxiety and depression left untreated during pregnancy, might be the strongest risk factor for PND. Women with previous episodes of PND have a recurrence risk of approximately 25% (Frieder et al., 2019). Other risk factors include previous experience with depression or bipolar disorder, family history of depression or other mental illness, mixed feelings about the pregnancy, a stressful life event during pregnancy or postpartum, childbirth complications, lack of strong emotional support, and drug or alcohol abuse problems (Saur & Santos, 2021).

Psychosocial risk factors that might increase the risk of PND in women include high life stress, lack of social support, current or past abuse, prenatal depression, and marital or partner dissatisfaction (O'Hara & Swaine, 2009; Ghaedrahmati et al., 2017; Silverman et al., 2017; Hutchens & Keraney, 2020). In this sense, mental health history, perceived stress and chronic strains such as work and financial demands more consistently predict PND in women, which might also be related to their socio-economic status (Castro & Couto et al, 2015). According to Yim et al. (2015) higher parenting stress would be a risk factor, as well as the quality of a woman's relationships in the perinatal period, where the relation to her partner and own mother seem to be the most pivotal. In this sense, a supportive relationship would be a protective factor against PND, whereas an abusive one would correlate with a higher risk. According to Yim et al. (2015) PND can be thought of as a psychological adaptation or by-product of modern civilisation, facilitating maternal disinvestment in offspring that are unlikely to survive and later reproduce, also broadcasting the need for support. These authors also propose that it may be a disease of our times in society, as early weaning, low fatty acid consumption, Vitamin D deficiency, sedentary lifestyles and isolation from family are more prevalent today than ever and all these factors have been associated with risk of PND.

In terms of the genetic contributing factors, several studies refer to the possible relation between the risk of developing PND and polymorphic variations in candidate genes within the monoaminergic system (MAO, COMT, 5HTT) involved in the process of affective regulation and cognition (Castro e Couto et al., 2015; Mitchell et al, 2011; Pretorius, 2009; Yim et al, 2015; Elwood et al., 2019). Yim et al. (2015) cite evidence regarding interactions between polymorphisms in the serotonin transporter gene and stressors, as well as a relation between PND and the oestrogen receptor, the oxytocin peptide, the glucose corticoid receptor and the CHR receptor 1 genes, where low oxytocin antenatal levels and corticotropin-releasing hormone (CRH) accelerated trajectories and higher levels in mid-to-late pregnancy can be risk factors. At the same time, these authors propose that some of these individual factors can interact and act together as a risk factor, for example, cortisol levels may affect gonadal and inflammatory processes, stimulating increases in placental CHR and impairing serotonin function. These genes have been also related to other psychiatric disorders such as Major Depressive Disorder (MDD) and some authors argue that PND is only a temporary and more specific presentation of the former (Castro e Couto et al, 2015). Currently under the fifth version of the Diagnostic and Statistical Manual (DSM-V), postnatal depression appears a subcategory under some of the broader diagnostic categories of depressive disorders. However, according to Pawluski et al., (2017) PND is likely not a mere extension of MDD as they have different neurobiological activation profiles and assuming PND as part of MDD would be overlooking the role of brain regions known to be particularly relevant for mothering and maybe only affected by maternal mood. Other authors believe that regardless of whether or not PND is a sub-category of MDD, the fact that it occurs around the birth of a child makes it worthy of special consideration due to its implications for the mother and baby (De Crescenzo et al., 2014). In this sense, a crossover between a woman's genetic vulnerability and her exposure to some or all of the mentioned psychosocial risk factors, could result in a higher probability of developing PND.

According to Vliegen et al. (2014), 30% of PND affected mothers in community samples and 50% in clinical samples continue to have major depression during their child´s first year and beyond, presenting in subgroups of mothers showing

(1) chronic major depression, (2) stable minor depression or (3) recurrent major depression without full recovery between episodes, suggesting that mothers that present PND cannot be considered a homogenous group. The authors relate chronic PND with lower quality of partner relationship, history of depression, sexual abuse, lower quality of maternal care, higher parental stress, contextual risk factors and personality-related vulnerability. In this sense, the chronic course of PND would be associated with higher levels of contextual risk that are stable over time, suggesting repeated or chronic exposure to stressful life circumstances.

1.3. Psychodynamic conceptualisations of maternal depression and its impact

Psychoanalytic theory and psychotherapy has focused on the underlying psychodynamic and developmental issues of depression rather than its manifest symptoms (Cregeen et al., 2017). This has provided a contribution to the understanding of depression and its origin as well as a clinical presentation that is not homogeneous. On the basis of the subject's life story, some psychoanalysts differentiate between a depression focused primarily on interpersonal issues such as dependency, helplessness, and feelings of loss and abandonment and a depression derived from an internalised self-criticism, concerns about self-worth, and feelings of failure and guilt, (Blatt, 1997). In the specific case of maternal depression, psychoanalysis has offered an understanding of its onset where it is believed mothers who suffer from depression have internal conflicts related to dependency, anger, and motherhood itself (Blum, 2007).

According to Blatt (1974) there are two main 'types' of depression: anaclitic and introjective. According to the author, anaclitic depression would be related to an early narcissistic injury and loss of the object, linked to what was described by Spitz in 1946. This type of depression presents as a need for gratification and therefore its primary feelings are those of helplessness and not being loved as well as a significant fear of being abandoned. Anaclitic depression is characterised by difficulty expressing anger and rage for fear of destroying the object as a source of satisfaction and there is relatively little internalisation of the experiences of gratification or of the object providing the satisfaction. This leads

to a constant demand for the visible and physical presence of objects, and separation and object loss are dealt with by primitive means, such as denial and a frantic search for substitutes. Abraham et al. (1911/1965) believed this was the prototype for melancholia. On the other hand, an introjective type of depression would be related to a punitive superego, meaning it has its origins in a slightly more developed stage in life, such as when oedipal conflicts are in place. In this type of depression there are concerns about receiving love and approval from the object, as well as about the object's response to and acceptance of one's feelings of love for the object. The relationship with the object is ambivalent, and the subject is unable to resolve and integrate the contradictory feelings. Rather than denial, the main defence here would be introjection or identification with the aggressor, tending to assume responsibility and blame and to be harsh and critical toward the self. Lastly, compensatory and restitutive hypomanic reactions in introjective depression do not require direct and physical contact with the object, but rather involve more symbolic derivatives such as recognition, approval, and material possessions.

Many links have been drawn between depression and a difficulty to express aggression, as a displacement of aggression towards the self (Bleichmar, 1996). In both types of depression exposed by Blatt, there is a part of the self that needs to be repressed, that is the potential anger towards the object that cannot be expressed for fear of losing its love and approval. These types of depression can also be observed in postnatal depressive episodes, and so can their links to transgenerational conflicts.

In line with Blatt's proposal, Beebe et al. (2007) conducted a study where they described two types of presentations in postnatal depression: the self-critical type and the dependent type. The first, similar to Blatt's introjective type, presents an excessive concern with self-worth and achievement, whereas the second, similar to Blatt's anaclitic type, presents an excessive concern with interpersonal relatedness. In their study, the authors concluded that self-critical mothers tend to be more concrete and controlling in their mothering, needing support to become more attuned with the baby's emotional cues. In contrast, the dependent mothers tend to become almost over-attuned as they might feel an intense need

for their child to engage with them. Therefore, they might need support leaving space for their child to disengage and differentiate.

The postpartum period involves a regressive trend that allows the mother to identify with her baby's needs and to be necessarily preoccupied almost exclusively with these. In healthy women, this trend is expected to be only temporary (Winnicott, 1956; Blum, 2007). However, for mothers who present with PND, something has been triggered with the birth of their baby that makes inhabiting a more functional state of mind a much harder task. A study conducted by Menos & Wilson in 1998 concluded that women with PND return to two main earlier modes of functioning: (1) a pre-subjective period of development where there is a limited distinction between self and others and the main feeling states are pleasure and unpleasure and (2) a transitional period where others are seen as 'separate but attached', a polarised fashion of good and bad, where separation, autonomy and intrusiveness are the main issues.

Several authors propose that the birth of a child and motherhood is an experience that confronts the new mother with a three-generation identity transformation: she sees herself as a mother to her child and as a daughter to her own mother (Halberstadt-Freud, 1993; Stern, 1995; Blum, 2007), which can be accompanied by a revival of past conflicts and anxieties. Halberstadt-Freud (1993) proposes that women who present with PND are still merged with their own internal imaginary mother, have remained more dyadic than triadic, and cannot afford to allow anything resembling separation or individuation to take place. The new mother tends to imagine the child as a part of her physical and emotional self and sees it as indispensable to her well-being. In this way, the imaginary and the real baby are not sufficiently distinguished, the baby´s crying becomes her own, and she faces an intensification of her own baby wishes and desires in relation to her internal mother, which she tries to deny and by this she loses sight of the real baby and its needs. According to this author, a mother with PND can only solve this conflict by hating her mother, her baby or herself, and through reaction formation she becomes too devoted, leaving no room for herself, unable to leave the baby alone. She resents the baby who forces her to take responsibility instead of being taken care of and enabled to mourn the mothering she missed. In this

sense, by an identification with a strong maternal super-ego, the new mother repudiates herself for having these feelings.

Similar ideas are elaborated by Blum (2007) who proposes three areas of conflict in the course of PND. The first one is dependency: the baby may arouse the mother's own unconscious wishes to be cared for and fed. If the mother cannot accept her dependent needs and ensure that she is in fact taken care of, and if she cannot tolerate her baby's dependency and her reactions to it, she would be vulnerable to developing PND. The second area is anger: Blum acknowledges how normal it might be for a mother to feel anger towards her new baby as it demands so much of her; however in PND he postulates a punitive super-ego that brings excessive guilt or fear of this anger, which may then be turned against the self in the form of depression. A third area of conflict is around motherhood: like Halberstadt-Freud above (1993), Blum proposes that mothers with PND may feel their own mothers were not interested or did not enjoy taking care of them as babies.

Additional to the mother's experience of having to take care of her baby, there is the added component of what the baby itself might bring to the relationship. According to Murray & Cooper (1997) poor motor functioning and neonatal irritability significantly increase the risk of the mother becoming depressed, thus suggesting that the infant's contribution to maternal depression can also be significant. Furthermore, Tronick (2007) proposes a model of mutual regulation, where mother and infant regulate affects through interactions in which affective mismatch and repair occur continuously, and contends that for mothers with PND, this capacity for repair would be compromised. Similarly, Salomonsson (2013) proposes a circular causality, where maternal negative mood compromises the child's functioning which then makes her mood even more negative, as well as innate factors in the baby, such as temperament difficulties, that may also contribute to the mother's sense of hopelessness.

1.3.1. Relational trauma

Maternal depression can often be related to the mother's relational past (Halberstadt-Freud, 1993; Stern, 1995; Blum, 2007). In this sense, Fraiberg and

colleagues' work published as 'Ghosts in the Nursery' in 1975 is a relevant piece. Freud (1909) stated that 'A thing that cannot be understood inevitably reappears; like an unlaid ghost, it cannot rest until the mystery has been resolved and the spell broken' (p. 122). Building on Freud's assertion, Fraiberg and colleagues worked on a clinical project involving troubled young parents and their babies, as an attempt to conceptualise the origin of the dynamics within these dyads. The 'ghosts' served as a metaphor for the visitors from the repressed past of the parents, as parent and child could find themselves "re-enacting a moment or a scene from another time with another set of characters" (p.388) which refer to the parent's childhood. According to these authors, the ghosts' activity was seen mainly in daily events such as feeding, sleeping, toilet training, or setting boundaries, depending on the vulnerabilities of the parental past. They wondered about the factors that would facilitate the repetition of conflicts from the parents' past in the present. Through their work with families and children, they found that in those parents in which the ghosts of the nursery had taken hold, there seemed to be a pattern: "these are the parents who, early in the extremity of childhood terror, formed a pathological identification with the dangerous and assaultive enemies of the ego, that is identification with the aggressor" (p.419).

In their search for ways to help parents and their children, the authors found that the key was in the fate of affects during childhood, since these parents seemed to have dissociated and repressed the affect associated with the memories of their own painful experiences as children. Their hypothesis was "that access to childhood pain becomes a powerful deterrent against repetition in parenting, while repression and isolation of painful affect provide the psychological requirements for identification with the betrayers and the aggressors" (p.420). Therefore, their work with families was aimed at allowing the parent to connect their experiences with the affect they once needed to repress to identify the haunting ghosts and their influence.

According to Daniel Schechter (2004) the parent's active role in the intergenerational transmission of trauma is clear, and therefore the treatment he proposed was focused on the mother's trauma-related distress, defences against trauma-associated affects, as well as on altering trauma-related mental

representations. However, according to Schechter, Fraiberg's case descriptions often also represent the infant as a passive recipient-host of the parent's trauma. He notes that the understanding of intergenerational violent trauma and maltreatment has broadened to accommodate greater complexity.

In this sense, while the parent may, despite her best intentions, set up her child for traumatic exposure via the 'compulsion to repeat' (Freud, 1920), the child's response to the parent and the parent's subsequent response to the baby's response, would be considered equally important. The infant and very young child can break through avoidant and dissociative parental defences with his or her unmodulated negative affect, with some children having an especially potent effect on the traumatised parent because of the young child's particular temperament.

According to Schechter (2004), a further significant aspect is the notion that the trauma-related enactment(s) by the parent would not be a direct repetition but rather a present affect-laden communication about past experience, occurring at particular points in her own and her child's development. In other words, relational history will not be identically repeated but will be filtered through the vicissitudes of unprocessed trauma across the intervening years. Schechter (2004) asserts that the child is therefore a much more of an active contributor to the intergenerational process than hitherto understood: "By rapidly shifting, intensely displayed outpourings of unmodulated affect from the infant or very young child's not-yet-mentalizing mind, buried, dissociated, or otherwise avoided feeling states may be unavoidably rekindled in the caregiver's mind" (p. 205).

Depending on whether the caregiver is able to reflect on this rekindling, it could lead to the mother–infant relationship moving forward, or to significant difficulties for onward differentiated development. The child will attempt to adapt to the communication of parental traumatic experience and may experience the communication by the parent as traumatic, developing a complex adaptation to this parental behaviour both to protect himself and to keep the parent engaged. This adaptation would be at the expense of the child's feeling of agency and safety in exploration or in guiding the relationship forward. The infant inadvertently both leads and follows the post-traumatically stressed mother into

her ‘sphere’ of trauma-associated references in order to continue to share her affective presence.

1.3.2. Maternal depression and its impact on mentalisation

Mentalisation is defined as the ability to understand one’s own behaviour and the actions of others in terms of underlying mental states, such as thoughts, feelings and wishes (Fonagy & Target, 1997). It is thought to evolve gradually in the context of the parent-infant relationship and depends mainly on the parent’s capacity to contain the child’s affects and to anticipate and adjust to the infant’s psychical and psychological demands (Fonagy et al., 1991). The parental capacity to recognise a personal psychological experience in the child and subsequently respond and reflect upon it allows the child to develop an understanding of his emotions, promotes self-regulation and helps build a reflective capacity for the child.

The capacity to reflect upon mental states is linked with psychological health, and it is not individual in its roots, as the development of a sense of one’s own mind and of other people’s minds takes place in the early relationship with others (Fonagy et al, 2002; Music, 2017). Therefore, neglect and abuse can be predicted to confer a risk of inability to connect with other people’s feelings and with the normal development of empathy (Main, 1985). The way the primary carer perceives and responds to a child’s physical and emotional needs will serve as a prototype for all subsequent relationships in adulthood, including the next generation of care-giving relationships (Sroufe et al., 1999).

In 1991, Fonagy and colleagues elaborated on Fraiberg’s theory with their study ‘Measuring the Ghosts in the Nursery’. This study involved expectant parents and their babies and concluded that parents’ attachment classification, their reflective capacity towards their child and the child’s attachment organisation were closely related. In other words, the study suggested that the intergenerational transmission of a secure pattern of attachment might depend on the caregiver’s capacity for mentalisation. According to Slade et al. (2005), a mother’s capacity to hold, in her own mind, a representation of her child as having feelings, desires, and intentions, allows the child to discover his own internal experience via his

mother's representation of him. Representations can be understood as a mental 'picture' resulting from the process of interpersonal experience that help humans to make sense of each other (Fonagy et al., 2002). It is the mother's observations of the changes in the child's mental state, and her representation of these first in gesture and action, and later in words and play, that is at the heart of sensitive caregiving, and is crucial to the child's ultimately developing mentalising capacities of his own.

According to Hobson (2002), the development of a mind and the ability to think are intrinsically related to the interaction and quality of the mother-infant relationship. The author emphasises the importance of the adult's capacity of having a mental space to think and name the child's states of mind, allowing him to feel understood and kept in mind. Moreover, the infant's growing capacity to interact and notice the world around him, evokes the mutual exploration of objects with his caregivers. This enhances an important developmental milestone described as joint attention and mutual shared attention to the same object, implying that both the infant and the caregiver have the same object in their minds (Emde, 1980; Bretherton, 1992). In this sense, the lack of joint attention and proto-declarative pointing might indicate that the toddler could struggle to empathise and comprehend other people's minds (Music, 2017).

A high maternal capacity for Reflective Functioning (RF), which is the operationalisation for the concept of mentalisation, would be linked to children with secure attachment, and a low capacity for RF is correlated to insecure attachment (Slade et al., 2005). In this sense, the parental capacity to reflect upon a child's mental states, would be the variable that links adult and infant attachment style could explains the transmission of attachment patterns from one generation to the next.

According to Murray et al. (2003), if a mother is suffering from postnatal depression, it can be difficult to focus on the baby's experience since the mother's preoccupation with her own feelings may cause her to miss the infant's cues and appear withdrawn. Postnatal depression can also be associated with intrusive and even hostile play on the part of the mother when she may fail to recognise the baby's discomfort and persist in trying to gain the baby's attention. Murray

(2003) asserts that depressed mothers are more likely than non-depressed mothers to give up breastfeeding early, and more likely to report difficulties managing their infant's crying and demands, since the mother may have a perception of the infant as a drain and hindrance to her, and she may also be struggling to adapt to a new identity as a parent.

Furthermore, a mismatch in attunement between mother and baby during infancy resulting from postnatal depression (or contributing to maternal depression) is associated with impairments in infant cognitive and emotional development, such as notably poor performance on object permanence tasks. They also associate maternal speech, which can be less infant-focused and more mother-focused in a mother suffering from depression, with difficulties in the infant's cognitive abilities (Murray & Cooper, 1997).

The association between Postnatal depression and Parental Reflective Functioning is not clear (Krink et al., 2018) however it has been argued that it can impose a limitation on mentalising and sensitive responsiveness towards the infant (Fischer-Kern et al., 2013, 2019; Ramsauer et al., 2014; Suardi et al., 2020; Alto et al., 2021). Luyten et al. (2017) reported a trend for pre-mentalizing modes (PM) to correlate positively with symptomatic distress, meaning that in the presence of heightened anxiety or depression mentalisation can decrease. According to Nijssens et al. (2020), distress activates the attachment system causing impairments in mentalizing, which can be accompanied by the use of PM. Furthermore, perceived stress and chronic strains can be a risk factor for PND in women (Castro e Couto et al, 2015) and stress is also associated with difficulties in reflective functioning (Luyten & Fonagy, 2015).

1.3.3. Measuring maternal reflective functioning

The Parent Development Interview (PDI) is the gold standard measure of Parental Reflective Functioning (Carlone et al., 2023). The PDI is a semi-structured interview intended to examine parents' representations of their children, themselves as parents, and their relationships with their children. The interview strives in several ways to approach parents' understanding of their child's behaviour, thoughts, and feelings, and asks the parents to provide real life

examples of charged interpersonal moments. The transcript is then read by a certified coder who utilises the Reflective Functioning Scale (RFS) (Fonagy et al., 1998) to assign a score to the interview. This scale of scores goes from -1 to 9, where -1 is considered 'antireflective', 5 is 'ordinary' and the baseline for an existing mentalizing capacity, and 9 represents an 'exceptionally reflective' capacity. A number of studies have used the PDI as a measure to draw a relation between RF in mothers and their sensitivity towards their infant as a key factor for the development of a secure attachment in children (Grienenberger, et al., 2005; Slade et al., 2005; Stacks et al., 2014).

Modelled on the AAI (Adult Attachment Interview), the PDI was specifically designed to assess a mother's present representations of her child, herself as a parent, and her relationship with the child. The development of the PDI and PDI-RF scale was motivated by the idea to assess parental reflective functioning more directly in the context of the actual ongoing relationship with the child, in contrast to the AAI-RF where this capacity is inferred from descriptions of memorialised childhood experiences with the interviewee's own parents (Schiborr, 2013). A recent Study by Sleed et al. (2020) explored potential difficulties in the use of the RFS in the PDI in comparison to the AAI where the adult is asked to think about themselves and other adults such as their parents, whereas in the PDI the adult is asked to think about their child. For example, they propose that imagining the intentions and feelings of a 2-month-old infant could be more difficult than imagining the experience of a 3-year-old child and therefore it is important to know if it works for parents of very young children. Furthermore, the authors wanted to understand if the RFS could measure a person's RF across different demographic conditions such as levels of risk or ability for language and cognition. This study concluded that the RFS used in the PDI showed high inter-rater reliability, internal consistency, and criterion validity.

The PDI, however, takes time to administer and then it must be transcribed and coded by a trained PRF coder. The time-intensive and costly nature of administering, transcribing, and coding this measure limits the sample sizes that are feasible to use in research (Carlone et al., 2023). In light of the growing attention to PRF in the literature, there was a need to measure PRF more

efficiently. This led to the development of the Parental Reflective Functioning Questionnaire (PRFQ; Luyten et al., 2017). The most recent version of the PRFQ is an 18-item self-reported questionnaire that assesses parental RF and takes 5 min to administer. It includes items related to parental interest and curiosity in their child's mental states and how these mental states may have an impact on behavior. Some studies to date have supported the PRFQ's reliability and validity (Anis et al., 2020; Carlone et al., 2023).

1.3.4. Psychodynamic conceptualisations of the impact of maternal depression on the young child

According to Salomonsson (2013) a mother with depression can relate towards her infant in a disengaged manner or else intrusively. In turn, babies of disengaged mothers protest and seem restless, whereas babies of intrusive mothers tend to look away. According to the author, the infant does not become disturbed by the mother's low-key affect, but more by experiencing a faltering of maternal containment (Bion, 1962). All infants, when seeking containment for their negative emotions, necessarily project these onto the mother. The problem for the depressed mother, Salomonsson (2013) asserts, is that she finds it too hard to receive and process these negative projections. As a result, the infant's emotions remain in an un-metabolised state, frightening the baby who becomes restless and unsettled. The frightened baby seeks comfort again from the mother, confronting her once again with an experience of malfunction. The baby avoids mother or becomes pushy, which in turn increases mother's despair. The baby may experience this lack of containment as emptiness, and later, as a child, create defences to manage this sense of restlessness or an emotional contact with vulnerability.

Emanuel (2006) states that a baby that is easily gratified can be idealised as 'perfect', so that the child is not seen for who it really is, with both positive and negative feelings. It can lead to over-dependency of the mother on her child, a reversal of the caregiver's role, with the child feeling at some level a sense of responsibility for cheering up mother and bringing an element of liveliness into the relationship. Alternatively, some vulnerable mothers are thrown into a state of depression by their attempts to focus on their child, who may be particularly

demanding and easily frustrated in temperament. In such a dynamic, the baby will unconsciously develop defensive forms of behaviour to deal with excessively long periods of inattention or inconsistent unpredictable responses. Infants have a limited mental capacity to deal with overwhelming sensory experiences (for example distress, excitement, terror, hunger, loneliness or intense pleasure) which they may perceive as persecutory or even life-threatening.

According to Emanuel (2006) some mothers cannot notice their baby's signals because they remind them of their own unmet needs as babies and noticing them is too painful to bear. When this is the case, the baby's only recourse is to intensify his efforts to evacuate the persecutory sensations that threaten to overwhelm him, attempting with greater urgency to gain entry to the mother's mind, with increased force and hostility, so that his communications can be received and understood. Emanuel adds that a depressed mother may sometimes respond in a very restricted way to the baby's varied communications, not differentiating between them, and in turn, the baby then struggles to learn to differentiate his own various feeling states as he has not had the experience of mother doing that for him. This can result in a restricted and rigid kind of thinking for the older child. On the other hand, some infants may give up on trying to 'get through' to the mother and may become depressed themselves or else, an alternative response to a deficit in attention resulting from maternal depression is the infant's unconscious turning away from states of dependency by becoming precociously self-sufficient and controlling, dealing with unmet needs by appearing to require little comfort or gratification from adults. Esther Bick (1968) described infants developing muscular 'second skin defences' as a way of holding themselves together in the absence of maternal containment. This type of 'second-skin' defence in their babies, may increase the strain on depressed mothers who are already suffering from a lack of self-esteem, and may become the recipients of the baby's feelings of vulnerability and helplessness, which have been split off and projected into her. In this way the baby remains out of touch with these unbearable feelings of loss or disappointment, and mothers are at the mercy not only of their own feelings of inadequacy, but of their baby's projections, which increase their burden of depression and sense of helplessness. Babies in this

state can make a mother feel even more useless and inadequate because they give the untrue impression that they do not really need her.

1.4. Conclusions

Postnatal depression is understood as a depressive episode presenting in women during pregnancy and/or after giving birth. Its duration varies; however, it has been associated to developmental difficulties in children. Genetic and psychosocial factors have been described as potential risks for PND where mental health history and perceived social support are often mentioned. From a psychoanalytic perspective, PND is thought to be linked with intergenerational trauma and the relational history of the mother, as well as difficulties with the integration of aggression. Furthermore, and in relation to its impact on the child, the relationship between PND and Parental Reflective Functioning is suggested to be in negative correlation, meaning that acute mental health symptoms of depression as well as life stress are likely to impair the mother's capacity to reflect on her own mental states as well as her child's.

The following chapter will provide a review of the concept of toddlerhood and how maternal symptoms of depression can impact on toddler development and more specifically, on play development.

Chapter 2. Toddlerhood and maternal depression

This chapter presents a psychoanalytic understanding of the main aspects of toddlerhood, including different authors' views on what healthy toddler development is. Furthermore, the potential impact of a mother's depressive symptoms on a toddler's healthy progression is addressed, considering the particular role of play and its development in the presence of maternal depression.

2.1. Definition of toddlerhood

Toddlerhood is the developmental stage that encompasses the transition from absolute dependency in infancy to the first steps towards independence and the entrance into the social and cultural world. Starting with the child's first steps, at around twelve months, it is the unstable character of these newly acquired physical movements – 'toddling' - that characterises this period of life (Zaphiriou Woods, 2011). As Winnicott (1966) once proposed, during this stage of life the child will explore the world by taking excursions around his or her environment and then returning to a secure base, often the mother. These excursions will be both physical and psychological, whilst the main caregiver's role in this process will play a fundamental part for the child's future development and will serve as template for further relationships (Rayner et al, 2005).

Toddlerhood presents some important themes and challenges related to attachment, autonomy, separateness and intimacy as well as affect regulation, empathy, aggression, sexuality and growth of imagination (Stern, 1995), and it is thought to culminate with the achievement of inner images of the mother and of her relationship to the child in her absence. If things go well, these images should be stable enough that the child can manage himself without her constant availability or that of a substitute mother (Freud, 1965; Mahler, et al., 1975). This is also known as object constancy. This developmental task can be facilitated through what Winnicott (1951) called a transitional object, which serves as a bridge for the gap the new child's motility brings, through creativity, play, language and symbols, allowing the child to develop self-realisation. A transitional object is a proto-symbol of the mother as the toddler attempts to

recreate her, with the object, in her absence. In the present day most mothers need to work while also having the task of caring for their children; however, this process can be continued by another significant person who can provide continuity, love and facilitate growing autonomy (Zaphiriou Woods, 2011).

Moreover, toddlerhood represents a crucial stage in the context of the child's neurobiological and emotional development, as brain growth is intrinsically connected to the emotional experiences of the child (Schore, 2015; Bernier et al., 2016; Immordino-Yang et al., 2019; Mueller & Tronick, 2019) and maternal sensitivity has been related to brain development in early infants (Bernier, Bell & Calkins, 2016). Toddlerhood is an enriching period in terms of brain activity, during which brain development tailors the refinement of language, social learning, memory, empathy and shame. The latter is related to the interaction and consolidation of the parasympathetic and sympathetic brain systems, which influence the interplay between arousal and inhibition of stimuli, fostering the child's affect-regulation through the mediation of a responsive parent (Schore, 2015). Further, the development of the frontal lobe also takes place during this period, corresponding to executive functioning which includes decision-making, affect regulation and planning (Thatcher, 1991).

2.2. The separation-individuation process

In 1975 Mahler, Pine & Bergman delineated the separation-individuation process, positing several different sub-phases of a young child's development through which the child becomes gradually aware of his separateness from mother. This implies the acquisition of a sense of an individual self and the psychological birth of an independent mind. Toddlerhood begins with the sub-phase dubbed ;Practicing Proper; as the child takes his first steps, describing an intensely curious child who has begun a love affair with the world (Greenacre, 1957). During this period, toddlers typically move a little distance from their mothers when exploring the environment, and parents remain a secure base for their emotional refuelling and joint and/or social referencing. In order to bridge the gap that physical separateness creates (now that the child can move on their own) toddlers engage parents with noises, gestures and eventually words, enabling a more 'long distance relationship' (Edgcumbe, 1981, p.97).

A measure of mutual aggression from both the toddler and the mother towards one another is an expected and necessary feature in development, because it facilitates separation (Mahler et al., 1975). In this sense, toddlerhood is characterised by a strong ambivalence in the relationship between the child and the mother, with the progressive distance achieved by the toddler then followed by periods of regression towards dependence, and the way the mother responds to this can significantly influence how the child experiences separateness. If parents enjoy their child and are affectively attuned (Stern, 1985) to them, the toddler should become able to self-regulate and progressively see himself or herself as an individual (Zaphiriou Woods, 2011).

At around 18 months, the child becomes more aware of their smallness and weakness due to the newly discovered separation from mother, and this necessarily challenges the illusion of control the child had hitherto enjoyed. This is what Mahler and colleagues (1975) described as the sub-phase of 'Rapprochement'. Toddlers can experience a sense of mastery in turning away and bringing back mother, as described in the observation Freud (1920) made of his grandson in the 'Fort-da' play. As Bergman (1978) proposed, "each time the toddler finds mother he brings along a new piece of the world outside, and each time he leaves her he takes with him a part of her. Increasingly this part is an image" (p. 158). During this sub-phase, it is expected that the child will take a step back from the new independence found in walking and seek the comfort mother can give as she did before he became mobile (Mahler et al, 1975). It is also around the 18th month of life that children are often able to recognise themselves in the mirror, possibly becoming more self-conscious or ashamed due to the realisation that they can be seen by others not only from the outside but also maybe on the inside.

After the rapprochement sub-phase, the anal phase arises and plays a key role in disrupting the rapprochement phase, paving the way for further independence (Zaphiriou Woods, 2011). Bodily pleasure, wetting, messing, and a resistance to being handled is observed, which relates to the child´s new sense of ownership of their body, as they become more able to control their own bowels. This is possibly why one of the very first words a child learns at this stage is often "no";

“No!” serves as a declaration of independence from parents (Fraiberg, 1959). Eventually, a preoccupation with cleanness and order can follow as a reaction formation to the previously sought dirtiness. It is also around this period that toddlers achieve toilet training, which can present its own challenges. Often faeces can be seen by the toddler as parts of their own body and getting rid of them can be felt as another separation, a fragmentation of their body or as something harmful (Klein, 1946).

This period can also be difficult for parents because it can awaken their own unresolved issues with anality, sexuality and aggression, also challenging these adults’ own infantile repression (Furman, 1992). The ambivalence regarding closeness and separateness, love and hate, becomes mutual. Parents need to regulate themselves in order to contain their child’s aggression and survive their attacks, so that the child can maintain a good image of his or her parents, overcoming earlier tendencies towards splitting (Klein, 1946) and fusing loving and aggressive impulses (Klein, 1935; Furman, 1992). This parental function allows the toddler to develop the ability to regulate his own emotions and impulses, transforming “greedy stomach-love to a truly constant love attachment with others” (Freud, A., 1953, p. 16).

Moving on from rapprochement, the toddler's vocabulary expands, and parents help their child to organise their affective life into words, allowing the toddler to build more complex representations of him- or herself and the world. The acquisition of language relates to parental sensitivity, as the attunement between carer and infant plays a fundamental role in the introduction of words that follow the child’s interest and state of mind (Hobson, 2002). The flourishing of language depends not only on cognitive capacity, but also on interpersonal interactions, emotional contingency and exposure to a speech-invested environment (Stern, 1985).

Moreover, language and communication place the individual in the mental and cultural realm, in which dialogues and conversations suggest the recognition of another responsive and interactive minded being (Reddy, 2008). The use of narrative to address mental states and feelings is also related to affect-regulation. Contemporary research suggests that putting feelings such as fear into words,

diminishes cortisol levels and helps facilitate soothing emotions and moods (Kircanski et al, 2012; Daubenmier, 2014). Language therefore allows for a different relationship between toddlers and their parents to emerge in the face of physical separateness, a relationship that remains containing for the child (Bergman & Harpaz-Rotem, 2004) even in the absence of the other. In other words, language puts drives into words, mastering them and creating a midway position between mother and child (Stern, 1985).

The separation-individuation process assumes a conceptualisation of healthy development where parents are expected to allow their child to recognise himself as an individual person. The more this happens, the more value the child attributes to his body as a container of his individual personality (Fraiberg, 1959). Battles with parents around who is in charge of this newly owned body start becoming noticeable, especially around toileting, feeding, dressing, bathing and other daily activities that involve a handling process of the body.

One of the most important achievements at this age is toilet mastery. In order for it to happen, some pre-conditions are needed: the child must be cognitively mature enough to be aware of his own bodily sensations and also have a positive enough relationship with his parents to want to please them by becoming clean and dry. A child should also have sufficient language development to be able to let his parents know when he has wet himself or is about to. Toilet training can be anxiety-provoking for the toddler since, as previously stated, defecating can be experienced as losing a part of the body and therefore involving another separation, and faeces can be perceived as destructive weapons in phantasies, which may make the child try to retain them. It is often at this point that toddlers begin to wonder about what happens both inside their own bodies and their mother's, leading to theories about pregnancy related to the bowels.

Due to the toddler's high investment in their body, they can become tremendously anxious about the slightest injury to it. It is in this narcissistic state that the already noticed anatomical difference between female and male bodies is given a new meaning in a process of après-coup (Freud, 1895/1950). It has been observed that for girls, the realisation that boys have a penis can be often experienced as a narcissistic injury and that for boys, the realisation of a lack of a penis in girls

can lead to the fear of losing their own (Freud, 1924, 1925). The attitude parents have towards the different genders is fundamentally important and will affect the identificatory process. It is usual at this stage for children to present a certain gender fluidity as they have not yet established gender constancy. Boys may think they can give birth to babies one day and girls may wonder 'when' they will grow a penis. In classical psychoanalytic theory, it was argued that establishing a sexual position was a bigger challenge for girls since they are compelled to give up the idea of having a penis. In 1926 Karen Horney proposed that penis envy could be more related to the social position of male supremacy rather than it being an ontological matter. Additionally, she stated that just as girls might feel envy for the boy's penis, boys might feel envy of the girl's womb and potential motherhood. In this sense, more contemporary theory (Tyson & Tyson, 1990) proposes that in fact the establishment of gender constancy could be more of a challenge for boys since in order to identify with a male figure they first need to dis-identify from the primary identification figure, who is most usually the mother.

Fathers have a fundamental role in the development of a child as a third person that can relate to him or her and facilitate the necessary level of separation with the mother, in order for the child to be able to enter the social world and access different gender identification models. Since the genesis of psychoanalysis, the role of a third party in the relationship between mother and child was illustrated through the theory of the Oedipus complex in Freud (1905). Here, the father would face the child with the reality that there are restrictions on his or her relationship with mother and in life, thereby initiating the child into becoming a social being. Post-Freudian authors such as Winnicott (1956) and Stern (1995) view these processes from a more relational perspective and have formulated that a father provides both a safe material and emotional environment for the mother to be available for the child.

Stern (1995) goes a step further, wondering if a father could actually fulfil the maternal role. Whichever theory or period in psychoanalysis, it is agreed that baby and mother function as one unit at the very beginning and this is necessary for the child's healthy development. However, gradual separation must occur in order for the child to understand that mother is not exclusive to him, and that life

sometimes involves some frustration, which will be presented to the child in small and age-appropriate doses. For this to happen, a third party is fundamental, whether it is a concrete person like the father or another relative, or a symbolic one like the daily demands on any mother.

2.3. Development of affect regulation

Fonagy et al. (2007) speak of affect mirroring as the mechanism through which an infant can develop affect regulation. Sensitive caregivers respond to their child's affective displays with contingent marked affective displays of their own, and this contingent marked mirroring of the infant's emotions is what enables the baby to modulate his or her own affect states. By marked, the authors refer to the exaggerated facial, vocal, and gestural displays that caregivers mostly intuitively make when responding to babies. By marking their affective displays, caregivers help babies to find their own emotional states reflected in the parent's own face. The marking serves as a signal that the caregiver is communicating something about the infant's affective state rather than their own. According to the authors, too much or too little mirroring can result in developmental psychopathology. Parents with use of pre-mentalising modes, tend to make malevolent attributions about their child's mind, which may lead to a feeling of non markedness in the child. This might ham the child's development of the capacity to reflect on emotions and their impact, resulting in affect regulation problems (Nejssens et al., 2020).

In a similar fashion, Bion's (1962) understanding of 'containment' is achieved when the mother has made sense of the infant's communication in her own mind, being able to respond appropriately to the infant and attend to his needs. This allows the infant to have the experience of a mother who can think about, understand, and process his feelings. The infant gradually becomes less overwhelmed by upset feelings, learning, through his experience of a thoughtful parent, how to make sense of his own experiences. If the infant's distress is taken in and absorbed by an attentive mother, who is able to receive the infant's communications, and reflect on them without becoming overwhelmed by anxiety herself, the infant has an experience of feeling that its communications have been understood.

2.3.1. Maternal depression and child affect regulation

In the presence of maternal depression, this capacity for mirroring and containing could be impaired. Winnicott (1971) also described one of the maternal functions as the mirror-role, stating that the first mirror of a child is the mother's gaze, meaning that the way the mother looks at and communicates about her image of her baby will contribute to that baby's internal image of himself. Along similar lines, Bailly (2009) when speaking about Lacanian theory, states that the mother's gaze is the child's first mirror and that the child's identity and notion of itself as a whole being is first formed in that gaze. He proposes that usually when one thinks about the quality of mother's gaze, it is filled with love and consistency, therefore giving the child a positive reflection of itself, and that this provides the 'proto-mirror' in which the child first develops its notion of self. However, he adds, in some cases the mother may fail as the child's first mirror, even if she is present: "She may see the child as a fragment of herself, or as a living creature with which she can't identify; or she may fail to anticipate the child's future development as a mature, talking being, viewing it simply as a parcel of needs and demands" (Bailly, 2009, p.38). In this sense, a mother who is severely depressed or mentally ill, or entirely self-focused due to fear of a violent partner, indeed for any reason, may provide the effect of a distorting mirror or no mirror at all for the child. According to Bailly, this distorting mirror may produce a narcissistic line of weakness or 'fault line' in the baby upon which his subsequent identity is built. Since the mirroring function is necessary for the child to gain a unified image of himself and become a social subject, the child who sees no 'alter ego' of itself may remain at the fragmented body stage for too long, with damaging long-term effects: "As a minimum of two subjects are necessary for any communication to take place, the child's lack of the subjective 'I' makes communication impossible" (p.39).

A study conducted by Gravener et al. (2012) provides a fine example of how this impaired mirroring function can present in toddlers. In this study two sample groups of mothers with depression and their toddlers were compared to mothers without depression and their toddlers. Maternal depression was assessed as well as the toddler's expressed emotion (EE), behaviour and attachment. According

to the authors amongst mothers with depression, maternal representations of their toddler relate to the extent to which children exhibit under-controlled, impulsive behavior and toddler of mothers with depression who are critical of their child are more likely to develop externalizing symptoms, which can be a precursor to later psychopathology, including oppositional behaviour and conduct problems. Furthermore, positive correlations between the presence maternal depression and toddler behaviour problems have also been described in literature (Guyon-Harris et al., 2015; Edwards & Hans, 2016; Fransson et al., 2020).

Similarly, a parent's capacity to mentalise or else understood as parental reflective functioning (PRF), has also been identified as a potential factor that can influence the development of affect regulation in toddlers and links between maternal depression and lower PRF have been drawn in previous literature (Fischer-Kern et al., 2013, 2019; Ramsauer et al., 2014; Suardi et al., 2020; Alto et al., 2021). For example, Borelli et al., (2021) describe that some aspects of parental RF might be associated with the toddler's coping when in emotional distress. In their study, it was observed that maternal RF increased, the distressed toddler was more likely to present mother-oriented behaviour and less aggression (Borelli et al., 2021). Similarly, Wong et al., (2017) conducted a study where mothers were asked to provide demographic data and to complete the Infant Behavior Questionnaire–Revised during a home visit when the infant was 7 months old and the Child Behavior Checklist when their infant was 18 months old. Additionally, during a lab visit when the infant was 16 months old, mothers participated in the Parent Development Interview–Revised Short Form, which was coded for RF. It was concluded that high parental RF was linked to a decrease in child behavioural problems when in distress. Similar findings were reported by Senehi et al. 2018.

2.4. Development of capacity to play

Play is a fundamental aspect of health in childhood and is intrinsically linked with language, the capacity to use symbols, separation, creativity, empathy and self-regulation. Winnicott has been one of the main psychoanalytic authors to develop an understanding of play, its relevance for child development, as well as its

relation to the material and affective environment. According to him, play starts with the body and, specifically, in the baby's investment of his own body and his mother's. According to Winnicott (1951), play is at the heart of creativity from the earliest days of life, as the illusion of omnipotence allows the child to populate his internal world and deal creatively with frustration. Other authors such as Klein (1932), believe that play allows the child to process unconscious phantasies and conflicts, and can be understood as an attempt to repair unconscious attacks to the loved object. From either perspective, play is thought to help the child face reality and regulate ambivalent states of mind.

According to Winnicott (1971), a creative and healthy way of living will be facilitated or impinged upon by the mother either allowing or not allowing her baby to transit from the illusion of omnipotence to disillusion in a nurturing way. In this process the creative and authentic self of the child can be developed, by means of a transitional space between the baby and the mother or mother figure that will vary according to the quality of the baby's experiences with her. Out of his experiences in this transitional space, the child´s capacity to recognise himself as separate, to play and to use symbols and language will emerge.

Winnicott (1951) spoke of a transitional space that serves as an interchange between inner and outer world in the experience of the progressive realisation of separateness from mother. This space is the baseline for the capacity to play. A child's ability to inhabit a transitional space depends on his experiences of mother and of his separations from her, and the child needs to feel he is able to magically control what is outside. Therefore, affective difficulties such as acute anxiety can pose a barrier for playfulness or creativeness, as well as very structured or non-child-led activities that leave little room for the child's creativity and authenticity. In infancy, this intermediate area is necessary for the initiation of a relationship between the child and the world and is made possible by good-enough mothering at the early critical phase, as there is no possibility for an infant to proceed from the pleasure principle to the reality principle unless there is a good enough mother.

In 1968 Winnicott described the different and consecutive stages of play, in a progression where the baby is born into a sense of being merged with mother. At

this point mother allows the child to believe he has created the world and is "oriented towards the making actual of what the baby is ready to find" (p. 596). Due to the mother's disposition to feed the baby's affective needs, the baby is able to develop the beginnings of a creative self. Eventually, the mother will progressively lower her adaptation to her baby, presenting pieces of reality and allowing the baby to realise he is not omnipotent. The object, namely the mother, is then repudiated, reaccepted and perceived objectively. Winnicott (1968) called this interaction a "playground" because according to him, play starts here. This playground is a potential space between the mother and the baby that will eventually allow the child to develop what Winnicott described as "the capacity of being alone in the presence of someone". At this stage, the child plays under the assumption that the person who he loves and relies on, is available and can remain available when remembered after being forgotten. If mother is able to facilitate these moments for her child, he will become able to allow and enjoy an overlap of two play areas (his and mother's) and mother will be able to introduce her own playing, paving the way for a playing together in a relationship.

Contrary to more classical psychoanalytic conceptions of play, Winnicott (1968) believed that play is exciting for a child not primarily because of the instincts involved, but as an activity in itself. Therefore, play needed to be studied as a subject on its own and not only as the sublimation of an instinct, as "when there is an evident instinctual involvement in play, the play stops, or it's spoiled" (p. 593). He also proposed that the nature of play is tremendously precarious, and this precariousness lies in the interplay of personal psychic reality and the experience of control of actual objects:

> *"This is the precariousness of magic itself, magic that arises in intimacy, a relationship that is being found to be reliable. To be reliable the relationship is necessarily motivated by the mother's love, not by reaction formations (…) the precariousness of play belongs to the fact that it is always on the theoretical line between the subjective and that which is objectively perceived."* (p. 596)

In other words, the possibility for creativity and for play to occur is dependent on the conditions the environment can provide and if these affective needs are not met, the capacity to play can be jeopardised. From this perspective, a

fundamental task for parents is to allow separation to take place by gradually lowering their adaptation to the child. This induces a gradual sense of lack in the child who uses play to shape the world to his desire (Winnicott, 1951). Play therefore allows more independence for the child because he can now create subjective objects in his internal world.

In 1942, Winnicott summarised the different reasons why children play, including pleasure, expressing aggression, mastering anxiety, gaining experience, making social contact, integrating personality and communicating with people, stressing the importance of play as a social and communicative phenomenon and also as a developmental achievement for expressing anger and linking ideas with bodily function, relating personal reality with shared reality. Play can help a child elaborate on painful or difficult experiences, by representing these through play but now from an active position. This can help enhance the child's sense of agency and mastery, as "they can be master of their universe, and get a chance to rewrite their history" (Alvarez & Phillips, 1998, p. 102). It is also through play that those in a child's caring environment can identify fear or concern about a child, especially when the activity involves excessive anxiety that disrupts play or causes compulsivity.

As the child develops, his ability to play flourishes and by the end of his first year of life, the child's ludic activities gain complexity, and joint attention and mutual sharing of a common object have an important role (Tomasello, 2020; O'Madagain & Tomasello, 2021). This experience depends on a continuum of mutual mother-child attunement and positive affective experiences, where the caregiver's mind provides predictability and flexibility to the child's experience (Music, 2017). The child needs an adult or older child who will 'play along' with his fantasies, so that he sees his thoughts or ideas represented in the other's mind, re-introjects them and uses them as a representation of his own thinking (Fonagy & Target, 1996).

Play is linked with the capacity to rehearse feelings and different states of mind. Role play allows the child to try out different perspectives and ways of being in other people's minds, enhancing the capacity for empathy and recognizing difference. Toddlers may use toys or role play to explore where parents are or

what they are doing when absent, which helps them develop a sense of individuality and sufficient object constancy to manage themselves in the absence of their parents. A toddler's image of his parents will be integrated as a positive one if positive experiences in his interaction with them prevail (Zaphirou-Woods, 2011). This means parents need to contain both their own feelings and their toddler's, allowing him to survive frustration and longer separation. Bergman (1999) proposes that a child is able to utilise and enjoy role play only when there is an established enough self that can put itself in the place of others and, according to Stoker (2011) in role play, both parent and child can enact their conflicts with each other regarding separation, reunion, aggression and reparation and it is in this process that the toddler begins to learn the difference between fantasy and reality. Thoughts and feelings can be frightening for a child due to lack of differentiating between both realms, and play allows the toddler to learn about this when adults share their knowledge and acknowledge the toddler´s feelings. Ultimately, this is how imaginative play can become safe as a symbolic arena for feelings and thoughts.

Furthermore, in the content of play children explore both external and internal worlds and manage to overcome painful experiences as well as expressing pleasurable ones. It is common to see in play some identification with parents such as 'caring' for dolls or pretending to go to work. Becoming like their parents is a way of internalizing them, their good aspects as well as their restrictions (Tyson & Tyson, 1990). Identifying with them and having a secure attachment to them helps regulate the child's instinctual urges through the wish to be like their parents and to please them. This way, the toddler trusts he will not risk losing his parents' love. This represents the precursor of a super ego agency, as the internalisation of authority figures.

In terms of brain development, play is intrinsically related to the executive functioning of the brain as well as enhancing motility and cognitive skills. According to Panksepp (2007) genetic research shows that socialisation is not mainly determined by innate characteristics of genes and chromosomes, but by the stimulation provided by the environment around the child. This author also

emphasises the need for playgroups, highlighting the importance of shared ludic activity concerning the development of the social brain.

2.4.1. Impact of maternal depression on toddler play

For Winnicott (1971), the infant can employ the transitional space when the internal object, namely the mother, is alive, real, good enough and not experienced as persecutory and this internal object depends on the existence and aliveness of the external object (the real mother). Failure of the latter indirectly could lead to deadness or to a persecutory quality of the internal object. Winnicott contends that if the inadequacy of the external object persists, then the internal object fails to have meaning to the infant, jeopardizing the capacity to play, to symbolise and with this the possibility of healthy development: “There is no health for the human being who has not been started off well enough by the mother” (1971, p. 13). Winnicott believed that living creatively is a healthy state, and that by contrast compliance is an unstable basis for health emotional life. Therefore, if the baby’s environment fails to allow him a healthy development in these terms, the defence of the compliant false self may appear, hiding the true self that has the potential for creative use of objects.

The loss of the object, namely the mother, including the psychological loss of the object relationally whilst still physically present, can be traumatic for the child, implying that the baby has experienced a break in life’s continuity, so that primitive defences become organised to defend against a repetition of ‘un-thinkable anxiety’ (p. 114) or a return of the acute state of confusion that belongs to disintegration of a nascent ego structure. In this sense he views the ‘deprived child’ as restless, unable to play and with an impoverished capacity to experience the cultural (or social) field (Winnicott, 1971).

In 1963, Anna Freud introduced the concept of developmental lines to enable a systematic assessment of childhood disturbances by contrasting the development of a particular child to the developmental norm. According to Anna Freud (1963) some children might present a very irregular pattern in their growth, and whilst this disequilibrium between developmental lines is not pathological per se, it can become a pathogenic agent where the imbalance is excessive.

Moderate disharmony does no more than produce the many variations of normality, however gross disharmony could be a precursor of psychopathology and considered an indication for child analysis (Freud, A., 1945). Anna Freud (1963) proposes that there often are developmental factors involved in these developmental variations, such as parents' personalities, family atmosphere and cultural setting. Furthermore, she suggests that mother's interest and predilection act as stimulants for infants, meaning the infant concentrates on developing along the lines that they feel elicit the mother's love and approval.

> *"Some mothers find no pleasure in the growing infant's adventurousness and bodily unruliness and have their happiest and most intimate moments when the infant smiles. We have seen at least one such mother whose infant made constant and inordinate use of smiling in his approaches to the whole environment… marked disinterest of the mother in the infant's body and his developing motility may result in clumsiness, lack of grace in movement, etc."* (p.263-264)

Relevant to this study, in this same paper (1963) Anna Freud suggests that maternal depression during the first two years after birth creates in the child a tendency to depression, because infants achieve their sense of unity and harmony with the depressed mother not by means of their developmental achievements but by producing the mother's mood in themselves. Furthermore, according to Pretorius (2020). When providing or failing to provide the appropriate opportunities for age-adequate play, parents facilitate or impede the child's progress on various lines of development. In particular, the parent's capacity to suspend their own view of reality and to pretend is crucial. For example, excessive parental participation may result in overstimulation, intrusion or rigidity. Parents who denigrate play because of its 'childish' and unrealistic content, interfere with the child's capacity to enjoy fantasies and enactments, and this can lead to inhibition as the child can perceive fantasy as a source of disapproval, danger, and shame.

Depending on the presentation of the maternal depressive symptoms, mothers can relate to their children in a disengaged way or else intrusively which in turn makes babies of disengaged mothers likely to protest, whereas babies from intrusive mothers tend to disengage themselves (Salomonsson, 2013). In

response to a possible inattentiveness from mother to the child, the child might try to get through to mother by becoming restless or hyperactive, or else this pattern can be internalised by the child, presenting difficulties in concentrating or paying attention. Similarly, this excess of energy could be linked to the child feeling at some level a sense of responsibility for cheering up mother and bringing an element of liveliness into the relationship (Emanuel, 2006). Infants may also identify with their depressed mother and become depressed themselves, similarly to children who disengage. Depressed children have been described to play less than their peers (Lous et al., 2000, 2002; Chazan & Kuchirko, 2019) and to offer and seek less comfort during play from peers or adults and show less exploration (Halfon, 2017). Similarly, Lous et al. (2000, 2002) observed that depressed children tended to explore the environment and the experimenter rather than staying with toys and activities, manifesting loss of concentration.

An alternative response to a deficit in attention resulting from maternal depression is the infant's unconscious turning away from states of dependency by becoming precociously self-sufficient and controlling, dealing with unmet needs by appearing to require little comfort or gratification from adults (Emanuel, 2006; Halfon, 2017). According to Esther Bick (1968), infants can develop muscular 'second skin defences' as a way of holding themselves together in the absence of maternal containment. A child who cannot bear to be in touch with feelings of dependency may reject other adults or a mother-like figure who may have something to offer, as a reminder of what they do not have themselves.

The aforementioned second skin defence involves a certain over-reliance on the body, in opposition to what would be expected in normative toddler play, namely the use of toys and symbolic play. Symbols and symbolic play find its origins in the process of separation in the mother-child dyad, where mother is expected to facilitate separation through introducing the child to toys and games. However, depressed mothers may struggle to introduce this separateness between her and her child (Halberstadt-Freud, 1993) and in fact, mothers with depression have been observed to engage less in play with their children (Tingley, 1994; Sohr-Preston & Scaramella, 2006). If the child cannot bear to separate from mother, it is unlikely he will have space to explore other objects, people and environments

and overall to develop the capacity to imagine and symbolise. According to the existing literature, children of depressed mothers might be able to develop symbolisation and symbolic play, depending on how pervasive the maternal depression has been in their development. However even having the capacity, it has been observed that these children spend less time playing symbolically than their peers (Tingley, 1994; Halfon, 2017), playing symbolically is easily interrupted by stress (Greenspan & Lieberman, 1994) there tends to be a preference for manipulative or non-symbolic play, symbolic play often needs to be initiated by others in order for these children to display this capacity and it tends to be quite simple in terms of narrative (Greenspan & Lieberman, 1994; Lous et al., 2000, 2002; Chazan & Kuchirko, 2019).

Difficulties in mother-child separation would have a direct effect on social play development, as letting others interfere with the dyadic functioning of the depressed mother-child relationship could be a strain for both mother and child. According to Chazan & Kuchirko (2019), children might elude interacting with others, using avoidance as though they felt threatened. Furthermore, Greenspan & Lieberman (1994) propose that when the child is not taught to handle overwhelming feelings such as loss or separation, there may be little or no progress beyond early dyadic experiences.

According to Chazan & Kuchirko (2019), children who present in an inhibited manner do not express conflict in an overt manner that would involve them in dispute with others. Rather, they tend to turn inward and direct their anxieties against themselves, make-believe characters, or abstract issues. This inhibition could be understood in relation to the pattern showed by children of mothers with depression who have identified with their mother's inattentiveness and mood and who in turn have not been able to integrate their aggressive feelings, in line with mother's internal conflicts with her own aggression (Blatt, 1974; Bleichmar, 1996). Furthermore, it has been observed that children of depressed mothers might present a restricted emotional range (Greenspan and Lieberman, 1994; Halfon, 2017) and difficulties in emotional regulation (Halfon, 2017; Chazan & Kuchirko, 2019).

A non-integrated relationship with aggression could also lead to a child feeling mother is not able to survive his aggressive feelings, allowing the intrusive type of mother to take control, thus the child presents as too compliant. On the other hand, the child that has become restless due to maternal disengagement could do the opposite and behave in an oppositional style. In both cases, as mother has struggled herself to integrate her own aggression, she is unlikely to support her child in doing the same.

Another potential characteristic of play in children of mothers with depression is a non-authentic or non-creative quality to their play, linked to a lack of apparent joy in play as well as uniqueness, where play may seem dull, repetitive or imitative. According to Greenspan & Lieberman (1994) children within an environment that does not facilitate symbolisation, might lack a unique signature in the symbolic elaboration of experience, so that the choice of pleasure, intimacy, exploration, anger, or negativism is not accompanied by a recognizable individual style on the part of the child. Similarly, repetitive play might be an indication of anxious feelings (Freud, 1920). In this sense reduced creativity, repetition and an apparent lack of affect could be considered anti-play behaviours, communicating a more severe compromise of the child's capacity to play. Repetitive play has been associated with psychological conflicts and maladaptive coping as well as neuroplasticity and neurobiological deficits, where the purpose of play is lost as it is used for self-regulation in the face of stress, interfering with any chance of social interaction (Singletary, 2015, 2019).

2.4.2. Interventions to enhance the toddler's capacity to play

As stated above, play is crucial in early childhood as it is linked to numerous areas of child development as cognition, academic achievement, social competence, and positive peer relationships (Conner et al. 2014). Unfortunately, not all children play skills sufficiently or at the expected time, and this can have several negative implications for young children, especially when engaging in social interactions. Some literature has covered the topic of interventions designed to enhance toddler's capacity to play, particularly in the presence of language delays or disability and/or trauma. Playing with toys as a means of environmental engagement has long been considered important in early child

development, however, children with highly significant disabilities often engage in toy play less frequently than their peers without disabilities (DiCarlo et al. 2002). Playfulness can also contribute to resilience. However, another issue that can often hinder trauma children's ability to engage in imaginary play and parents' ability to be involved in playful interactions with their young children is chronic stress and trauma (Cohen et al. 2013).

A study conducted by Conners et al. (2014) sought to determine the effects of early intervention on the play skills and language development of 2-year-old children. The setting was held in the children's educational environment facilitated by their educators in a private pay child care centre in a suburban area of the Midwestern United States. In the toddler room, children were given daily play time, calendar time, and story time, naptime after lunch, and instruction and practice with regard to numbers, shapes, and colours. Play and language were incorporated into the children's daily activities. The intervention took place over a 4-week period, in the morning twice each week in a small, distraction-free room at the child care centre. During the intervention, the experimenter and the five participants were present in the room in which the intervention took place. Various books and play sets were chosen by the experimenter for the intervention each day. The first 2 weeks involved a 'bedtime' theme, and the last 2 weeks involved a 'kitchen/grocery store' theme. There were two different books for each theme, with a corresponding play set of toys for each book. To begin the intervention, the experimenter read a story to the participants. When the story was finished, the experimenter introduced the toy set that corresponded to the story. Then, the experimenter modelled and described how to play with the toys. The children then were given 5 minutes of free time to play with the toy set. The experimenter facilitated the play as needed by modelling different play behaviours, encouraging pretend play, and providing praise throughout the session. After this time, the participants were given 5 minutes of free time to play with the same toy set without facilitation. This gave participants the opportunity to explore and play independently. When the free-play session ended, participants helped to clean up the toy set. Following clean-up, the experimenter facilitated a review session with the participants. They reviewed the book that was read, the play

Behaviours that took place, and the overall theme of the story and toy set. Their results suggest that the intervention was effective in increasing the complexity of play for the children who received the intervention. Children in the intervention group increased the amount of time spent engaged in pretend play and regarding language development, results indicated that the children in the intervention group increased auditory comprehension, expressive communication, and total language scores.

Another study conducted in an educational setting with toddlers with disability, included in a mainstream school, was conducted by DiCarlo et al. (2002) where the main aim was to enhance these children's toy play and non-prompted toy play. Following initial observations of three toddlers that indicated toy play was less frequent than that of their typically developing peers, preference assessments were conducted of selected toys. The toddlers were then provided with repeated choices of preferred toys in a child-directed manner. After providing a choice between preferred toys, the staff member waited 3–5 s for the child to initiate movement toward the toy. If the child began to initiate movement with his/her arms or hands, the child was left alone. If no movement toward the toy was noted, physical assistance was provided to the child paired with a specific verbal direction to play with the toy. Praise was given to the child upon manipulation of the toy. The staff member waited until toy manipulation ceased and then continued the 3–5 s wait time for the provision of physical assistance. After 2 min, if the child was not playing independently, a new choice was provided using the same procedures as in the previous experimental condition. Overall, toy play as well as non-prompted toy play increased for all three toddlers. For two of the toddlers, toy play increased to a level commensurate with that of their classmates who did not have disabilities. Small increases also occurred in the number of toys played with by each toddler.

Lastly, Cohen and colleagues (2014) conducted a study on a parent-toddler group intervention named NAMAL (Hebrew acronym for Let's Make Room for Play), designed for mothers and their toddlers who live under the chronic stress of recurrent missile attacks in Israel. The major objective of the program is to bolster children's resilience by enhancing their playful interactions with their

mothers. The main aims of this model of interventions are to provide opportunities for exclusive mother–child interactions; raise parents' awareness of their central role in building the child's sense of uniqueness, trust and self-reliance; educate mothers about the importance of supporting the expression and regulation of emotions and teach skills for attuning and reflecting feelings as well as soothing skills; sensitise mothers to their role in supporting their child's curiosity, creativity and imagination through play; and to help mothers identify signs of stress in children, understand the children's feelings about traumatic events, help them create a coherent and empowering narrative and increase their sense of competence in coping with the stressful events. Each meeting was organised around a theme that is introduced via a saying with a developmental or a relational message. This was an important feature of the program and was designed to counteract the negative potential of traumatic events and to increase the level of reflection and symbolisation of caregivers. The sayings typically had a double meaning, one concrete and one abstract, which makes their use playful. The saying was introduced and explained briefly at the beginning of each session and all the activities were connected with this message. At the end of each session, the facilitators summarised the meeting by pointing out how the activities were connected with the day's message. Reports collected from 70 mothers after their participation in the program highlighted the success of the intervention and the changes in the children and parents, as well as in their interactions with each other. Follow-up interviews conducted a year after the intervention provided further information on the long-term positive effects of the program.

Interventions designed specifically to scaffold child's capacity to play are not widely reported in the literature, however the above mentioned studies suggest that perhaps the presence of an adult who is able to facilitate playfulness in toddlers could yield benefits to their development. In terms of parent-toddler individual or group interventions specifically where play is a measurable outcome, the literature is quite elusive, which might highlight the need for this aspect of development to be further researched.

2.5. Conclusion

Toddlerhood is a pivotal stage in development where multiple milestones are achieved and others start to pave their way, however, these milestones can only present in health and the role the caregivers play is fundamental. The capacity of the parent to be sensitive and responsive to the child's needs is likely to impact the child's capacity to follow the path of healthy and normative development and the presence of maternal depression can propose a barrier to this. Play in toddlerhood is a good indicative of development and it can inform on the quality of the mother-child relationship, which is why this is an aspect of toddlerhood that is of relevance to this project. Although the literature in this field is not vast, toddler play in the presence of maternal depression has been described as deviating from its normative progression which in turn might communicate disturbance in the mother-child relationship. Some interventions directed at improving toddler's capacity to play have shown some benefits, however the literature around this topic is scarce.

The next chapter will cover the literature and evidence on intervention models for PND in consideration of its impact on the child.

Chapter 3. Supporting the mother-child dyad

The previous chapters have offered a review of the potential risk factors that could lead to the presence of postnatal depression in women, their experience of motherhood and its impact on the child's development. Additionally, they have covered an understanding of the developmental stage of toddlerhood as well as reviewing the existing literature on the specific impact maternal depression and maternal RF can have on toddlerhood and toddler play. This chapter will discuss the different modalities for treating postnatal depression and the evidence for each, considering their impact not only on maternal mood and maternal RF but also on the child's development.

3.1. Evidence base for psychological therapies for PND

Several psychosocial and pharmacological alternatives for treatment have been adapted from Major Depressive Disorder to PND. Psychological therapies from different theoretical approaches have proven to be helpful for maternal depression, in comparison to routine care (Milgrom et al., 2011). Pharmacological treatment has also proven to be effective in some cases. Antidepressants are recommended for severe PND, for symptoms that do not resolve with psychological therapy alone, when rapid treatment is needed and or when it is preferred by the patient. There remains a consensus supporting the use of SSRIs in PND. Overall, sertraline is the SSRI with the most evidence in the treatment of PND (Frieder et al., 2019). However, psychological interventions are commonly preferred due to the potential risk for breastfeeding of prescribed medication (Fitelson et al., 2011; Stuart & Koleva, 2014).

A meta-analysis conducted by Cuijpers et al. (2015) reviewed a number of therapeutic interventions aimed at mothers with depression, with the number of therapy sessions ranging from 8 to 16. A small to moderate effect was found on children's mental health and a small to moderate impact was found on parenting/marital distress and on the patterns of interactions between mothers and their children. More recently in 2021, the same author and his colleagues led a metanalysis of psychological treatments for perinatal depression including IPT and counselling. This time the effects of the interventions were moderate to large,

remaining significant at one-year follow-up. The authors also found that apart from the effects on depression, we found indications that the interventions also had positive effects on social support, anxiety, functional limitations, parental stress and marital stress.

Similarly, in 2016 Stephens et al. conducted a metanalysis of ten studies assessing the effectiveness of psychological therapies for the treatment of postnatal depression. These studies reported on 14 psychological intervention arms: 7 using cognitive behavioural therapy, 2 using interpersonal therapy, 2 using counselling, and 3 using other interventions. Psychological interventions resulted in lower depressive symptomatology than control both immediately after treatment and at 6 months of follow-up. The authors did not find any significant differences between the various types of therapy. Additionally, they also concluded that these interventions led to improvements in adjustment to parenthood, marital relationship, social support, stress, and anxiety.

In 1997, Cooper and Murray conducted a randomised controlled trial to test the effects of routine primary care, non-directive counselling, cognitive–behavioural therapy and psychodynamic therapy in treating PND. The results showed that all three treatments had a significant impact on maternal mood, and only psychodynamic therapy produced a rate of reduction in depression significantly superior to that of the control. However, the benefit of treatment was no longer apparent by 9 months postpartum, and it did not reduce subsequent episodes of postnatal depression.

Psychosocial interventions aimed at enhancing support, including home visits and different types of psychotherapeutic interventions, are recommended for women with mild PND to address the challenges associated with the transition to parenthood (Stuart & Koleva, 2014). CBT and Interpersonal Psychotherapy (IPT) are the two modalities with the most research supporting their efficacy towards a decrease in depression and anxiety, recovery rates, mother–infant interaction, stress reduction, and marital functioning (Sockol, 2018). CBT is based on the concept that one's thoughts affect mood and functioning. Negative thoughts about self, others and the future are targets of the treatment and behavioural change focuses on increasing pleasurable activities. On the other hand, IPT is

based on the concept that social support and interpersonal problems affect mood and functioning. Interpersonal problems such as disputes, transitions and grief and loss issues are addressed, and behavioural change focuses on increasing social support and improving interpersonal communication. Interpersonal Therapy (IPT) has shown good results in the treatment of perinatal depression, possibly due to its focus on areas that relate to this type of depression such as low social support, marital dissatisfaction, role transitions and challenges to interpersonal relationships (Sockol, 2018).

Further studies concluded that other types of therapy for PND such as counselling or psychodynamic psychotherapy are equally helpful (Stephens et al. 2016; Stamou et al., 2018). For example, in a review conducted by Stamou et al. (2018), it was concluded that CBT was more effective on cognitive focus, behavioural tasks, and organisation, meanwhile a psychodynamic approach was more effective on relationships. The authors assess CBT as a good alternate for treatment, since its results are fairly democratic: its positive therapeutic outcome on PND is not impacted by the socioeconomic status of the population and it can be delivered by various mental health professionals of different backgrounds, or even delivered by non-experts, such as lay people, or health visitors. However, the authors declare that whilst CBT can be an effective treatment for PND in the short-term, its clinical effect long-term is questionable.

In terms of engagement with individual treatment for depression, according to Cooper & Conklin (2019) longer treatments and a comorbidity with a personality disorder are associated with higher drop-out rates as well as being from an ethnic minority due to more contextual barriers to accessing treatment. On the contrary, educating and guiding clients' expectations, attending to their preferences, and fostering the therapeutic alliance were variables associated with higher treatment engagement. Furthermore, women with PND might face certain barriers when seeking treatment, due to both maternal and health care aspects. Stigma around the diagnosis was a contributing factor for not seeking treatment and the authors suggest that education on PND as well as a therapeutic alliance with the health professional are facilitators for starting treatment (Dennis & Chung-Lee, 2006). This aligns with Bilszta et al. (2010) finding of the following perceived barriers by

women with PND: expectations of motherhood; not coping and fear of failure; stigma and denial; poor mental health awareness and access; interpersonal support; baby management; help-seeking and treatment experiences and relationship with health professionals. These findings suggest there is a need to help health professionals to be aware of the personal and societal barriers preventing mothers from acknowledging their distress.

3.2. Evidence for psychoanalytic intervention

Psychoanalysis describes humans as struggling with unconscious urges that impact on their character, relationships, interests, passions, conscious attitudes, and cognitive capacities. Therefore, in the case of maternal depression, this type of therapy focuses on helping mother to get in contact with unconscious ambivalence toward her child, her partner, or her maternal role and helping the young child to get in contact with his unconscious affects (Salomonsson, 2014).

A number of studies have shown the promising effects of psychoanalytically informed practice in the treatment of different mood disorders. A study conducted by Fonagy et al. (2015) showed a modest improvement in depression for a group of participants who were treatment resistant (not specifically women) receiving Long-Term Psychoanalytic Psychotherapy (LTPP) versus a control group, until termination of treatment. According to this study, differences emerged from 24 months post-randomisation: the LTPP group mostly maintaining the gains achieved while the control group appeared to be at greater risk of relapse. At 2-year follow-up, almost one-third of the participants receiving LTPP were still in partial remission, compared with only 4% of those in the control group. At that time, 44% of the LTPP group no longer met diagnostic criteria for major depressive disorder, compared with 10%of those receiving treatment as usual alone. This study suggests that LTPP for depression might take a longer time than other approaches to see its effects, but that these will last.

It is arguable that LTPP owes its effects to its length, since it tends to be a longer process than other types of therapies. However, a study conducted by Zimmermann et al. (2014) proposes that its efficacy is related to both the length of the process or number of sessions, as well as the psychoanalytic technique.

The authors quote Blagys and Hilsenroth (2000) to delineate seven interventions that distinguished psychodynamic therapy from CBT: (a) a focus on affect and the expression of patients' emotions; (b) an exploration of patients' attempts to avoid topics or engage in activities that hinder the progress of therapy; (c) the identification of patterns in patients' actions, thoughts, feelings, experiences and relationships; (d) an emphasis on past experiences; (e) a focus on patients' interpersonal experiences; (f) an emphasis on the therapeutic relationship; and (g) an exploration of patients' wishes, dreams or fantasies. The author concluded that the higher dose seems to be responsible for the fact that psychoanalytic therapy is effective in helping patients to reduce their interpersonal problems and improve their self-love during treatment. On the other hand, psychoanalytic techniques such as explorations of patients' fantasy lives and discussions of patients' early memories seem to facilitate sustained change after therapy. An interesting addition these authors bring, is that other than the therapist interventions in a strict sense, the effects of psychoanalytic technique would be more related to the contents of the sessions. In this sense, they propose that psychoanalytic therapies provide time, space and an inter-psychic dimension for containment and 'reverie', so that patients are more likely to say things that are hard to say and that are almost never said to anybody else, therefore suggesting that changes in interpersonal problems and self-acceptance may simply require enough time spent in a caring therapeutic relationship.

3.3. Rationale and evidence for a focus on the mother-child relationship

Some studies support the importance of a focus on the mother-infant relationship additional to the treatment of maternal depressive symptoms, since the later does not necessarily cover the outcomes for the child involved (Nylen et al., 2006; Forman et al., 2007; Stein et al., 2018). According to Guedeney (2014), a depressed mother must be viewed as an adult with depression as well as a depressed parent interacting with her child. Therefore, treating a mother's depression without addressing her parenting behaviours does not sufficiently protect children from the potentially negative effects of having a depressed mother. Several authors support the idea that in the process of treating PND, the mother-child relationship must also be addressed, as treating maternal symptoms

will not guarantee a change in this relationship or the thriving of the child developmentally speaking (Murray et al., 2015; Tsivos, et al., 2015; Letourneau et al., 2017; Goodman & Garber, 2017; Ericksen et al., 2018; Salo et al., 2019), and the possible negative effects of depression on the child's development might be compensated by maternal involvement in childcare (Sliwerski et al., 2020). Furthermore, according to Cicchetti et al., (2004), ignoring relational issues in depressed mothers may perpetuate maternal depression. For example, the child may experience behavioural problems, and this may lead to feelings of guilt in the mother arising from the fear that her depression has interfered with effective parenting.

A review of forty papers conducted by Letourneau el al. (2017) exploring the effect of PND treatment on parenting and child development, included interventions based on interpersonal psychotherapy (IPT), cognitive behavioural therapy (CBT), peer support, maternal-child interaction guidance, and other interventions, such as massage. The review concluded that maternal-child interaction guidance and psychotherapeutic group support produced large effects on parenting and child development. Similarly, a systematic review conducted by Tzivos et al. (2015) investigated the effect sizes of interventions for PND that assessed the quality of the mother–infant dyad relationship and/or child outcomes in addition to maternal mood across nineteen papers. They concluded that interventions focused on the dyad relationship, namely mother–infant therapy, designed to promote maternal responsiveness, had the greatest efficacy at reducing symptoms of PND. For the child, there might be a period of adjustment for the infant following improvements in maternal mood and therefore time may be needed to make an appropriate conclusion about child outcomes after an intervention.

A recent review of parenting interventions for early years conducted by Jeong et al. (2021) analysed the data from 111 papers from which 102 were RCTs. It was concluded that in order to effectively improve child socio-emotional development and reduce behaviour problems in children, interventions need to support parental behavioural management skills, parental mental health, and encourage nonviolent discipline. Additionally, these authors found evidence of improvement

in parenting knowledge, parenting practices, and parent–child interactions; however, the reviewed interventions did not reduce maternal depressive symptoms significantly. According to Jeong et al. (2021), this is possibly due to the fact that few of the parenting interventions analysed addressed parental mental health explicitly. Interestingly, they cite a group in Uganda as an exception where sessions covered stimulation and responsive caregiving as well as parental emotional regulation and coping strategies. This intervention achieved better outcomes in the reduction of maternal depression.

3.3.1. Psychoanalytic dyadic interventions and their impact on mother and child

Therapists with an ego-psychological orientation warn against attributing mental capacities lying outside the baby's developmental timetable, relying on developmental models delineating behaviour and facultative capacities, which makes them reluctant to view the baby as an active participant in psychotherapy (Salomonsson, 2014). This is quite different from a psychoanalytic approach to the therapy of the parent-child relationship, where the baby or young child is seen as a subject in their own right, within the dynamics of the therapeutic process. Different models within this approach will view the child either as a catalyst fuelling the therapeutic process in the mother, or as someone who needs to communicate with the therapist. This will lead therapists to address the child in two different ways: some will talk to the mother about her baby, while others will talk to the baby about mother's suffering and their own (Solomonsson, 2014).

There are several arguments for inviting the participation of the baby or child in the therapeutic process, such as the fact that the baby's ego is immature, which would make him/her prone to become involved in an emotional disturbance with mother, but also to look for containment from a therapist who offered it, allowing a window of chance for undoing the effects of trauma (Norman, 2001). Recognizing babies as a subject also promotes a gap between mother and baby that has previously often not existed for the depressed parent who has identified the baby with "some internal object in [their own] mind rather than [having built] an empathic relationship with the infant" (Salo, 2007, p.18). This becomes even clearer when the therapy involves a toddler rather than an infant, where these

urges will manifest in the session through play, words, body language and tone of voice, and both parties actively seek containment from the therapist.

In the RCT referred to above conducted by Fonagy et al. (2016) in order to assess the efficacy of individual psychoanalytic parent-infant psychotherapy (PIP) for mothers presenting with mental health problems and their infants, there were no differential effects between treatment and control groups on measures of infant development, parent–infant interaction, or maternal reflective functioning. However, there were favourable outcomes over time for the PIP-treated dyads on several measures of maternal mental health, parenting stress, and parental representations of the baby and their relationship, indicating potential benefits for improving mothers' psychological well-being and their representations of their baby and the parent–infant relationship. In 2015, Majlis W. Salomonsson et al., published a follow up study reporting four and a half years on from a PIP intervention conducted with depressed mothers and their babies. Results showed that scores for the mothers of the treatment sample were then commensurate with levels in the community. PIP treatment seemed to have helped the mothers to recover more quickly on personal well-being, to become more sensitive to their babies' suffering, and to better support and appreciate their children throughout infancy and toddlerhood. Barlow et al. (2015), conducted a review of PIP treatment for mother and infant mental health and their results showed no clear evidence of improvements in parent-reported levels of depression, and no clear evidence of a difference for parent-infant interaction. However, there were improvements in the proportion of infants securely attached at post-intervention and a reduction in the number of infants with an avoidant attachment at post-intervention as well as significantly fewer infants with disorganised attachment at post-intervention. In a review conducted by the same authors in 2016, they concluded that PIP seems to improve child outcomes but there is not enough evidence to consider this approach as superior to other models of intervention.

A plausible explanation for variability in results could be once more the consideration of case specificity: Salomonsson (2014b) conducted a review of RTCs involving mother-infant psychoanalytic treatments and concluded that the maternal disposition to treatment was key for the outcome and that 'suitability' for

psychoanalysis was in fact poorly related to outcomes. Salomonsson explains that mother–infant therapy yielded better results if the mother was emotionally involved in the therapeutic process and saw herself as ‘part of the problem’. The author quotes Blatt (2006) to illustrate differential results for the two types of mothers he could identify as ‘Abandoned’ and ‘Participator’, corresponding with prior studies on ‘anaclitic’ and ‘introjective’ patient categories. Here it was found that classical psychoanalysis especially helped introjective patients, whereas supportive therapy was better for the anaclitic patients. Similarly, in 2011, Salomonsson described two types of babies: those evidently ‘affected’ by the relational disturbance and those who seemed ‘unaffected’. Among Affected babies, dyadic relationships and sensitivity among their mothers improved significantly more from PIP than treatment as usual, and the superior effects of therapy applied especially to Participator mothers and Affected infants.

Additionally, for abandoned mothers and unaffected infants, PIP and treatment as usual seemed to be of equal value. Blatt (2006) also states that mothers with high social adversity improved their interactive behaviour with the infants only from non-directive counselling, meaning that perhaps disadvantaged mothers may benefit more from a method that provides advice and support. Additionally, the author suggests that mother-infant psychotherapy may be particularly helpful if a baby has functional symptoms like gaze avoidance, fretting, mood instability, sadness, insomnia, and feeding problems. If the symptoms seem to reflect the baby’s internalisation of the mother’s projections, a focus on the baby is even more crucial. However, when the mother is in distress, but her infant is relatively healthy, an excessive focus on the infant could cause a damage in the therapeutic alliance with the mother.

PIP tends to focus on babies, however the effects of maternal depression in childhood might not become apparent until the child reaches toddlerhood and an impairment on his socio-emotional skills is observed. A toddler could play a different role in the therapeutic space in comparison to a baby, perhaps tending to claim a more active role instead of being given one. They could also be seen more as a small ‘human’ in their own right, rather than just a container for projections. Specifically for the stage of toddlerhood and derived from Child

Parent Psychotherapy (CPP) (Lieberman, 2004) which is normally aimed at parents and children between three and five years of age, Toddler-Parent Psychotherapy (TPP) applies the same model to this specific earlier stage in development. This intervention is derived from the work of Fraiberg, Adelson, and Shapiro (1975) and involves mothers and their toddlers seen in therapy sessions together. Through joint observation of the mother and the child, opportunities arise to observe the influence of maternal representations on the character of interactions between mother and child. This type of intervention has shown good evidence of its efficacy in fostering secure attachment in toddlers of depressed mothers (Cicchetti et al., 1999, 2000; Toth et al., 2006). At follow-up (Guild et al., 2017) findings indicated that children who received TPP were more likely to evidence secure attachments at post-intervention, which in turn was associated with more positive peer relationships at age 9. Furthermore, a recent systematic review and meta-analysis conducted by Sleed and colleagues (2022) on psychoanalytic and psychodynamic Interventions with children under five years of age and their caregivers, included 77 studies addressing various types of interventions rooted on psychodynamic theory. In this review, it was concluded that in 73% of these psychoanalytically informed intervention models, positive changes were shown in relation to maternal depression.

3.4. Rationale and evidence for interventions to enhance maternal reflective functioning

Both maternal depression and pre-mentalising modes or low parental reflective functioning have been associated with disadvantages in child development (Wong et al., 2017; Borelli et al., 2021) and often maternal depression and a lower capacity to reflect can overlap (Fischer-Kern et al., 2013, 2019; Ramsauer et al., 2014; Luyten et al. 2017; Suardi et al., 2020; Alto et al., 2021).

Despite mentalisation being a feature that is expected to develop during childhood, it is still possible to support its development at a later stage where this has not happened. Fonagy & Bateman (2006) believe that therapy has the potential to recreate an interactional matrix of attachments in which mentalisation develops and flourishes. The therapist's mentalizing can foster the patient's mentalizing, which is a critical facet of the therapeutic relationship and the

essence of the mechanism of change. The value of therapy is the experience of another human being's having the patient's mind in mind. Similarly, Pawl & Lieberman (1997) state that an intervention aiming at changing disturbed parental care-giving representations, should do so through the provision of a therapeutic alliance that will provide the mother with a new and secure relationship with the therapist. This will possibly be the main therapeutic factor; changes in a mother's representations are thought to occur through the relationship with a caring clinician. This relationship allows her to explore previously denied or distorted affect about her experiences with her own care-givers, and its consequent impact on her own parenting behaviour and her child's emotional experience. Since the cycle of abuse can come to an end if abused mothers are able to mentalise their past abusive experiences, mentalisation-based interventions were developed to help mothers at high risk of repeating the abusive parenting (Camoirano, 2017).

Short-term attachment-based intervention has been proven to change a mother's mental representation of caregiving, when it comes to a discrete problem such as child behaviour (Suchman et al., 2004, 2010). However, a short intervention can be limited for outcomes with mothers who have longstanding interpersonal difficulties. According to Steele et al. (2010), over a year of weekly treatment is needed for high-risk, multi-problem families. Suchman et al. (2004) propose that these types of interventions should be multi-level, as mothers will have a better chance to improve their relationship with their child if they exist within a good enough environment. Addiction, mental health or housing problems are some issues that could further hamper a mother's capacity to provide good enough care for their child. Such problems also need to be acknowledged and support given where possible. Another important component would be psychoeducation: in order for the parent to make reasonable inferences about the emotional states underlying their own and their children's behaviour, intervention will need to expand the mother's knowledge of children's emotional needs and abilities at different ages. Suchman et al. (2004) also propose that interventions aimed at scaffolding reflectiveness in mothers of toddlers would yield the greatest benefits, as early caregiving relationship representations of the parent become more accessible within the context of a current, newly formed relationship with their child. The specificity of the toddler-aged child as a pivotal window for intervention,

could also relate to the developmental realities described in the previous chapter, toddlerhood presents parents with several challenges and the ghosts or representations which were not provoked whilst the child was still an infant might then become apparent.

Different studies have supported the use of therapeutic interventions to enhance a parent's reflective functioning, for example a meta-analysis conducted by Camoirano in 2017, reviewed a number of studies assessing models aiming at improving parental reflective functioning, to investigate whether these interventions indeed scaffold maternal reflectiveness in women with a history of neglect and abuse. The author concludes that most of the reviewed studies showed that mentalisation-based clinical interventions were effective in improving maternal mentalisation and quality of caregiving; this is highly relevant and especially so for those mothers who have a history of maltreatment and who are thus at high risk of becoming maltreating parents. Furthermore, Barlow and colleagues (2021) conducted a metanalysis of early dyadic interventions showing that these interventions have a non-significant but moderate improvement in PRF in the intervention group and a significant reduction in disorganised attachment in children, concluding that relational early interventions may have important benefits in improving PRF and reducing the prevalence of attachment disorganisation.

In terms of mothers suffering from depression, Salo and colleagues' (2019) mentalisation-based parenting group intervention for prenatally depressed mothers bring a discussion topic for each session, one chosen to activate the reflectiveness of the mother, including feelings and thoughts related to the pregnancy, maternal representations of their childhood history, their ideas about the child, their experience of being a mother and their hopes about their own as well as their child's future. Additionally, each session includes cognitive and affect regulation techniques with direct attention on handling the current depressive mood and related somatosensory experiences, such as sleep and eating patterns. The authors also try to include interactive opportunities with the babies such as 'Theraplay' (Jernberg, 1984) which is described by them as an active, adult-led, playful parent–child interaction therapy. These activities are designed

to promote affectionate contact through physical touch, reciprocity, synchrony and joint attention. In 2019 the authors conducted an RCT to test the effectiveness of their model which showed that the intervention group displayed higher maternal sensitivity, higher RF and more reduction in depressive symptoms than the control group when babies were 12 months old.

Similarly, in Sleed and colleagues' (2022) review, 70% of the studies showed positive changes in parental reflective functioning. Some of the studies mentioned include Suchman et al.'s (2016) 'Mothering from the Inside Out' mentalisation-based individual therapy for mothers enrolled in mental health services; as well as Maxwell et al.'s (2021) study on the impact of the 'Circle of Security', an attachment-based group intervention, on maternal depression and reflective functioning. Their study concluded that compared to mothers in the control condition, treatment group mothers reported significantly improved parental mentalizing and self-efficacy regarding empathy and affection toward the child; reduced caregiving helplessness and hostility toward the child; and reduced depression symptoms, at the end of treatment.

In terms of RF and treatment engagement, a study conducted by Taubner et al., 2011 on the role of RF in the psychoanalytic treatment of chronic depression, it was concluded that RF predicted changes in general distress after 8 months of psychoanalytic treatment and that patients with higher RF were able to establish a therapeutic alliance more easily compared to patients with low RF. This is relevant when thinking of the therapeutic alliance as a protective factor for engagement in treatment for women with PND (Dennis et al., 2006; Bilszta et al., 2010). Furthermore, in a study conducted by Jorgensen et al. (2021) with adolescents with a diagnosis of Borderline Personality Disorder in a Mentalisation-Based Group treatment, lower reflective functioning was the only significant predictor of dropout.

3.5. Evidence for group interventions

The evidence for the use of group or individual therapy varies. Wierzbicki & Barlett (1987) found no differences between both settings in the treatment of mild depression from a CBT approach, whereas Stuart & Koleva, 2014 propose that

an individual approach to these intervention models would yield the most therapeutic benefits. Another paper by Cuijpers et al. (2008) states that for depression, this is true in the short term but at follow-up differences are no longer significant. These authors add that the drop-out rates they found were lower for individual therapy in comparison to groups. Tucker & Oei (2007) on the other hand propose that group therapy efficacy versus individual depends on the symptom presentation, for example it works well for depression but less so for substance dependency.

Regardless of these different results, groups can provide a normalizing and destigmatizing space for mother−infant difficulties, reducing social isolation (Kurzweil, 2012) along with the fact that they provide the most cost-effective model for intervention (Steele et al., 2010). Similarly, Clark et al. (2008) propose that given the social isolation and lack of emotional support often associated with PND, a group format may be particularly advantageous for this population. According to these authors, the relational focus of a group helps mothers understand how depression affects them and their relationships with others and to develop ways of relating and coping more effectively. This way, when mothers' social and emotional needs are met, they may become more emotionally available to their infants' psychosocial needs'.

Furthermore, toddlerhood is a developmental stage where social skills are initiated in the family environment and by parents who regulate their children through reciprocal social interaction, which in later life are translated into peer and loving relationships (Sroufe, 2005). According to Music (2017) "where parents are more responsive to children, the children become more responsive to peers, more prosocial, emphatic and have better friendships" (p 185). Other relationships also influence the development of the child, such as group interactions, peer relationships and siblings (Music, 2017). The seeds of interpersonal skills are sown in the early years, since children are equipped to foster multiple relationships, beyond dyadic interaction, in order to develop the social brain, therefore group interventions could also better address this need in comparison to individual settings.

Based on psychodynamic theory, Clark et al. (2008) developed The Mother-Infant Therapy Group (M-ITG) for women who are experiencing depression in the postpartum period, their infants, and their significant others. In their model there is a developmental therapy group component that addresses the infant's psychosocial and developmental needs while the mother–infant dyadic therapy component fosters healthy attachment relationships. Additionally, the model allows for partners to join as the authors state that the role spouses can play as a source of emotional support to their partners and in mitigating the impact of the mother's depression on the infant needs recognition.

This model aims at addressing the mother's intrapsychic conflicts related to her own experiences of being parented; reducing the mother's social isolation; providing an emotionally responsive environment for the infant; facilitating positive mother–infant interactions; enhancing the quality of the mother's relationship with her partner; and improving the mother's functioning within and outside her family. Sessions run across twelve weeks with a two-part format in which six to eight mothers meet in a therapy group for half an hour while their infants meet in a developmental therapy group. These groups are followed by a half-hour session during which mothers and infants reunite for dyadic group therapy. When testing their model, the results indicated that women in the M-ITG groups had significantly fewer depressive symptoms and experienced their infants as more reinforcing than did the depressed women in the waitlist control group (WLCG). Furthermore, mothers in the M-ITG group also showed significantly more positive affective involvement and communication in interactions with their infants than did mothers in the WLCG.

Another example for working with mothers with depression and their children is Ericksen et al.'s (2018) therapeutic playgroup model for depressed mothers and their infants. This model aims at targeting different areas of improvement, such as parenting behaviours related to mother's sensitivity to her infant and mother's internal representations of the child. The authors propose that through psychoeducational components, the mother becomes more aware and observant of her baby, increasing her capacity to play, which then reinforces the interaction as well as maternal mood and sense of competence. They also pay attention to

the therapeutic relationship, where the therapist becomes a secure base for the mother, allowing therapeutic change through play, movement, and thinking together. It is expected that with support from the therapist and an embodiment experience of joyful encounters, mothers can try new parenting behaviours and thus begin to create new internal working models.

3.6. Conclusion

Treating maternal depression is a fundamental task when thinking not only about the experience of women who suffer from it but also about the impact of this experience on the development of young children. Depression in mothers can be treated through a wide range of alternatives that include pharmacology and psycho-social interventions, however the evidence suggests that in order to have an impact on child development it is important to address not only the maternal symptoms but also the mother-child relationship. Both individual and group intervention models are considered in this chapter, where psychoanalysis is considered to play an important role in informing the theory and practice of many of these interventions. The benefits of facilitating a community-based group space where both maternal mood and the mother-child relationship can be thought of are discussed, as these can provide an alternative to isolation and the social needs of toddlers.

Chapter 4. Maternal depression and reflective functioning in the parent-toddler groups: a statistical analysis

4.1. Background and rationale

Mentalisation can be defined as the ability to understand one's own behaviours and the actions of others in terms of underlying mental states, such as thoughts, feelings and wishes (Fonagy & Target, 1997). The parental capacity to mentalise is understood as parent's capacity to hold the child's mental states in mind (Slade et al., 2005) and this capacity has been associated with healthy child development (Katznelson, 2014; Nijssens et al. 2020).

It has traditionally been assumed that depression impairs mentalizing (Fischer-Kern et al., 2013, 2019; Ramsauer et al., 2014; Suardi et al., 2020; Alto et al., 2021). A mother suffering from depression may struggle to focus on her child's experience while her mind is occupied with her own feelings, which may cause her to miss the child's cues and respond accordingly (Murray, 2003). From a psychoanalytic perspective, it is understood that the depressed mother may fail to see her child as a subject in its own right. Instead, she may see the child as a part of her physical and emotional self and sees it as indispensable to her well-being (Halberstadt-Freud, 1993). The child can also represent figures belonging in the parental past or an aspect of the parental self that is repudiated, becoming a recipient for externalisations and projections from mother which prevents her from being attuned to her child. The child can arouse the mother's own wishes to be cared for perhaps feeling resentful towards her child. A punitive super-ego brings excessive guilt or fear of this anger which may be turned against the self in the form of depression (Blum, 2007). According to Halberstadt-Freud (1993) and in line with Fraiberg and colleagues (1975), mothers with depression may have had the experience of perceiving their own mothers were not interested or did not enjoy taking care of them as babies. In other words, depression can hinder a mother's capacity to mentalise for herself and her baby, however, other studies do not deem the presence of depression as necessarily detrimental for mentalising (Vrieze, 2011; Katznelson, 2014; Cordes et al., 2017; Garset-Zamani et al., 2020; Georg et al., 2023). Given the mixed nature of findings, more

research is needed in order to further understand the relationship between mentalisation and depression in mothers which is the first aim of this study.

Furthermore, maternal depression has also been associated with impairments in the socio-emotional development of their children (Valla et al., 2016; Granat et al., 2017; Camisasca et al., 2017). As reviewed in chapter 3, research supports the use of therapeutic interventions to enhance a parent's reflective capacity (Camoirano, 2017; Salo et al., 2019; Sleed et al., 2022) and more specifically the use of group settings (Clark et al., 2008; Steele et al., 2010; Kurzweil, 2012) as well as psychoanalytically informed dyadic interventions (Cicchetti et al., 1999, 2000; Toth et al., 2006; Majlis W. Salomonsson et al., 2015; Fonagy et al. 2016;Guild et al., 2017; Sleed et al., 2022). As its second aim, the current study will explore the impact of a specific psychoanalytically informed group intervention, namely the Anna Freud Centre's Parent-Toddler Groups, on the capacity to mentalise in mothers with depression.

4.2. The Anna Freud Centre's Parent-Toddler Groups (PTGs)

The Anna Freud Centre's Parent–Toddler Groups are rooted in Anna Freud's work with children at the Jackson Nursery in Vienna in 1937. Here, she started developing her study of early childhood based on her observations of children, which became a main component of her 'double approach'. This approach integrated direct child observation with the psychoanalytic reconstruction of childhood experience from the psychoanalyses of children and adults, enabling the detailed study of developmental processes and the construction of a theory of normative and pathological development. This allowed her to identify disturbances that were developmental rather than neurotic, leading to the broadening of child analytic theories and techniques. These interventions aimed at freeing and supporting development rather giving insight and this approach is now referred to as 'developmental therapy' (Zaphiriou-Woods & Pretorius, 2016).

The Anna Freud Centre's Parent-Toddler Groups as they are known now, emerged as an informal offshoot from the Well Baby Clinic that Anna Freud had asked Joyce Robertson to set up as part of the Hampstead Child Therapy Course and Clinic in 1952. Joyce Robertson recognised that once babies became active

toddlers, the mothers attending her clinic could benefit from meeting together with her in small weekly groups. Here they could share the challenges of this new stage of development through talking and playing together (Pretorius, 2011). Historically, a number of groups were held at the Anna Freud Centre as well as in community settings. Since the Centre's move from Hampstead to Central London, only the community-based groups remain active. Each group meets once a week to talk and play for one and a half hours with a free-play child-led play structure. There are three set moments in each session that frame the sessions: the beginning, a snack time in the middle of the session and 'tidy-up time' five to ten minutes before the end. The groups are led by a qualified Child and Adolescent Psychotherapist and one or more assistants who have a postgraduate qualification related to child psychoanalysis. For this specific piece of research, only the data from the groups based at Anna Freud Centre, which are no longer active, will be used.

The early intervention therapeutic space provided by the Anna Freud Centre's Parent-Toddler Groups aims at supporting parents and their toddlers in order to prevent later disturbances from arising in the children's development, through the understanding of unconscious processes and normal toddler development. This group approach was thought to welcome any parent-toddler dyad and not specifically mothers with depression, however many of the referrals received by this service included this type of population.

Zaphiriou Woods & Pretorius (2016) (themselves both former clinical leads of this service) described the different interventions they utilise in order to contribute to the development of the toddlers and their parents:

4.2.1. Facilitating play and playfulness

Toddlers may use play to express intense feelings and fantasies in an enjoyable and safe way, and to master age-appropriate anxieties. The toddler group staff encourage parents to share their toddlers' play as well as encouraging play between toddlers. Such interventions may strengthen the attachment relationship but also promote separation and individuation, as toddlers and parents discover through playing together or apart, that they have different minds. Furthermore,

through parallel play, the toddlers are helped to discover each other as playmates and companions, and this helps to prepare the way for peer relationships in nursery and beyond.

4.2.2. Verbalizing toddlers' feelings and wishes

Verbalising toddlers' feelings helps them to learn to delay action, to communicate through language, and to distinguish between fantasy and reality. The toddler group staff often verbalise what they perceive as the toddlers' feelings and wishes, supplying words to identify and legitimise the toddlers' experience. This helps the toddlers build up coherent representations of their internal states, helping them to feel less helplessly overwhelmed and more in control of their impulses. Helping parents to empathise with their toddlers strengthens attachments.

4.2.3. Managing aggression and setting limits

Aggression and conflict are a normal and necessary part of development that allows toddlers to build a sense of self, separate from their parents and contribute to learning. Both the toddlers and the adults caring for them may find the toddlers' ambivalence and aggressive outbursts hard to manage, since they evoke similar feelings in them. The toddler group staff sometimes needs to act quickly to protect toddlers from hurting themselves or one another, and to reassure all members of the group that aggression can be safely contained. They may also intervene to prevent fights over toys and to promote turn-taking and sharing. They may verbalise the toddlers' frustration at having to wait, and also give voice to their own pride and pleasure when they manage to be patient or kind.

4.2.4. Supporting toddlers' moves towards independence and autonomy

Progressive moves towards separation from mother contribute to the toddlers' increasing sense of competence and mastery, preparing the way for their independent functioning at nursery and beyond. Most parents feel pride as their toddlers begin to take ownership of their functioning and self-care. However, some parents need support to let go gradually, especially when their toddler's separating stirs up their own unresolved feelings about separation and loss. The

staff try to join with them in finding solutions, supplying some ideas and guidance, but mainly helping them to pick up on their toddlers' cues and work out what is best for them, hoping that by encouraging the parents' self-reliance, they can enable them to do the same for their toddlers.

4.2.5. Feeding back observations and understanding behaviours

Parents are encouraged to observe their toddlers' behaviours and to think about what might be going on in their minds in order to enhance their emotional awareness of their toddlers, and to enable them to understand and respond to them in their own right. The staff use their knowledge of child development to help parents recognise what is age-appropriate in their toddlers, which may help them to better tolerate their toddlers' dependency and attachment needs, and/or their urge to separate and individuate. Many parents believe that good parenting involves the elimination of aggression, conflict or ambivalent feelings. Putting challenging behaviours in a developmental context or linking them to external events may reduce parental anxiety, freeing them to be more in touch with their toddler's feelings and fears.

4.2.6. Recognising and containing the parent's experience

The toddler group staff offer a supportive relationship to each parent, holding in mind their individual needs, and offering them one-to-one time in each session to communicate their current state of mind. This process may help parents to process potentially overwhelming feelings and experiences without having to cut themselves off from their toddlers or externalise and project onto them, blaming, rejecting and trying to control them. The holding (Winnicott, 1960) provided by the group and the therapist may enable them to become more accepting of their own and therefore of their toddlers' dependency needs and means that they are less likely to feel envious of the good care their toddlers are receiving. The attention paid to their own feelings may also help them to differentiate better between their own and their toddlers' needs and feelings, and to listen more attentively to the child.

4.3. Empirical research on effectiveness of the PTG

There have been a few studies conducted concerning the effectiveness of the PTG and its impact on RF. Camino Rivera et al. (2013) assessed the PTG's impact over on maternal reflective functioning, based on coding of the PDI administered with mothers and toddlers joined the group and after they left in a small pilot study. In total 12 mothers participated in the study and entry PDI scores ranged between 2 and 3, with a mean of 2.58 (SD=0.515). Exit PDIs scored from 2 to 5, with a mean of 3.58 (SD=.996). The analysis of the difference between entry and exit showed that the average of the exit PDIs was higher than the entry PDIs average and that this difference was statistically significant (N=12, Z= -2.521; p=0.012, 2 tailed). There was also a strong correlation between the level of reflective functioning on exit, with the length of time the mother attended the group with her child (N=12, rho= .776, p= 0.003). These results regarding the improvement in RF from entry to exit times were later replicated in an unpublished research project by María-Paz Saenz as part of her MSc studies at the Anna Freud Centre in 2015 with a bigger sample of 25 mothers. This study showed a statistically significant difference in the means for mothers' RF between T1 (M= 3.36, SD= 1.36) and T2 (M= 4.09, SD= 1.27); (t (21) = 2.84, p=0.01, 2 tailed). The present study has a sample of 28 mothers at entry and 24 at exit, representing a replication and an extension of previous studies while focusing on the specific effect on mothers with depression.

4.4. The Present study

Given the limitations in existing research on the relationship between mentalisation and depression in mothers, and the effectiveness of the PTG specifically, this study aimed to explore the reflective capacity of depressed mothers in the Anna Freud Centre's Parent-Toddler Groups (PTG) and compare it with non-depressed mothers who participated in the PTGs at baseline and after attending the groups. The research questions leading this study are (1) is maternal depression associated to lower reflective functioning when compared to non-depressed mothers? And (2) does participating in the PTG enhance reflective functioning in mothers with depression?

Based on the literature reviewed above and in previous chapters of this project, it is hypothesised that mothers with depression will present lower RF at baseline in comparison to mothers without depression and that mothers with depression will significantly improve their RF after attending the groups.

The rationale for this study relates to the fact that the PTG model is a psychoanalytically informed group intervention for any mothers and toddlers who might be struggling in their relationship. The groups are not an intervention tailored for depressed mothers, yet many participant mothers were referred because of current or past difficulties related to postnatal depression. Being able to assess the effectiveness of this model on the enhancement of maternal reflective capacity in mothers with depression is not just relevant for the use of this model in particular but also to bridging the gap in current knowledge about what helps mothers with depression improve their reflective capacity in general.

4.5. Methods

4.5.1. Participants and data collection

This study conducted a secondary data analysis using the existing PTG database which includes 160 dyads. The main data used for this study consists of the demographic information of these families as well as the Parent Development Interview (PDI) which is administrated by the PTG staff before the dyads start their participation in the groups (Time 1) and around the time the families plan to end their attendance (Time 2). Out of the total number of cases in the data base, only 64 had both an entry and an exit PDI interview. From these cases, 24 entry and 20 exit interviews were already transcribed as they had been included in Camino Rivera's (2013) and Saenz's (2015) previous studies. In this sense, there is an overlap in some of the cases used in this study and the previous studies mentioned above, however this study has the merit of looking specifically at the differences between mothers with depression and mothers without depression, whereas the previous studies mentioned above assessed the RF at Time 1 and 2 for the total group of mothers without accounting for these differences.

A research assistant employed by the Anna Freud Centre transcribed the interviews for four more cases which were selected due to the availability of their data, as older cases were not accessible. The final sample included 28 mothers at baseline (Time 1) and 24 mothers from the same group as the original for the after-treatment measures (Time 2) as the timeframe for this project did not allow for more interviews to be transcribed. Out of the total 52 interviews transcribed, 44 were double coded by certified PDI coders, accounting for 84.6% of the total number of interviews, while the remaining ones were coded by a single certified PDI coder who blind to the cases while coding.

Mothers were selected for this sample on the basis of the availability of the key data (i.e., having a coded entry and exit PDI) and then divided into 2 groups: if they presented one or more depressive episodes around the time their child was born, they were identified as 'depressed'. If they had a complete absence of reported mental health difficulties, they were identified as 'non-depressed'. This clinical information was gathered by the clinicians when the entry PDI was conducted as well as through the referral to the groups. Mothers who attend the PTG are asked by the lead therapist to attend for at least one year when joining. Mothers in this sample attended a PTG for an average of 18 months (Mo= 16 months).

Regarding the demographic information for the baseline sample of 28 mothers, the age average for these women was 34 years old (Mo= 35) with a minimum of 23 and a maximum of 41. 11 of them had only one child (the child attending the group with them), 23 mothers lived with their child's father and 14 mothers were full-time parents. Additionally, 10 mothers were of white ethnicity, while 18 were of other ethnic groups. 18 reported their first language as English, 13 of them had been diagnosed with a depressive episode, either postnatal or other, after their child was born and the children of these mothers were all aged between 1 and 2 years old, given the population served by the PTG, with half of them being boys and the other half being girls.

The data analysed in this study include a dyad's demographic information, referral and closing forms, weekly observations, as well as pre and post PDIs. Data was kept in a digital and confidential folder, to which the researcher was

granted access after the project proposal was submitted for Data Processing Impact Assessment (DPIA) approval to the AFNCCF, as the data under the new UK General Data Protection Regulation (GDPR). This approval was granted on 9.6.2018.

4.5.2. Measures

The Parent Development Interview (PDI)

The PDI (Slade et al., 2004) is a semi-structured interview intended to examine parents' representations of their children, themselves as parents, and their relationships with their children. The interview is audio or video recorded and the transcript is then read by a certified coder who utilises the Reflective Functioning Scale (RFS) (Fonagy et al., 1998) to assign a score to the interview. This scale of scores goes from -1 to 9, where -1 is considered 'antireflective', 5 is 'ordinary' and the baseline for an existing mentalizing capacity, and 9 represents an 'exceptionally reflective' capacity.

4.6. Results

In order to address the first research question, namely the correlation between the presence of depression and RF, an Independent Samples t-test was conducted. To address the second research question regarding the effectiveness of the PTGs, a paired sample t-tests was conducted on each group of mothers. All analyses were conducted using SPSS.

4.6.1. Reflective functioning at baseline

An Independent Samples t-test showed that at baseline, levels of reflective functioning in mothers who had experienced depression (M= 4.08, SD=1.038) and those who had never reported mental health difficulties of any kind were not significantly different (M=4.20, SD=1.373); t (26) = .270, p= .790.

4.6.2. Do the parent-toddler groups improve RF in mothers?

In order to address the second research question from this study, namely whether attending the PTG helps depressed mothers to enhance their reflective capacity,

a paired-samples t-test was conducted on each group to test the difference between the level of reflective functioning of mothers before they started attending the PTG (Time 1) and after they completed their attendance (Time 2), in order to evaluate whether the PTG help improve RF in mothers. For mothers with no history of mental health difficulties, there was a significant difference between the scores for 'Time 1' (M= 4.29, SD=1.383) and 'Time 2' (M=5.07, SD=1.328); t (13) = -2.797, p= .015, with a medium effect size (g=0.57). This suggests that mothers with no history of mental health difficulties who attend the PTG, improve their reflective functioning during treatment.

In terms of the mothers with current or past history of depression, there was a non-significant difference between the scores for 'Time 1' (M= 4.10, SD=1.101) and 'Time 2' (M=4.30, SD=1.160); t (9) = -.462, p= .662, with a small effect size (g=0.18). This suggests that mothers with a history of depression who attend the PTG, remain just below ordinary RF over the course of treatment.

4.7. Discussion

In terms of the research questions that guided this project, we first focused on the levels of RF in mothers with depression when compared to their non-depressed counterparts in the context of their attendance to the PTGs. Results showed that before attending the PTGs, RF of depressed mothers did not differ significantly from non-depressed mothers. These findings suggest that perhaps depression alone as a factor might not always compromise RF. Furthermore, this study suggests only non-depressed mothers improve their RF after attending the PTG.

In this study, depression did not seem to influence maternal reflective functioning in a significant manner when compared to non-depressed mothers at baseline. This suggests that perhaps the presence of depression does not always pose a hinderance to the mother's capacity to mentalise. Other studies have also suggested RF in women with depression does not differ significantly from the RF of non-depressed mothers (Vrieze, 2011; Katznelson, 2014; Cordes et al., 2017; Garset-Zamani et al., 2020). Acute depressive symptoms have been found to be an obstacle for reflective functioning (Luyten et al., 2017: Nijssens et al. 2020),

however this may no longer be the case once these symptoms are less severe. Furthermore, a systematic review conducted by Georg et al. (2023) concluded that parents who experience depressive symptoms show a slightly decreased mentalising in the relationship with their child. They state that these impairments are present in some mentalising skills but not in others.

Although this study did not assess the levels of depression in mothers, perhaps depressed mothers in this study did not present with severe enough symptoms to affect their RF.

Another aspect explored by this study was the response to the treatment model offered to mothers by the PTGs. In this study, only non-depressed mothers showed improvement in RF. Even though previous studies addressing the effectiveness of the PTGs did not look at differences between depressed and non-depressed mothers, they also reported improvement in maternal RF. A plausible explanation for these results is that the PTG as a model can be effective for a population that does not present depression, however perhaps depressed mothers might need a more specific type of treatment.

The PTGs are a psychoanalytically informed model that provides a group community-based setting where both mother and child are present to play with each other but to also promote and offer other relationships for both. The staff is there to provide psychoeducation as well as to model playfulness, boundary setting and reflectiveness. The group is used as a resource for mothers to support each other and more individual difficulties are often given particular attention by the group lead through one-to-one conversations or else referring to a consultant for and individual space. Cohorts normally are asked to commit their attendance for at least a year, with dyads normally attending for 18 to 24 months. The PTG model is not aimed at depressed mothers, however plenty of referrals included depressed mothers and their toddlers.

According to Guedeney (2014) interventions targeting mother's representations and internal working models are suitable for mothers with postnatal depression. Psychoanalytic approaches to therapeutic interventions have also shown efficacy for depression (Cooper & Murray, 1997; Fonagy et al., 2015) and this efficacy ,

according to Zimmermann et al. (2014), is related to the length of the process (as it tends to be longer than other approached) as well as the psychoanalytic technique as these provide time, space and an inter-psychic dimension for containment where users are more likely to say things that are hard to say, suggesting that changes in interpersonal problems and self-acceptance require enough time spent in a caring therapeutic relationship. (Blagys and Hilsenroth, 2000). Similarly, Pawl & Lieberman (1997) propose that a key component in intervention aiming at changing disturbed parental care-giving representations is the therapeutic alliance. The relationship with the therapist is thought to provide the mother with a new and secure relationship that can promote changes in a mother's representations through exploration of previously denied or distorted affect about her experiences with her own caregivers and its impact on her own parenting behaviour. In terms of mentalisation, Fonagy & Bateman (2006) believe that therapeutic relationship has the potential to recreate an interactional matrix of attachments in which mentalisation develops and that the therapist's mentalizing can foster the patient's mentalizing.

In this sense, the PTGs theoretical background follows similar guidelines, however the type of therapeutic relationship hereby described, and its depth might not be attainable in a group setting. According to Stuart & Koleva (2014) individual approaches tend to show better results, however group settings have other benefits such as providing a normalizing and destigmatizing space for mother−infant difficulties while reducing social isolation (Kurzweil, 2012) cost-effective manner (Steele et al., 2010). The PTGs offer individual consultancy with a child analyst for parents on a one-off basis (perhaps twice) when the staff members believe a parent might need further support in thinking about certain topics the group is not able to address to the appropriate extent. Perhaps for mothers with depression it would be helpful to consider a parallel individual and systematic therapeutic space. Similarly, Jeong et al. (2021) have stressed the importance of addressing parental mental health explicitly in interventions aimed at depressed mothers. The PTGs' guidelines touch on the issue of parental mental health through their mentalisation-based practices as well as their aim to Recognise and contain the parent's experience, however for this population it might be important to consider a more targeted approach.

Another element of the groups that has been supported by literature is the psychoeducational component (Suchman et al. 2004; Ericksen et al., 2018; Salo et al. 2019) as well as the inclusion of the child in the intervention. When treating PND the mother-child relationship must also be addressed, as treating only the maternal symptoms does not guarantee the thriving of the child (Norman, 2001; Cicchetti et al., 2004; Tsivos, et al., 2015; Letourneau et al., 2017; Goodman & Garber, 2017; Ericksen et al., 2018; Salo et al., 2019).

Similarly, more lengthy interventions like the PTGs seem to have more lasting results. According to Steele, Murphy & Steele (2010) a short intervention can be limited for outcomes with mothers who have longstanding interpersonal difficulties and over a year of weekly treatment is needed for high-risk, multi-problem families. In this sense, the PTGs comply with these requirements as they see families weekly for at least one year.

Suchman et al. (2004) propose that mothers will have a better chance to improve their relationship with their child if they exist within a good enough environment. Mental health or housing problems can further hamper a mother's capacity to provide good enough care for their child, therefore such problems need to be acknowledged and supported when possible. Contextual factors such as high life stress and lack of social support have been described as main risk factors for maternal depression (O'Hara & Swaine, 2009; Yim et al. 2015; Ghaedrahmati et al., 2017; Silverman et al., 2017; Hutchens & Keraney, 2020) which is why according to Sockol (2018) Interpersonal Therapy (IPT) has shown good results in the treatment of perinatal depression, possibly due to its focus on areas that relate to this type of depression such as low social support, marital dissatisfaction, role transitions and challenges to interpersonal relationships. In this sense, perhaps models such as the PTGs would benefit from creating a more active network with other community services such as home visiting and make this type of support part of their guidelines for the treatment of depressed mothers.

Thirdly, maternal depression is not homogeneous (Vliegen et al., 2014), and so depending on its presentation, the therapist might need to adapt their approach. This is where propositions such as Salomonsson's and Blatt's on the different types of depression are rather relevant. To summarise, Salomonsson (2014b)

speaks of ‘Abandoned’ and ‘Participator’ types, similar to Blatt’s (2006) ideas on ‘anaclitic’ and ‘introjective’ patient categories. Classical psychoanalysis mostly suits introjective patients, whereas a more supportive approach works better for the anaclitic patients. For Solomonsson (2011) If the child is presenting symptoms as an internalisation of the mother’s projections, a focus on the child is crucial. However, when the mother is in distress, but her infant is relatively healthy, an excessive focus on the infant could cause damage in the therapeutic alliance with the mother.

Lastly, a fourth possibility for these results is that the measure used, namely the PDI, assuming it was applied properly, may not be sufficiently sensitive to change of maternal reflective functioning in time. Mentalisation is a multi-layered construct that can be highly volatile to internal and external circumstances and as such it is not static. It can improve in time when facilitated and it can also decrease in moments of stress (Fonagy et al. 2002; Luyten & Fonagy, 2018). The participant mothers in this project might have faced the interview the second time after exiting the service, perhaps with less urgency or with conflicting feelings about leaving, potentially having less of a wish to share their thoughts and feelings in depth with the therapist. It might also be relevant to wonder how the reflective capacity of a mother is activated when the questions asked are already known to the mother. The use of the PDI has raised questions before, for example, Camoirano (2017) says the RF scale scores are very dependent on language skills, which can propose a barrier for women who are bilingual and with limited education, who could find it challenging to use language to communicate and describe emotional and cognitive states. This variable did not reach significance when explored in this study, however it is worth considering. Similarly, Fonagy et al. (2016) also raised doubts about the lack of sensitivity of the PDI-RF due to its reliance on the use of mental-state language after their RCT’s results found no significant increase in maternal PDI-RF in mothers who received psychoanalytic parent-infant psychotherapy (PIP), which strongly focused on the mothers’ mentalizing. Subsequently, the authors used a qualitative measure named Assessment of Representational Risk (ARR; Sleed, 2013) to evaluate PDI transcripts and this showed that only mothers in the PIP group showed a significant decrease in representational risk. Furthermore, Sleed

et al. (2020) suggest the PDI and the RF coding system may not be suitable for parents of new-born infants or those with learning difficulties.

4.8. Conclusion

The present study aimed at addressing two research questions regarding whether depression in mothers impacts their capacity to reflect in comparison to their non-depressed peers and whether the PTGs are suitable model of intervention for mothers with depression and their toddlers. A quantitative approach was used to explore these questions and the expected hypothesis based on previous research were that mother with depression would present with a lower RF at baseline compared to non-depressed mothers, and that the PTGs would help these mothers improve their RF. None of these hypotheses were confirmed. The discussion proposes that depressed participant mothers could benefit from spaces such as the PTGs if these considered some more case specific aspects to their model, as a depressed mother might need a different approach instead of a more universal type of intervention. Similarly, maternal depression is heterogeneous, therefore thinking of case specificity might be equally relevant. Finally, some questions are suggested in terms of whether the PDI is able to accurately measure the change of RF in time.

4.9. Limitations

In terms of the first part of this study, namely the correlational research, its benefit lies in the potential uncovering of relationships that may have not been previously known. However, it does not provide a reason for that connection between two variables. In the case of this study, it is possible to see how two variables may influence each other or not, but causation is not explained. Secondly, with this methodology it is not possible to determine which variable is responsible for influencing the other although we may infer on the basis of previous research. Thirdly, even when we may draw some correlations, it is not possible to guarantee that other variables not accounted for were not part of the equation.

Furthermore, in terms of the second part of this study, there are limitations to the use of a quasi-experimental research model as well. The lack of randomisation in this study makes it difficult to affirm that the outcomes obtained in this study

can only be attributed to the treatment model assessed. Overall, the sample for this study was small which imitates the possibility for assuming a big portion of the general population that did not participate in this study would behave in the same way if this study was replicated. Similarly, quantitative research in general can propose limitations to a thorough understanding of the studied phenomenon, especially when what is being studied is related to human experiences.

The use of multiple coders could propose a minor discrepancy in the criteria for scoring each individual PDI which is the main measure used in this study. Other limitations related to the use of the PDI and the RF scale are that the measure may be insensitive to treatment change in samples of distressed mothers seeking emotional support (Sleed et al., 2013), and qualitative changes are not measured by this scale (Fonagy et al., 2016).

Lastly, a potential limitation for this study could also be the fact that even though maternal depression plays a fundamental role in this study, the criteria for selecting participants for this group did not include additional tools to identify the presence of depression in mothers other than the referrer's information and the mothers' self-reports. Perhaps using further measures at T1 to confirm the presence of depression and the level of acuteness would have provided more accurateness about this criterion.

4.10. Future research

Further research is needed to expand our knowledge regarding the influence of depression on a mother's capacity to mentalise for herself and her child. Measures could be used to determine the acuteness of the depressive symptoms and its relationship to RF or perhaps a distinction between types of depression (see chapter 1) and its relationship to RF. In terms of the non-significant change in RF in depressed mothers at Time 2, further research would be needed in order to assess potential qualitative changes in maternal representations as well as a better understanding of what constitutes a helpful intervention for supporting the mentalising capacity of depressed mothers. Future research should also explore the development and implementation of case-specific intervention models tailored to the needs of depressed mothers participating in PTGs. Investigating

the heterogeneity of maternal depression and its implications for intervention outcomes is crucial for developing targeted and adaptive intervention strategies.

Finally, further refinement and validation of outcome measures are also needed to accurately assess changes in RF over the course of PTG interventions as well as other interventions to evaluate the relative efficacy of different intervention models for mothers with depression and their toddlers. Comparing PTGs with alternative interventions or treatment modalities can provide valuable insights into the optimal approach for addressing maternal depression and promoting positive parent-child relationships.

Chapter 5.

Markers in the play of toddlers of depressed mothers: a qualitative multiple-case study

5.1. Introduction

A significant body of research has investigated the characteristics of the mother-child relationship and the role it plays in child development (e.g. Fraiberg, Adelson & Shapiro, 1975; Fonagy et al 1991; Zeegers et al, 2017), as well as the impact of the added component of maternal depression (Cuijpers et al.,2014; Guedeney, 2014; Stuart & Koleva, 2014; Ericksen et al., 2018). Interventions aimed at supporting the mother-child relationship in order to promote healthy child development have also proven different levels of efficacy and tend to focus on maternal aspects of the dyad rather than the child (Salomonsson, 2014; Tsivos et al., 2015; de Camps Meschino et al., 2016; Letorneau et al., 2017; Salo et al., 2019).

Most of this research has taken a quantitative approach, evaluating the change attributed to an intervention by contrasting the results of measures at the start and the end of their study. Qualitative research can capture aspects of the human experience that may be particularly relevant for clinical contexts such as mother-child interventions, complementing the potentially reductive nature of a purely quantitative approach, as these tend to offer a not in-depth take snapshots of a phenomenon (Rahman, 2020).

In order to gain a more nuanced understanding of the role of maternal depression and maternal reflectivity in child development, a qualitative approach will be used for this study where play is understood as a part of development that can account for different aspects of a child's health:

> *"At the normal end of the scale there is play, which is a simple and enjoyable dramatisation of inner world life' (Abram, 1997). 'Play (…) belongs to health: playing facilitates growth and therefore health."* (Winnicott, 1971)

A child's capacity to play can provide insights into the child's past and current relationship with their mother. The use of objects, imagination, language and peers form part of the developmental tasks of toddlerhood. How children navigate this time in their lives will likely be related to the mother's capacity to have her child in mind and see them in their own truth (Fraiberg et al., 1975; Winnicott, 1971; Bailly, 2009). This means a mother's capacity to mentalise is closely linked to a child's capacity to play. As described in previous chapters, theory and research suggest that play in children of depressed mothers can present different variations that can inform the observer about the level of disruption there is and has been within a dyad (Bick, 1968; Chazan & Kuchirko, 2019; Emmanuel, 2006; Freud, A., 1963; Greenspan & Lieberman, 1994; Halfon, 2017; Lous et al., 2000, 2002; Pretorius (2020); Salomonsson, 2013; Singletary, 2015, 2019; Sohr-Preston & Scaramella, 2006; Tingley, 1994; Winnicott, 1971). Therefore, studying the child's play could allow an insight into a child's participation in the groups, instead of only focusing on maternal aspects. Moreover, this study focuses on toddler play, as toddlerhood is a developmental stage where play takes a fundamental role in the child's journey towards learning and relating to others. Toddlerhood also serves as a pivotal window for intervention as it presents parents with several challenges, ghosts and representations that might not become apparent while the child remains an infant (Suchman, 2004)

When looking into the existing theoretical background on the effects of maternal depression on child play, it is apparent that this is not a subject that has been widely explored or written about. The present study aims at exploring the development of play in toddlers of mothers with depression in comparison to their peers. Based on theory, previous research and a focus group involving clinicians with an expertise in early years, this study will propose a series of clinical markers that can potentially be observed in toddlers of mothers with depression and use a multiple-case study methodology to test them. In other words, the present study aims at answering the following research questions: Do toddlers of depressed mothers play in a way that is different from their peers? Can we identify any associations between toddler play, maternal aspects and the attendance of these dyads to the PTGs? Similarly, this study hypothesises that the proposed play markers associated to the presence of maternal depression, will predominantly

be found in children of mothers with depression. Furthermore, it is also expected that these markers will not be predominant in children of non-depressed mothers.

5.2. Methodology

5.2.1. Research design

The research design is a multiple case study. In case study research, a ‘case’ can be a single individual, as well as another entity such as an organisation or community (Yin, 2003). There can be single or multiple case studies, and these are often used when ‘how’ or ‘why’ questions are leading the research; when the researcher has little control over the events studied; and when the focus is on a contemporary phenomenon within some real-life context. Additionally, a central feature is the use of triangulation of data sources to gain a multi-perspective account.

Multiple case studies are used when more than one case is available to be analysed, allowing the data to be more robust and compelling when answering the research questions. According to Yin (2003), one should consider multiple cases as multiple experiments, in order to follow a ‘replication’ logic as opposed to a ‘sampling’ logic. This means cases should be selected (a) either to explore whether they conform to a set of theoretically derived propositions or (b) to determine whether they contradict them, but for predictable or theoretical reasons. These are known as ‘literal’ and ‘theoretical’ replications, respectively.

Yin (2003) explains that replication logic is different from the sampling logic in that in sampling logic, a number of participants are assumed to ‘represent’ a larger pool of people, allowing statistical generalisation. On the other hand, replication logic allows for analytic generalisation, meaning that the replications are used to support a previously studied piece of theory while also considering rival explanations for the phenomenon of interest. In this sense, replication logic could be considered to be more thorough. According to Yin (2003) replication logic along with the use of multiple sources of data and triangulation of the analysis strengthen the validity and reliability of a study.

A research design with these characteristics requires the development of a strong theoretical framework, which needs to state the conditions under which certain findings are likely to occur (a literal replication) as well as those under which they are likely not to occur (a theoretical replication). The theoretical framework becomes the means towards generalisation of theory, therefore when the predictions are not met, theory must be modified.

In a Multiple Case Study design, each individual case must be regarded as an individual and complete study, whose conclusions need to be replicated by other individual studies. These are then cross-analysed and contrasted with the theoretical background of the study. In the case of the present study, two groups are considered, with five cases each. Both groups involve parent-toddler dyads who participated in the PTG. The first group comprises dyads where mothers have a history of depression, while mothers in the second group have no known previous history of mental health difficulties. Each group includes five cases, that is, ten dyads in total. With a theoretical framework based on the impact of maternal depression on children's play and potential play markers, in this study the cases of depressed mothers will act as a literal replication. Additionally, in order to explore whether these markers are only found in the depressed group as theory predicts, the second group of non-depressed mothers is selected as a theoretical replication.

5.2.2. Cases and setting

As described, the setting for the case selection is the Anna Freud Centre's Parent-Toddler Groups (PTG). The model for these groups has been described in the previous study, including its aims and structure. The staff for each group commonly includes a Child and Adolescent Psychotherapist, as well as one or more clinical assistants. The staff members keep clinical records for each dyad during their participation in the groups, including pre- and post-intervention measures such as the PDI used in this research, and primarily weekly comments and/or observations. These observations serve as the main data used in the present study and these normally involve the child's play, interactions between mother and child or the staff members and the dyad.

The PTG have been operating for several decades, however the service has systematised data around each participant dyad only during the last ten years. This was an important factor in the selection of the cases for this study, as older cases might not be available digitally or might not have enough data to build a case, whereas more recent cases have more available and robust data. This constraint meant that pairing the cases in each group in terms of similar demographic information was difficult; however each group has diversity within its units of analysis.

In 2000, the service manager asked the clinicians to start gathering data on their participant dyads. These data were systematised in the service´s data base in 2016, with the information from a hundred and sixty dyads. Because the first study on this research focused on the results of the PDI measures, a selection had to be made considering the existence of both entry and exit interviews. This reduced the list to sixty-four cases. Many of these interviews were not transcribed yet, therefore a pragmatic decision was made in order to speed the process of analysis, and the list was again reduced to cases that had already been transcribed. Twenty-four cases were left for time 1 and twenty for time 2. A research assistant employed by the Anna Freud Centre agreed to transcribe the interviews for four more cases based on availability of data, yielding a final number of cases of twenty-eight and 24 respectively.

For the previous study, twenty-eight dyads were selected for a quantitative analysis, and from these cases, ten were selected for this study: five examples of dyads where the mother had depression and five where the mothers were not depressed and had no history of mental health difficulties. In the case of mothers with depression, they were selected on the basis of their diagnosis being explicit in their referral to the PTGs, whereas non-depressed mothers were selected on the basis of self-reporting an absence of mental health difficulties history as well as no mention of this in their referral.

The decision on what cases were included in the study was made on the basis of availability of data for case study research. Due to changes in UK data protection law in 2018, the data from older cases had to be deleted. Therefore, out of these twenty-eight cases, only eighteen participants were accessible.

Finally, the cases for this study were selected based on the availability of their data, as well as the sufficiency of it. This means cases with more than thirty pages of clinical records were considered, in order to have enough material for a case study.

The families that were selected for the 'depressed' group were diverse. Mothers were of different ethnicities and their ages ranged from early twenties to mid-forties. Three of the mothers had a university education (Grad), all of them were full-time mothers (FTP) at the time, and all of them had a diagnosis of depression (dep) while three of them presented a co-morbidity. Three of the mothers were taking antidepressants (AD) for their depression while they attended the groups.

Table 1: Demographics in the Cases Where Maternal Depression is Present

M	Age	RF1	RF2	Ethnicity	Ed	FTP	Diag.	AD
Beth	20s	4	4	Mixed B&W	GCSE	yes	dep-BPD	yes
Hina	20s	5	4	South Asian	A Level	yes	dep-trauma	no
Ana	30s	6	5	Latino	Grad	yes	dep	yes
Kathy	40s	5	6	White	Grad	yes	dep-OCD	no
Lucy	30s	4	5	White	Grad	yes	dep	yes

In terms of the families that were selected for the 'non-depressed' group, all mothers were in their thirties and had an educational level up to postgraduate education (PG), revealing a general higher educational level than their depressed counterparts. Three of these mothers were full-time parents at the time they attended the groups and there was diversity in terms of ethnic background. Only one mother was White British, whereas one was of Asian origin, one mother was Latin-American, one mother was of mixed White and Asian background, and one was a first generation south Asian British born.

Table 2: Demographics in the Cases Where Maternal Depression is Absent

M	Age	RF1	RF2	Ethnicity	Ed	FTP
Molly	30s	6	5	White British	PG	no
Elly	30s	6	7	Asian	PG	yes
Manira	30s	5	5	South Asian	PG	yes
Caitlin	30s	5	7	White/Asian	PG	no
Lorna	30s	5	6	Latin	PG	yes

5.2.3. Measures and instruments

This study involved secondary data analysis, meaning the data used for this study was collected before the researcher was involved in this project.

As part of the PTG policy for tracking progress and facilitating research, the staff members would seek consent from the parent involved, before they began participating in the groups. This consent allowed the staff to video-record each session, keep records such as measures and weekly observations, and to use this data for research after the dyad ceased participation.

The weekly observations registered by staff members are the main source of information analysed in this study. These observations were written as 'vignettes', meaning they are a sequential description of an event observed by the staff member involving an individual child, which was added to their records after each group session.

The data analysed in this study include a dyad's demographic information, referral and closing forms, weekly observations, as well as pre and post PDIs.

5.2.4. Ethical considerations

Data was kept in a digital and confidential folder, to which the researcher was granted access after the project proposal was submitted for Data Processing Impact Assessment (DPIA) approval to the AFNCCF, under the new UK General Data Protection Regulation (GDPR). This approval was granted on 9.6.2018 and no further ethics approval was needed as the AFNCCF was the data owner. Additionally, for confidentiality purposes, the original names in each case studied were changed. The families were asked at the start of their attendance if they would be willing to allow their data to be used for research purposes. All participant families have given written consent for their data to be used for research purposes. The researcher also signed an individual Non-disclosure and Confidentiality agreement with the data owner. Both this document and the DPIA can be found in the Appendix of this thesis.

5.2.5. Data analysis

Different authors have different views on how to best approach case study research (Eisenhardt, 1989; Simons, 2009; Stake, 2005; Merriam, 2009; Thomas, 2010; Westerman, 2011). In this study, Robert Yin's (2003) approach will be adopted. The author states that it is best to have an existing theoretical hypothesis that can guide the sampling process. In his view, a case study uses qualitative data as its primary resource and 'Pattern Matching' is the most appropriate data analysis strategy.

Yin (2003) discusses two main types of pattern-matching in theory-testing: dependent variables design and an independent variables design. The present study is considered to fall into the dependent variable category, given its characteristics. The dependent variable would be the presence of depression in mothers, predicting a certain outcome when the variable is present and another different one when it is absent. According to Yin (2003) the initially predicted value must be found for each element of a pattern of dependent variables and pattern matching in the dependent variables design should be rigorous, such that the hypothesis is disconfirmed even if only one variable of the pattern does not behave as predicted.

When the dependent variable is present, i.e., maternal depression, it is expected that associated child play markers will be present, whereas in the case of non-depressed mothers, it is expected that these play markers will be absent. This concurs with the idea of 'necessary condition proposition' and 'sufficient condition proposition'. In the first, a case must be selected in which the dependent variable is absent. Pattern matching in this case consists of checking whether the predicted outcome is absent in the observed pattern. In the second, a case must be selected in which the variable is present. Pattern matching in this case consists of checking whether the predicted outcome is present in the observed pattern (Hak & Dul, 2010).

5.2.6. Play markers in children of depressed mothers

In order to develop markers in toddler play associated with maternal depression, two main sources were used. First, a group discussion was conducted online for an hour, with four Child and Adolescent Psychotherapists, accredited by the Association of Child Psychotherapists (ACP), who had vast work experience with Early Years. Secondly, theory on child play in relation to maternal depression was examined.

In the group discussion, the main researcher shared the aim of the meeting with the clinicians, namely thinking about play in toddler of depressed mothers based on their work experience and theoretical knowledge. The clinicians had a non-structured conversation while the main researcher took notes and at the end, these notes were fed back to the group. Three main themes emerged from the discussion: use of objects and people; non-reliance on parent; and quality of play.

With regard to use of objects and people, the clinicians agreed that a child with a depressed mother would be more likely to find it difficult to play and use toys. Children might be expected to present as rather absent, uninterested or even mindless, perhaps mirroring an experience of maternal inattentiveness due to depression. As their capacity to play and imagine could be hindered, children might also show a reliance on their body in their playful activities, instead of toys or symbols. When thinking of the use of others, they thought the child might be less interested in sharing playful experiences with others, both adults and peers, or else they might use others in an instrumental way as objects, instead of socially relating to them.

Secondly, under the theme of non-reliance on the parent, the clinicians thought there might be a preoccupation with mother and her wellbeing or a difficulty in experiencing her as a secure base, which could create an obstacle to playing. The child might find it painful to leave mother momentarily in order to explore and play, as well as struggling to allow others to break into the dyadic space. On the other hand, if the child is able to move away and play, perhaps there might be a difference between playing with mother and playing with others, as mother

possibly would struggle with staying engaged or facilitating creative play, whilst others might not.

Thirdly, under the theme of quality of play, clinicians thought the child's play might appear non-authentic or non-creative and perhaps imitative or repetitive, as well as joyless. There were questions related to the expression of aggression in play, as a mother who is depressed might not have integrated her own aggression. The child could either present as very inhibited in his play and display of normative aggressive feelings, or alternatively they might appear quite dysregulated and easily frustrated. In this sense, a limited range of emotions was also thought of.

Additionally, a child might face his mother's depression with a manic defence and so his play could present as hyperactive in an attempt to enliven mother and avoid thinking. This, as well as difficulties in the mother-child relationship, would be a barrier for the child to develop symbolic play and a narrative to go along with it.

All these variances in play could mean these children do not present as age appropriate in their play, which is another marker suggested by the group of clinicians.

In this process, it was found that the propositions made by the group of clinicians greatly coincided with the existing literature on the subject (Winnicott,1971; Greenspan & Lieberman, 1994; Tingley, 1994; Lous et al., 2000, 2002; Emanuel, 2006; Sohr-Preston & Scaramella, 2006: Halfon, 2017; Chazan & Kuchirko, 2019), thus the markers that emerged in conversation with the clinicians served as a guide to discuss these papers as well as some of the relevant literature included in previous chapters of this project.

Play inhibition is the first marker clinicians thought of, which can be understood as a difficulty to play. As discussed in the literature review section of this research, play is fundamentally based on the mother-child relationship, and maternal depression can propose a barrier for creativity, play and symbolisation. Inhibition in child play is something that has been described in literature before in

association to maternal depression. Emanuel (2006) for example proposes that in response to a possible inattentiveness from mother to the child, the child might try to get through to mother by becoming restless. This is something also described by Salomonsson (2013), who proposes that depending on the presentation of the depressive symptoms, mothers can relate to their children in a disengaged way or else intrusively. According to the author, babies of disengaged mothers protest, whereas babies from intrusive mothers tend to look away.

Infants who are restless may eventually give up their efforts and become depressed themselves, similarly to children who disengage (Emanuel, 2006). Depressed children have been described to play less than their peers (Lous et al., 2000, 2002; Chazan & Kuchirko, 2019) and to offer and seek less comfort during play from peers or adults and show less exploration (Halfon, 2017). Another obstacle to play could be a **difficulty to separate from mother**, which was also mentioned in the group discussion and as an effect of maternal depression in the literature review chapters. If the child cannot bear to separate from mother, it is unlikely he will have space to explore other objects, people and environments and overall to develop the capacity to imagine and symbolise (Winnicott, 1971). Play starts in the relationship with mother who might facilitate separation through introducing the child to toys and games. However, depressed mothers have been observed to engage less in play with their children (Tingley, 1994; Sohr-Preston & Scaramella, 2006).

This difficulty to separate would have a direct effect on **social play** development, as letting others interfere with the dyadic functioning of the depressed mother-child relationship could be a strain for both mother and child. According to Chazan & Kuchirko (2019), children might avoid interacting with others, using avoidance as though they felt threatened. Relationships with others could lack the spontaneity, warmth, and joy of human companionship. Developmentally, this play is at an early level, as it is not yet using consensual symbols or communicated through the reciprocal use of language. Furthermore, Greenspan & Lieberman (1994) propose that when the child is not taught to handle aggression or other overwhelming feeling such as loss or separation, which is a

risk in the presence of maternal depression, there may be little or no progress beyond early dyadic experiences.

Another potential consequence of a non-integrated relationship with aggression could lead to a child feeling mother is not able to survive his aggressive feelings, allowing the intrusive type of mother to take control, thus **the child presents as too compliant**. According to Chazan & Kuchirko (2019), inhibited children do not express their conflict in an overt manner that would involve them in dispute with others. Rather, they tend to turn inward and direct their anxieties against themselves, make-believe characters, or abstract issues. On the other hand, the child that has become restless due to maternal disengagement could do the opposite and behave in an **oppositional style**. In both cases, as mother has struggled herself to integrate her own aggression, she is unlikely to be able to support her child in doing the same.

The potential pattern of inattentiveness that some depressed mothers might present, might also be linked to **hyperactivity in children**, which is another marker the group discussion identified. According to Emanuel (2006) the child can internalise this pattern, presenting difficulties in concentrating or paying attention. Similarly, the author says the excess of energy could be linked to the child feeling at some level a sense of responsibility for cheering up mother and bringing an element of liveliness into the relationship. Additionally, Lous et al. (2000, 2002) observed that depressed children tended to explore the environment and the experimenter rather than staying with toys and activities, manifesting loss of concentration. A child that feels the need to permanently move and cannot concentrate is therefore less likely to engage in play.

An alternative response to a deficit in attention resulting from maternal depression is the infant's unconscious turning away from states of dependency by becoming **precociously self-sufficient** and controlling, dealing with unmet needs by appearing to require little comfort or gratification from adults (Emanuel, 2006; Halfon, 2017). According to Esther Bick (1968), infants can develop muscular 'second skin defences' as a way of holding themselves together in the absence of maternal containment. A child who cannot bear to be in touch with

feelings of dependency may reject other adults or a mother-like figure who may have something to offer, as a reminder of what they do not have themselves.

The aforementioned second skin defence involved a certain over-reliance on the body, which could relate to the use of the body in play described by the clinicians. This was thought of in opposition to what would be expected in normative toddler play, namely the use of toys and symbolic play. As discussed in the literature review chapters, symbolisation and symbolic play finds its origins in the process of separation in the mother-child dyad (Winnicott, 1971). Therefore, **symbolic play** is something children of depressed mothers might struggle with. According to the existing literature, children of depressed mothers might still be able to develop symbolisation and symbolic play, depending on how pervasive the maternal depression has been in their development. However even having the capacity, it has been observed that these children spend less time playing symbolically than their peers (Tingley, 1994; Halfon, 2017), playing symbolically is easily interrupted by stress (Greenspan & Lieberman, 1994) there tends to be a preference for manipulative or non-symbolic play, symbolic play often needs to be initiated by others in order for these children to display this capacity and it tends to be quite simple in terms of narrative (Greenspan & Lieberman, 1994; Lous et al., 2000, 2002; Chazan & Kuchirko, 2019). This last aspect was also highlighted by the clinicians.

Another marker suggested by the clinicians was a potential non-authentic or non-creative quality to the play of these children. This is difficult to define but it is possibly linked to a sense of joy in play as well as uniqueness. The play of children whose mothers are depressed may seem dull, repetitive or imitative. According to Greenspan & Lieberman (1994) children within an environment that does not facilitate symbolisation, might lack a unique signature in the symbolic elaboration of experience, so that the choice of pleasure, intimacy, exploration, anger, or negativism is not accompanied by a recognizable individual style on the part of the child. Similarly, repetitive play might be an indication of anxious feelings (Freud, 1920). In this sense reduced creativity, **repetition** and an apparent lack of affect could be considered anti-play behaviours, communicating a more severe compromise of the child's capacity to play. Repetitive play has

been associated with psychological conflicts and maladaptive coping as well as neuroplasticity and neurobiological deficits, where the purpose of play is lost as it is used for self-regulation in the face of stress, interfering with any chance of social interaction (Singletary, 2015, 2019). Another aspect related a child's authenticity to their **expressions of emotions**. The clinicians in the discussion group thought of possible difficulties in emotional regulation, displays of normative aggression and tolerance of frustration. This is a subject that was also discussed in the literature review chapters, where the relationship between a child's emotional development and maternal role is described (Bion's, 1962; Fonagy et al., 2007; Nejssens et al., 2020).

In terms of the literature related to children of depressed mothers, it has been observed that these children might present a restricted emotional range (Greenspan and Lieberman, 1994; Halfon, 2017) and emotional dysregulation (Halfon, 2017; Chazan & Kuchirko, 2019). Following the theoretical propositions described above, children's ability to express needs and wants is promoted by the caregiver's ability to respond to these expressions appropriately as the child has the experience that his emotional expressions are understood (Fonagy & Target, 1997; Herman et al., 2020). A child that expresses little or no affect might be mirroring mother's response to them or experience emotional communication as aimless due to failed attempts to engage mother in the past. Thus, both repetitive play and limited emotional expression denote a certain withdrawal from socialisation.

In an attempt to synthesise the ideas that emerged from this discussion, a list of markers was developed. It is important to note that all these markers can at times also be present in normative toddler development, as they relate precisely to the developmental challenges inherent to toddlerhood. However, when these are perceived to be rigid, long lasting and therefore pervasive, they can be considered to constitute a developmental disturbance. These markers will be considered to be present in the case of child if they present this quality.

Table 3: The Play Markers Related to the 'Quality of Play'

Marker	Definition
Inhibition/Hyperactivity	The child struggles to engage in play either due to inhibition or to hyperactivity.
Repetitiveness	The child presents a repetitive quality in his play.
Uncontained Affect	Child's affect in play might be hyper aroused. The child can become easily frustrated, over-excited and difficult to soothe.
Age inappropriate	The child's play can present as delayed or seemingly more developed for his age.

Table 4: The Play Markers Related to the 'Content of Play'

Marker	Definition
Predominantly manipulative play	The child's play presents mostly as non-symbolic.
Symbolic play only present if facilitated by others	Symbolic capacity in the child often needs facilitation from others.
Precarious structure and/or narrative	When symbolic play is present, its complexity and durability is precarious.
Limited Range of Emotions	The child does not display various emotional reactions in his play. Play seems rather affect-less or emotionally limited.

Table 5: The Play Markers Recognised as Part of 'Social Play'

Marker	Definition
Over-proximity to / excessive distance from mother: Over-independent or over-dependent in relation to age	The child struggles find an age-appropriate distance from mother, becoming either overdependent or seemingly independent.
Over-Compliance/Opposition	The child presents as compliant or else oppositional towards others.
Difficulty engaging with others in play	The child struggles to play with others, particularly peers and other adults different from mother.

5.2.7. Deductive thematic analysis

Thematic analysis involves searching across a data set, to find repeated patterns of meaning (Braun & Clarke, 2006). In deductive thematic analysis, the codes (play markers) and their connections have already been derived from the literature and are represented by the propositions. Therefore, when analysing the data, the researcher is not exploring the data to generate themes, but rather is interested in 'matching' data to the propositions to establish whether the propositions explain the data. This is in contrast to an inductive approach where the analysis is data-driven and themes are expected to 'emerge', Theoretical or

deductive thematic analysis would tend to be driven by the researcher's theoretical or analytic interest in the area and is thus more explicitly analyst-driven.

For this study, the proposition or hypothesis is that in the presence of maternal depression, most of the described play markers are present in toddlers and consequently, in the absence of maternal depression most of these markers are also absent. In a practical decision made by the researcher, a cut-off point of 50% is considered to confirm or discard the hypothesis. This means in the case of children of depressed mothers at least 50% of the markers need to be present in children in order to confirm the proposition and equally, in the case of non-depressed mothers, children should not meet more than 49% of them. This process is described in the table below:

Table 6: Description of the Process of Deductive Thematic Analysis Used

Theory	Replication	Hypothesis	Observation	Confirmation
Maternal depression predicts the described play markers in toddlers	Literal	In presence of maternal depression, more than 50% of the markers are found	Analysis of clinical material	Confirmation or discarding of theory
	Theoretical	In absence of maternal depression, less than 50% of the play markers are found		

When searching for themes, the data can be interpreted with either a semantic approach or a latent one. With a semantic approach, the themes are identified within the explicit or surface meanings of the data and the analyst is not looking for anything beyond what a participant has said or what has been written. For latent thematic analysis, the development of the themes themselves involves interpretative work, and the analysis that is produced is not just description. In latent analysis, assumptions, structures and/or meanings are theorised as

underpinning what is articulated in the data which has been found compatible with psychoanalytic modes of interpretation (Braun & Clarke, 2006).

When doing thematic analysis, it is important that the researcher's theoretical position is made clear and that methodological and interpretative decisions are explicit, as the notion that one is simply giving voice to the data could be naïve.

In the case of this study, a latent approach will be used to analyse the data. This will require a level of psychoanalytic interpretation in order to identify semantic content and match it to the established play markers. To fit this purpose, the researcher and supervising team have a good level of training in psychoanalytic theory and psychoanalytically informed clinical skills. The joint work between the researcher and the supervising team allowed for a triangulation of the analysis of the data, as discussion were held in relation to the interpreted semantic content the main researcher identified in the different segments of data. This triangulation is also thought to be a method to address potential bias on the part of the main researcher, as the analysis of each case was conducted in knowledge of which group they belonged to.

In terms of the procedure for this type of analysis, Braun & Clarke (2006) describe the following steps:

Familiarising with the data

Transcribing data, reading and noting down initial ideas. In the case of this study, this meant reading through the data while having in mind the pre-existing themes related to play markers, therefore highlighting those extracts of information that were related to the pre-conceived themes that were also thorough enough to inform them.

Generation of initial codes

Coding features of the data in a systematic fashion across the entire data set, to find examples of the presence or absence of play markers. This means focusing on relevant pieces of information such as vignettes that describe a sequence of events in relation to the dyad's participation in the groups.

The vignettes were initially grouped into initial codes related to the markers such as type of play, relation to peers, other adults, mother, etc, using a word

document. The different vignettes were first categorised into these broader themes for further analysis in order to be appropriately assigned to one of the themes pre-conceptualised as play markers.

Searching for themes

Collating codes into potential themes, gathering all data relevant to each potential theme. A theme captures something important about the data in relation to the research question and represents some level of patterned response or meaning within the data set. In the case of this study, the themes have been pre-conceptualised in relation to the play markers described above and the relevant vignettes were gathered in groups under each marker. As described previously, these themes were formulated through an understanding of the literature and a discussion with psychoanalytically trained child psychotherapists.

Any selected vignettes initially coded under relation to mother would be grouped together to analyse whether the marker of over/under dependency to mother was present. Similarly, any vignettes initially coded as type of play, would them be matched to either manipulative or symbolic and assigned to the relevant marker.

Reviewing themes

Checking in the themes work in relation to the coded extracts (vignettes) and the entire data set, generating a thematic map of the analysis, related to the described play markers. In other words, this phase involved building an intra-theme coherence, ensuring each theme was well represented and explained by the selected vignettes.

Table 7: Examples of Theme Assignment

Reading Data	Initial Coding	Theme Assignment
Rohan continued to play excitedly and somewhat chaotically for the rest of the group, racing around the room, exploring all the toys.	Hyperactive play	**Quality of play** Inhibition/Hyperactivity
Mother asked him if he wanted to swing and placed him in the swing. She seemed to be leading the choice of activity.	Compliance	**Social play** Over-compliance

Defining and naming themes

Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme. For this study, the themes were described in advance in the list of play markers, therefore this stage of the analysis involved a revision of the coherence between the vignettes and their assigned theme, as well as the inter-theme or overall story of each case.

Producing the report

The final opportunity for analysis. The report includes a selection of vivid, compelling extract examples, and final analysis of selected extracts relating to the research question and literature. In the case of this report, it also involves a cross-case analysis section as per the replication logic of the present multiple-case study

5.3. Literal replication: cases of five children of mothers with depression

5.3.1. Eric and Beth

i) Presentation

Eric was 15 months when he started attending the groups with his mother Beth, who was in her early twenties. Beth was of mixed White-Black Caribbean heritage and had an education to GCSE level. At the time she was a full-time mother. Eric's father was also in his twenties, had a degree and worked as an accountant and was of White-British heritage.

When Beth and Eric started participating in the groups, Beth had struggled with depression and borderline personality disorder from her teenage years. She had been seen by Parent-Infant Psychotherapy and was using medication as treatment. The PIP service referred them for the PTGs as they were concerned about Beth's mental health history.

Beth and Eric attended for two years and two months, for a total 40 sessions and their attendance was inconsistent (53%). Their inconsistent attendance to the groups was a concern for the staff members and was addressed with mother on a number of occasions.

As usual, before starting their participation in the groups, the group leader invited mother for the entry PDI interview. It was a rather short interview as Beth did not expand much on her ideas. She mentioned she believed Eric was a happy child and she had more concerns about herself and how to handle her depression and her tendency to isolate whenever she feels low. She mentioned she is glad to have the support of her family and being able to offer her breast to Eric whenever he is upset, as this always soothes him. For her, the most difficult part of being a parent is not being able to have as much alone time.

In this first interview, Beth scored 4, which is just below ordinary reflective capacity. In her interview she uses mentalising language but does not develop these ideas.

ii) Analysis of Play Markers

Quality of play

Eric was able to play, therefore the 'inhibition' marker was not found. However, the quality of his play did present other markers, including 'repetitiveness' and 'age inappropriateness'.

The type of repetition he showed in his play was not the kind where one can see frantic mindless play, indicative of anxiety. It was the type of repetition where he would choose the same kind of game session after session, without much exploration or experimenting.

> *"Eric pointed towards the location of the train box, attracting his mother's attention. Beth said: 'Is it the train you are looking for? You remember it well.' Beth commented that last time they came they played with the train set. The group leader helped them to the box and Eric came to take some pieces of the truck out and the assistant helped him build one. He then took the little wagons and put them together with the magnets. When the magnets did not work, he seemed to get impatient, he frowned and moaned. The assistant showed him that he could try the other side of the magnet or find another train in the box. He did and so formed a long string of trains. He moved them along the truck making the sound of a train running." (1 year, 11 months)*

Playing with the train pieces was a frequent choice for Eric and it is something his mother quite liked doing as well, in preference to other games. Perhaps Eric felt this game could allow him to spend time with his mother, who otherwise might be doing something separately. What can also be observed from this vignette is the manipulative nature of his play, where there is a lack of symbolic components, except for the end where he makes the sound of a train. At the same time, when he finds himself frustrated, he moans instead of actively looking for the help of the adult who is playing with him.

> *"Eric started to take out different pieces from the train box, holding them up as if showing them to the group assistant whilst each time making a slight sound. The assistant nodded whilst naming each of the pieces he takes out. Eric then picks up a large wooden tunnel block from the box and inspects it for a few seconds before placing one of the trains inside it. Eric held the block at a slightly tilted position, so the train slides*

through the tunnel and to the other side. He then pushes his hand through the tunnel and tries to retrieve the train. He seems to struggle with this, but he soon manages to pull the train back. Eric continues to do this a few times before dropping the block back in the box, standing from the carpet and walking back over to his mother who is seated on one of the chairs by the snack table." (2 years)

In this vignette, it is possible to see how after some months Eric still persists with the train game. This time there seems to be more reciprocity in his action of showing the adult the different pieces and waiting for her to name them. However, it is worth noticing that by his second birthday, he is still making sounds instead of saying words, as well as the absence of imaginative components in his play.

In this sense, Eric is not showing an age-appropriate development, as his play is rather monotonous, mainly manipulative and with very little presence of symbolisms or words. Even a year later around his third birthday, this type of play was predominant, therefore this last marker is also found.

"Eric picked up a playdough tub before standing up from his seat to get a plastic knife from the kitchen. He came back to the table and used the knife to scoop the playdough out of the tub. He held the playdough in his hand and showed it to the assistant before giving it a squeeze. The assistant commented on how squidgy the playdough was. Eric then put the playdough on the table and began rolling it, using his hand before taking hold of a star shaped cutter and using it. One side of the star was cut off as he tried to peel it out of the cutter, and he held it up to the assistant to show her. She commented, 'oh yes it's broken'." (3 years)

Content of play

As stated above, Eric mainly presented a manipulative type of play, therefore this marker is also found. However, there were a few vignettes where he showed symbolic play. This type of play was often enhanced by another adult.

"Eric looked at the baby toys laying in the push chairs. He said 'baby'. The group assistant said: yes, they are babies. He took a toy bottle and put it in his mouth as if drinking from it and then offered it to the assistant. The assistant pretended to drink from it, and then to feed the baby toy with the bottle. Eric smiled and did the same. He then pushed the pushchair away with the baby toy on it." (1 year, 11 months)

In this vignette, it is possible to see Eric using words and finding interest in playing with someone else, as well as in pretend play. This shows Eric had some capacity to symbolise. His symbolisation in this exchange starts from a more concrete level, where he pretends the bottle is real and even perhaps thought it was. It is then the adult who shows him how to reach more complexity in his attempt to play symbolically, by proposing to feed the doll with the bottle. This allows him not only to pretend the baby is real as well as the bottle, but also to change roles from child to carer. After this he pushes the baby away, perhaps finding this type of play overwhelming. In this sense the marker of symbolic play being facilitated by another can also be found.

> *"Eric played the Duplo house with the group assistant. He 'posted' the packages through the little post-slot. He then opened the doors and took them out. He allowed the assistant to have a turn and gave good eye contact. He then took a Duplo figure and made him 'walk around'. The assistant took another figure and made it 'walk' close to his figure and said 'hello'. Eric grabbed her figure out of her hand. They repeated the sequence, and he grabbed her figure again. They repeated it again and she held tightly to her figure. He accepted this and their Duplo figures began to interact as they said 'hello' and then move apart. He placed his figure in the house and closed the door. The assistant made her figure knock on the door and say 'hello'. It was the longest sequence of reciprocal play that she shared with Eric." (2 years, 3 months)*

This vignette is another example of a similar situation, where Eric, now over 2 years old of age, is able to play with someone else, showing an attempt to symbolise, but it is the adult who proposes a narrative to this game. The marker on play narrative is therefore found. As noted by the clinician, it seems these sequences of reciprocal play were not common. This can also provide information about the development of his social play.

In terms of his range of emotions in play, it is difficult to exemplify how this marker is found as it is more of a perception that while analysing Eric´s vignettes, very little is said about his displays of emotion. There is a lack of information about affective responses or manifestations while he is playing, giving an image of a boy who might have looked rather serious most of the time.

Social play

Eric's clinical notes give the impression that he did not seek containment from mother very often. Contrary to this, he was regularly seen playing by himself with mother near him. It is not clear whether he did not enjoy engaging with others or if mother did not encourage this type of exchange in the group.

> *"Eric attended with his mum and maternal aunt. The two young women tended to play with each other as if they were children, without involving Eric, who played in the kitchen area. The group leader talked to them a little about their game, and then drew their attention to Eric who was playing on his own. She suggested they could play with him. Beth moved to the kitchen area. About 15 minutes later, the leader re-entered the hut to find the two women playing on their own again and Eric on his own." (1 year, 10 months)*

In this vignette we can see how mother herself finds it hard to relate in a way that involves more than two people, almost wanting to go back to her own childhood and leaving her child apart. In other words, Beth remains in a dyadic way of relating and remains far from the rest of the group. Perhaps this is something Eric experienced regularly and so he learned to entertain himself. Additionally, he does not seek to engage with other people in the scenario of his mother not showing interest in him, which might speak of little exposure to socialisation.

> *"Whilst many of the other children played outside today Eric and his mum remained inside for the whole group. Eric played independently with many different toys. Beth remained by Eric's side, joining in on his play every now and then but otherwise occupying herself with the books in the story corner, building the train tracks and stacking the stacking cups." (2 years, 4 months)*

This vignette is another example of a similar dynamic when Eric is already 2 and 4 months. At this age, children might be expected to show interest in expanding their social circle and skills. However, Eric at this point was still predominantly playing on his own in a way that could be considered over-independent and yet, not socialising. In this sense, the marker on proximity to mother is found.

Another marker found is that of over-compliance. Particularly at the beginning of this dyad's participation in the group, it was common to see Eric's mother leading

his play or teasing him, without Eric showing much opposition or resistance. It was almost as if he just let things happen to him.

> *"Eric arrived with both parents. His mum placed him in the red car and pushed him around the hut three times. She then asked him if he wanted to swing and placed him in the swing. She seemed to be leading the choice of activity. Eric and his parents spent quite a lot of time indoors while the rest of the group members were outside." (1 year, 7 months)*

This vignette is an example of how Eric is described in his notes as a child who sometimes felt quite absent, as well as a family who tended to isolate from the group. Eric could be moved as if he was a baby who could not protest, however he was almost 18 months at this point, when children can be expected to express more will and a wider range of emotions.

> *"Eric came to the group with his mother and maternal grandmother. Eric was playing with the running balls game happily for a while. Then Beth took a dog toy and moved it from its string. Eric chased it trying to reach it but each time he got close to it, his mother would move it away. Both mother and grandmother laughed. Eric looked serious and soon lost interest in the game and went outside." (1 year, 7 months)*

In this second vignette, we can see some aggression coming from mother and his grandmother towards Eric. Mother seems to engage more with her own mother rather than her child, which could provide information on her capacity to relate outside of a dyad. Eric's response to this frustrating situation is to move away rather than becoming upset and expressing his discomfort. It is clear this 'game' fails to engage him as he leaves when he realises his mother's attempt is not to have a shared experience.

Eric did not remain compliant with everyone, as he could show some aggression towards peers and later, towards other adults. However, his oppositional reactions, according to his notes, never happened with mother.

> *"It was near the end of the session. Eric got the medical kit that he and his mum had just packed away and said to the leader 'you are very sick'. She said she would like to play with him next time as there was no time left today. She held the case closed and he got angry. He tried to pull it away from her, but she repeated that it was time to put it away. He pulled*

more and glared at her. She suggested they could say goodbye to the butterflies (the mobile). He accepted this, and she asked if he wanted to be picked up. He held up his arms and she picked him up. They blew the butterflies until his mum returned." (3 years)

In this vignette, Eric is able not to be compliant with a group staff member, although he was now 3 years old, which could be considered late to start displaying this type of aggression and assertiveness. Often this type of behaviour is seen in younger toddlers around the age of 2. In this case, mother is not around while the conflict takes place. Perhaps she wished to avoid these scenarios, as on the few occasions that are described when mother decides to face Eric's aggression, she offered her breast to calm him down.

The third marker found in this section is the difficulty to engage others in play. Even though Eric at times was able to play with other adults and show some interest in peers, what it is mostly described about him is a sense of isolation from the group and at times even from his mother.

"Eric pulled or tried to hit each child and we had to intervene fast to prevent anyone from getting hurt. At snack time, Beth called Eric to her and picked him up to breastfeed him, which kept them both away from the rest of the group members gathered around the table." (1 year, 5 months)

In this vignette it is possible to see that Eric initially did not know how to approach peers and perhaps he even found them distressing. Very few vignettes during his participation in the groups, show him sharing some play with other children. Regarding adults, as Eric grew up, he started claiming his mother more and often rejected other adults from engaging with him.

"For the rest of the group Eric explored and played with many toys. At times when he needed help Eric asked for his mother's help, not seeming to want the help of another adult. He similarly didn't seem to want to engage in play with anyone other than his mother." (1 year, 5 months)

Even though Eric was at times able to play with others, mostly adults, the majority of the time he either played by himself or wanted no one else but his mother. His

own mother struggled with being a member of the group, as her attendance was often inconsistent, which she attributed to her depression. This possibly had an effect on Eric's social development. Additionally, when Eric was a little older than 2, mother was pregnant with a second child. This might also have had an impact on him and his wish to remain close to his mother.

iii) Summary of Markers Found

Table 8: Summary of Markers Found for Eric

Quality of play	
Marker	**Presence**
Inhibition/Hyperactivity	Not found
Repetition	Found
Uncontained Affect	Not found
Age inappropriate	Found
	Total Found: 2/4

Content of play	
Marker	**Presence**
Predominantly manipulative play	Found
Symbolic play present if facilitated by others	Found
Precarious structure and/or narrative	Found
Limited range of emotions	Found
	Total Found: 4/4

Social play	
Marker	**Presence**
Proximity to mother: Over-independent or over-dependant in relation to age	Found
Over-Compliance/Opposition	Found
Difficulty engaging with others in play	Found
	Total Found: 3/3

iv) Conclusion

According to the researcher's interpretation of the data, Eric presented 9 of the 11 described markers, which equals 82% of them, supporting the hypothesis that in the presence of maternal depression, most markers are present in children.

Beth had a long history of depression as well as a personality disorder, which might have brought further difficulties to her mothering as well as for Eric's development. Eric was described as a child with significant delays in terms of his social and symbolic play and as the groups provided him with a space to access play and other ways of relating, he was able at times to be playful and engaging. However, this play was inconsistent and quite delayed for his age, which was possibly related to mother having a very conflictual relationship with the group. This can be identified in her frequent absences as well as the rejection of the staff's perspectives on her, Eric and their relationship. By the end of their participation in the groups, the group leader suggested nursery could be a good space for Eric to further develop his social skills and language, however mother was very firm in that he would be home-schooled. Considering the presented data, it is a possibility that mother had an internal struggle with allowing her son to develop.

Finally, in her exit interview Beth again scored 4, remaining at a below ordinary capacity to mentalise. When she was asked about what she could take from her participation in the groups, she said she was able to participate in a social environment more consistently, which was always hard for her. However, she adds she found it difficult to feel comfortable as she felt observed as there were cameras. She does not mention Eric much in terms of the benefits of the groups, except for the fact that she felt he was able to deal better with things not going his way in the group, as opposed to home.

Additionally, it is worth mentioning that her capacity to mentalise as measured by the PDI, did not improve and stayed just below ordinary capacity even after being seen by two different services, PIP and the PTG.

5.3.2. Rohan and Hina

i) Presentation

Rohan and Hina started participating in the groups when Rohan was just over a year old. Hina was a single mother from South Asian heritage in her late twenties, who came to the UK to study. During her stay in the UK, she became pregnant through rape from a man who she did not have a relationship with and who was then not involved in Rohan's life.

Hina received honour-killing threats from her relatives in her home country, as she was pregnant without being married. When she gave birth to Rohan, she did not want to engage with him, and it was apparent she had developed depression. However, her depression was not diagnosed until she reached the services at the Anna Freud Centre, therefore she was not receiving any treatment, neither pharmacological nor psychological. She was referred to the Parent-Infant Psychotherapy (PIP) service, where she was seen as a patient along with Rohan. As Rohan was reaching toddlerhood, they were referred to the PTG.

During their participation in the group, Hina was applying for asylum in the UK, which was granted near the end of their attendance.

They attended for a total of 42 sessions over the course of almost two years (63%).

Amongst the concerns mother shared in her entry PDI interview were Rohan's high levels of energy and strong tantrums, as she worried this might have brought them problems where they lived, which was a precarious and insecure housing situation. She also mentioned that he was very emotionally connected to her, so when she was upset, he would become upset as well, and that they both find it hard to be apart from each other. Hina was worried she did not know how to be a single mother.

In this interview she scored 5, which represents an ordinary reflective capacity.

ii) Analysis of Play Markers

Quality of play

The first marker found under this category is Repetition. Rohan tended to play with the same toys or activities for several weeks in a row; an activity that seemed to be particularly satisfactory for him was water play, which, due to the family's living conditions, he was unable to do at home.

> *"Rohan played by the sink for a long time. He moved his hands around the cube full of water, sometimes quite strongly, splashing water outside of the sink. He put his hands to feel the tap water running on them. He moved the plates and cups around, he even drunk the water using one of the cups. His excitement went up and he was splashing quite hard. Finally, as it was tidy up time Hina said to him that it was time to change his clothes. He accepted it moaning a little bit and allowed his mum to take off his t-shirt. Before leaving he started exploring the kitchen cupboard and wanted to carry on playing. His face's expression looked more relaxed. Then outside he joined a girl who was looking at a spider on a flowerpot. He was looking at it with interest." (1 year, 6 months)*

In this type of play, Rohan seems to be immersed in the sensory experience of feeling the water and exploring everything he can do with it. There seems to be an overexcited quality to the play as well as a certain mindlessness as he absorbs bodily sensations. Rohan sought out water play l systematically for at least a month and in his water play, he would repeat certain actions a number of times. It seems water play was soothing for him and helped him move on to more structured or even social activities.

The type of hyperarousal just described could be associated to the marker of hyperactivity, which can also be observed in the following vignette:

> *"Rohan entered the toddler hut with a wide smile and immediately raced over to the red toy car and attempted to climb through the window to get inside. After being helped to open the car door to get into the seat he started to drive the car enthusiastically around the room. Rohan continued to play excitedly and somewhat chaotically for the rest of the group, racing around the room, exploring all the toys." (2 years, 8 months)*

In this vignette, Rohan's play is again described as rather overexcited, rushed and showing a difficulty in settling and staying with an activity for a longer amount of time. From these observations, the marker of hyperactivity is found.

Another marker found in this category is Uncontained Affect. It has been already described that Rohan could experience some hyperarousal in his play, as well as a tendency towards self-harm in the initial interview (head-banging).

The following vignette is an example of how Rohan sometimes presented strong emotional responses to frustration:

> *"Rohan went to the sink and started playing with water. He played with the cups pouring water from them. Then he began pouring water on the assistant. She showed him how to keep the water in the sink so as not to make the floor slippery. Rohan carried on spilling the water on her and onto the floor. His mother was close to him and told him not to do it. The assistant suggested they could go outside where he could spill water on the grass. His mother told him they would go outside. He moved his body backwards, holding his hands from the sink and cried, tensing all his body and looking distressed. His mother told him that he would continue playing. She said: look at (assistant) she is taking the bucket outside. Rohan calmed down a bit." (2 years)*

In this vignette, the adults are proposing an alternative to his play, so that he can continue pouring the water. However, he is not able to listen and follow their logic, even as a two-year-old who could be expected to better understand verbal communications. It seems he becomes rigid and only sees others frustrating his play, rather than connecting with the situation and assessing what is taking place at that moment.

After what has been described and what will be argued in the next sections, it is considered Rohan's play was not age appropriate, therefore this last marker is also found. Rohan's play was mainly sensory, manipulative and with very few symbolic components. He also struggled to relate to peers, to communicate and self-regulate.

Content of play

As described above, Rohan's play was mainly of a manipulative nature, however there were a few moments in which he presented some symbolic content in his play.

> *"Rohan played with the assistant by the little toy house. Rohan took hold of a small pig and she took hold of a larger pig and chased after the smaller pig. Rohan seemed to find this play exciting, laughing loudly and happily. Rohan then took hold of a toy crocodile and played that the crocodile was chasing after the small pig. He then moved the crocodile around the room and played that it was biting his mother's feet. The group leader then took hold of a toy lion and played along with Rohan with the lion and crocodile chasing each other." (2 years, 5 months)*

In this vignette it is possible to see how an adult follows Rohan's play and proposes a game where there is reciprocity, symbols and a narrative. Rohan is able to engage in this game, but only once the adult has initiated it. Therefore, this marker is also found.

Even though Rohan was capable of displaying some symbolic play, the structure and narrative of his play remained quite simple, considering his age.

> *"Rohan played for some time with the toy fire engine and truck, while making the sound of a siren. He moved the ladder on the fire engine up and down. He then used the ladder as a ramp for some of the toy cars, pushing them up the ladder and depositing them into the back compartment of the truck." (2 years, 9 months)*

In this vignette, Rohan is near his third birthday and his play remains mostly manipulative with some imaginative components such as the siren sound and perhaps the recreation of an emergency. However, there is still an absence of characters and the development of a story.

Social play

The first marker found under this section is Proximity to Mother. In the case of Rohan, he transitioned from rejecting others in preference of his mother, to allowing some exchange with others and showing a preference for becoming more independent.

“The group assistant tried to join in Rohan’s play and offered him a ball. He refused strongly, pushing her with his hand and bringing his mother close to him. Hina put him on the swing. He was still moaning as Hina carried on talking to the group leader. The assistant offered to pass the balls to him, but he did not accept them and moaned to his mum. Hina said that he wanted her to play with him, so she did. He quickly wanted to get off the swing and went inside clinging to his mother. His body seemed rigid and his face in distress.” (1 year, 8 months)

This vignette is a clear example of how Rohan wanted to remain close to his mother, while not accepting any other adult or peer who might offer a playful exchange. Part of the aims of the group for this dyad was to offer mother some respite from her son, as they could sense a need for some distance in the relationship. Perhaps Rohan was resisting this attempt, however in the next vignette he seems to have accepted the reality that mother is not always available:

“Hina was talking to the group leader. Rohan started walking the steps to go outside. He walked very carefully. The group assistant offered her hand, but he refused and was very concentrated in doing it properly. He went to the little house and they both played hide and seek there. He smiled widely. After that he run and went to the small slide. He walked the steps up and then came down in the slide. He seemed to be challenging himself to do things without his mother.” (1 year, 8 months)

Perhaps it was early for Rohan to learn that he needed to sometimes find comfort in others and that he might need to rely on himself more. This might be why he needed to strongly claim his mother at first while after he seems to almost have given up this wish. It is possible that this sad realisation allowed him to access other social experiences that could further develop his playfulness, as mother had a very occupied mind at the time.

A second marker found under this category is that of Compliance. Especially at the beginning of their participation in the groups, it became apparent to the team that mother could become quite controlling of Rohan’s play and he would often lose interest and leave, instead of displaying agency or protesting.

“Later, after the snack time, Rohan was playing inside with a new toy, a colourful cash machine. Rohan was trying to find out what it was about.

His mum was telling him which buttons to press. He responded to her demands quickly but looked a bit serious. Then he tried to press or touch something different, and his mum immediately corrected him. Rohan went to play with something else." (2 years)

This vignette is an example of what is described above. Additionally, one of the goals the group staff agreed on for Rohan, was to help him develop in a more assertive way, as often he would be seen relinquishing toys or activities of his interest when being interrupted or frustrated by others, whether this was mother or peers.

Rohan was able to express some healthy aggression towards mother at times:

"Rohan wanted to play with bubbles. Hina took him outside and started trying to make some bubbles. Rohan was moaning and trying to get the bottle and the stick from her. Finally, she gave up. He held the bottle and the stick. Hina seemed uncomfortable with this. She kept helping to hold the pot in his hand. He tried to resist this and walked a few steps away. he blew very hard but couldn't make bubbles. The group leader said to Rohan that perhaps he could put the stick a bit closer to him mouth and blow softly. He did and he produced bubbles. He was very happy, smiling and running to get the bubble." (2 years, 1 month)

In this vignette, Rohan does not comply with mother's wishes and prioritises his own. As this started happening around his second year of life, it could be possible to think his anal phase was emerging. At the same time, perhaps the group was facilitating a space where he felt safe to do this as he might have perceived his mother would be able to tolerate his aggression with the support of the group.

The last marker to be found in this section is the difficulty to engage others in play. As seen previously, Rohan was able to play with other adults on several different occasions. It is often the case with toddlers that the first people they engage with outside their relationship with mother is with other adults, possibly because other adult look more like mother than their peers, for example.

"Rohan played with water for a few minutes, placing the ducks in it, splashing his hands strongly in the water, then slowly and concentrated he tried to get the small pieces of grass inside the water and put them outside. Rohan and the assistant hen put some small pieces of grass

inside the water and looked at them. He was very absorbed in the play forgetting for a while about his mother. Finally, he took the whole bucket and splashed all the water on himself, looking very satisfied when he did it. He repeated this many times." (1 year, 8 months)

This vignette is an example of how he did often play with adults. However, playing with peers was more difficult for him, as he either did not show interest or found it hard to be assertive with them.

"Rohan saw the red car and touched it. The group assistant asked him if he wanted to get inside it. He pushed the car as if unsure what he wanted to do. Another girl came and got quickly into the red car. Rohan seemed disappointed but then he took a football and passed it to the assistant. She passed it back to him. Two boys came looking at what was going on with the footballs. The assistant passed another ball to Rohan, but he instead took two balls and ran to his mum. He repeated this several times." (1 year, 8 months)

This vignette offers an example of the difficulties described above. Rohan's relationships with peers remained a concern for mother even as he became a little older and joined nursery, where according to her he struggled to play with other children. However later when it was time to do the exit interview with mother, she said Rohan was making new friends.

iii) Summary of Markers Found

Table 9: Summary of Markers Found for Rohan

Quality of play	
Marker	**Presence**
Inhibition/Hyperactivity	Found
Repetition	Found
Uncontained Affect	Found
Age inappropriate	Found
	Total Found: 4/4

Content of play

Marker	Presence
Predominantly manipulative play	Found
Symbolic play present if facilitated by others	Found
Precarious structure and/or narrative	Found
Limited range of emotions	Not Found
	Total Found: 3/4

Social play

Marker	Presence
Proximity to mother: Over-independent or over-dependant in relation to age	Found
Over-Compliance/Opposition	Found
Difficulty engaging with others in play	Found
	Total Found: 3/3

iv) Conclusion

According to the researcher's interpretation of data, Rohan presented 10 out of the 11 described markers, which represents 90% of them, supporting the hypothesis that in the presence of maternal depression, most markers are present in children.

Rohan presented a more general and apparent delay in his development and play, different perhaps from other cases where only some aspects seemed to be affected. This might be related to the fact that his mother's mind was permanently busy with the fear and sadness she experienced because of his existence. In this sense, mother possibly had strong conflicting feelings about Rohan, a need for control and difficulties seeing him for who he was and his needs.

When they joined their PTG mother was able to share her concerns and feelings with someone who could listen and contain them. Perhaps this allowed Rohan to rely on the group to care for his mother and explore a little more his own needs

and wishes, as well as providing respite for both Rohan and his mother from each other.

In the exit PDI interview, mother scored 4, which stands for a reflective capacity just below ordinary and also below her initial score at the beginning. Additionally, it is worth mentioning that her capacity to mentalise as measured by the PDI, oscillated between ordinary and below ordinary, even after being seen by two different services, PIP and the PTG.

5.3.3. Gianni and Ana

i) Presentation

Gianni was referred to the PTG by a health visitor, given some concerns around his development. He was the youngest of two fraternal twins in a family of a mother, a father and a primary school-aged sister. Mother was of Latin-American origin, in her mid-thirties and was at the time a full-time mother, having an undergraduate degree. Father was of Southern-European Heritage and worked in banking.

Gianni had so far grown up with some mild health complications that made him rather restless and uncomfortable. Mother presented with post-natal depression and was taking medication for her mood at the time she attended the groups with Gianni and his twin Mateo. Both twins were conceived through in vitro fertilisation.

When they joined the group, mother was in her late thirties, while Gianni was one year and 7 months old. They attended 49 sessions over the course of a year and eight months (72%), however on 6 occasions she sent the children to the group with their nanny.

In the initial PDI interview, mother described Gianni as a creative, funny and energetic child, who could sometimes behave rather impulsively and had difficulties regulating his frustration. According to her, he could bang his head against the floor if he became very upset. This was a concern for her, as well as his speech delay.

In the interview, it was apparent that mother was able to reflect on her own thoughts and feelings as well as Gianni's, however there appeared to be a sense of guilt and insecurity in her mothering. When her interview was scored, she reached a 6, which means her capacity to reflect is slightly above average.

It is relevant to mention that in their participation in the group, a split between both twins regarding their relationship to mother became apparent. Gianni's brother presented a much more normative development and he used mother for regulation and safety much more than Gianni. This situation gave the impression that Gianni was excluded from their dyad and perhaps this was related to mother's concerns with Gianni as she found him more problematic. Perhaps for her it was easier to keep Mateo closer than Gianni.

ii) Analysis of Play Markers

Quality of play

Gianni's play showed evidence of the delay of his development in general and particularly in his play. The marker of age inappropriateness is met on various occasions, which will be indicated as the case is described.

One of the markers found under this category is that of hyperactivity. It is expected that a toddler will want to explore their environment and discover which the toys he might find attractive to play with. However, it seems for Gianni it became difficult at times to engage in actual play as an apparent need to keep moving tended to prevail.

As is described a couple of times in his clinical notes, during the beginning of his participation in the groups, Gianni would often display large amounts of energy in his explorations, going from one toy to the other rapidly. There are a couple of vignettes that illustrate this:

> *"Gianni played with lots of energy, using lots of space, running between the inside of the playroom and the outside in the garden and around the side path., playing with the toy cars, toy phones, with the stacking cups and skittles, etc." (2 years, 3 months)*

> *“Gianni moved between the different toys at a faster pace than his brother, who spent longer playing with each toy. Gianni and his brother played energetically and a little chaotically throughout the group. Their play revolved around crashing a lot of the cars- crashing them together and crashing them to the floor.” (2 years, 7 months)*

In both these vignettes, a sense of heightened energy is portrayed, beyond the level of ordinary excitement expected in a toddler that is finding joy in playing and moving. The description ‘chaotically’ is also used in the second vignette, which gives a sense of playful activity that seems rushed and unorganised.

Engaging in play in toddlerhood often involves children exploring their own mind and that of the others who join them in play. When a parent has struggled with depression, exploring minds and developing an imaginative capacity can involve fear or discomfort for a child. Hyperactivity and inattentiveness in early childhood can be related to a pattern of disengagement in mother, reflecting her own inattentiveness towards her child, causing the child to display hyperactive behaviour in an attempt to get mother´s attention. Perhaps these were factors that affected Gianni´s early participation in the group, especially when considering that his brother was using mother more and, in this way, Gianni could at least be in his mother’s mind, even if it was as a concern.

Furthermore, fast-paced and inattentive play like Gianni’s can pose difficulties for learning which would then translate into cognitive delays.

Another marker present under this category, when investigating Gianni’s play and participation in the groups, is that of uncontained affects.

On several occasions Gianni’s mother mentioned her concerns about Gianni being difficult to soothe and how he would sometimes bang his head against the floor when having a tantrum. Although this type of self-harm was not observed in his clinical notes, there was an example of uncontained frustration:

> *“Gianni and his brother were clinging tightly to mother as they entered the toddler hut. She took a seat on the carpet and both boys cuddled up closely to her. Gianni was particularly distressed, crying loudly. His crying continued for quite some time with nothing able to calm him down.*

He rolled around on the floor crying loudly and remained in a distressed state. Ana appeared to find this particularly difficult. She explained to the group leader that Gianni had had a health scare earlier in the week and had been for lots of tests at the hospital." (2 years, 11 months)

Emotional regulation is an aspect of toddler development that can be affected by the experience of being mothered by someone who is experiencing depression. If mother's depression has meant she is not able to attend to her baby or child, the toddler may find himself without resources to soothe himself or might not find mother reassuring. Perhaps this was the case for Gianni, who understandably was in a vulnerable state after having some difficult experiences that week. However, the relentlessness of his frustration seems to go beyond what would be expected for a child his age.

Another example of uncontained affects is illustrated in the following episode of hyperarousal for both twins while engaged in play:

"Gianni and his brother were taking a few of the toys into the garden. This became a 'game', with both soon taking several of the toys and throwing them outside. The group leader intervened and explained that the smaller toys had to stay inside as they may otherwise get lost. The boys continued to play outside, playing with the toy cars, taking it in turns to drive in the 'yellow car' which they were using to tow another car." (3 years, 4 months)

When children's personal resources for regulating their own emotions are not well developed, their excitement in play may become heightened and uncontained as in the above example, where Gianni has engaged in play with his brother in their usual active fashion. However, this game then becomes disruptive, and it calls for an adult's boundary to find containment again. This adult is not mother but the group leader, perhaps indicating that mother may have found it difficult to cope with her children's dysregulation and to contain it herself.

This can be considered an example of age inappropriateness, as Gianni's emotional regulation would not match the expectations for his age.

Content of play

After his second birthday, Gianni started showing a little more symbolic play, which normally happened when others were involved. These pieces of symbolic play did not seem to take place when playing on his own, therefore it is possible to think that the following marker is present: Symbolic play present if facilitated by others.

> *"Gianni and his brother played well together, following each other, and communicating with each other. Both used the toy brooms to sweep all over one of the toy cars before helping each other to fill up the cars with 'petrol'." (2 years, 5 months)*

In this vignette Gianni is able to use a toy such as a broom to pretend he is cleaning, as he might have seen the adults around him do. At the same time, he and his brother pretend to put petrol in the cars. In a later vignette he can also be seen pretending to have a picnic with peers in the garden. These records reveal a capacity to use symbols in play and use his imagination. However, this type of play was very infrequent. Another marker can be found here in terms of a precarious narrative, as for a child his age, more elaborate stories could be expected.

Gianni mainly presented a manipulative type of play, even as he grew older. He enjoyed driving the cars and playing with the small cars and the ramps, mostly looking for movement.

> *"Gianni and his brother played with water by the sink, filling up the watering cans and using the water in the watering can to fill up the two large plastic bowls in the sink as well as the smaller plastic jugs. Gianni soon ran off to play elsewhere whilst his brother continued to play by the sink." (2 years, 7 months)*

> *"Gianni showed interest in playing in the cars with his brother. Soon another toddler joined them outside to play with the bubbles. The twins enjoyed being 'chased' by the bubbles whilst driving in their cars. After a little while both boys jumped out of their cars and held up their hands directing us to stop blowing the bubbles." (2 years, 11 months)*

As seen in both these vignettes, even as Gianni approached his third birthday, the type of play he enjoyed the most were activities where the main aim was to manipulate objects and have sensory experiences, which for his age could be considered rather rudimentary and therefore not age appropriate.

Social play

From the beginning of his participation in the groups, Gianni appeared more comfortable moving away from mother to explore and play, in opposition to his brother who tended to stay closer to mother for longer. An interesting and related piece of information provided by mother is that Gianni started walking before his brother at 8 months, however his speech development was behind his brother's.

It was often seen at the start of the group that both boys would come in their buggy after having had a nap, and it was always Gianni who woke up sooner as if he was very eager to use his energy and start playing.

> *"Gianni took his mum's hand and wanted to lead her somewhere. As Ana was sitting down with his brother on her lap, the leader asked Gianni if (assistant) could take his hand and go with him. He accepted that and led the assistant to the brooms." (1 year, 11 months)*

This previous vignette gives an example of how perhaps Gianni had to physically grow up sooner than his brother, as there might have not been enough space for him to be depending on his mother, given that his brother claimed that place. It was often seen in his participation in the group that he would look for the other adults in the room to play with and became rather attached to the staff from the start. This perceived independence could be considered to be not age appropriate, as it would be expected at this stage to use mother more for safety. In this sense, the marker related to proximity to mother is met.

Even while this was the case, he still was selective of his bonds, as it seemed that his mother, his brother and the staff were his safe relationships within the group. It was often seen that in the presence of new members or unfamiliar visitors, Gianni would show some suspicion. In this sense, while he seemed to have relinquished his mother, he did not form attachments to strangers, who seemed to represent some threat.

His time in the group allowed Gianni to claim back his place next to mother, however there were still difficulties around strangers, event at a more advanced age:

> *"Gianni arrived at the group with his mum Ana. Gianni appeared a little quieter and shyer in today's group, remaining seated on his mum's lap for quite some time after arriving and continuing to remain by her side throughout the group. Ana commented on how it was probably feeling a bit strange for him being at the group without his brother." (3 years, 3 months)*

At the age of three, children commonly become interested in other adults and peers, however it might be that this part of development was a little delayed in Gianni, as he had only recently been able to access the safety of mother's company more freely with the support of the group. This safety is necessary for children to then want to explore other relationships. This is yet another example of his play not being age appropriate.

Further in this matter and as mentioned before, Gianni kept a safe social bubble that included his mother, his brother and some adults he formed an attachment with. Peers other than his brother were not mentioned much in his clinical notes, which the exception of a couple of examples. It is possible that Gianni thought of his brother as a part of himself and felt that they both were part of one dyad along with mother. Perhaps his brother was not seen as a peer in his own right. In this sense, the marker on the difficulty with engaging others in play can be met as well.

However, in time Gianni started showing some interest in peers, although he did not always know how to approach them:

> *"Gianni looked curious about a game between another toddler and the staff member. He slowly made his way over to them pulling mother along. He gave the skittles they were playing with a little kick so that they all knocked over. The toddler seemed upset about this, commenting 'no, it's my house'. Gianni then walked away to play elsewhere, seating himself by the little helical toy and beginning to play. The staff member joined him in his play and whilst he did interact, he seemed withdrawn and didn't speak much." (2 years, 10 months)*

In this vignette, Gianni shows interest in an activity that involves a member of staff he likely felt safe with and another child. He wants to bring his mother for safety as a younger child might be expected to do. He wants to find a way to be included in this group but needs support and is rejected by the child. His subsequent behaviour suggests that this seems to hurt him, possibly re-experiencing the exclusion from the relationship between his mother and brother. His tendency towards relinquishing his wishes could be interpreted as a form of compliance, therefore this marker is met.

With time, Gianni was more able to play in groups of peers and enjoy this, possibly due to the space the group provided to explore new relationships and ways to engage with other people.

> *"Gianni attempted to engage another boy by calling him and asking him to 'come and play'. They all played along pretending to have a picnic in the garden, with Gianni bringing out the toy pizza. At snack time they played a game, peeking their heads under the table in search of each other, giggling lots in response." (3 years, 2 months)*

iv) Summary of Markers Found

Table 10: Summary of Markers Found for Gianni

Quality of play	
Marker	**Presence**
Inhibition/Hyperactivity	Found
Repetition	Not Found
Uncontained Affect	Found
Age inappropriate	Found
	Total Found: 3/4

Content of play

Marker	Presence
Predominantly manipulative play	Found
Symbolic play present if facilitated by others	Found
Precarious structure and/or narrative	Found
Limited range of emotions	Not Found
	Total Found: 3/4

Social play

Marker	Presence
Proximity to mother: Over-independent or over-dependant in relation to age	Found
Over-Compliance/Opposition	Found
Difficulty engaging with others in play	Not found
	Total Found: 2/3

iv) Conclusion

According to the researcher's interpretation of data, 7 out of the 11 established markers were present (64%), supporting the hypothesis that in the presence of maternal depression, most markers are present in children.

The difficulties that were more pervasive seemed to be those related to his place in a dyad where he felt displaced. This had repercussions on several aspects of his play development such as the use of symbols for speech and imaginative play, as well as his social play, concentration, and emotional regulation.

He received support to address these difficulties during his participation in the groups, and he was able to speak and play much more along the lines that would be expected of a child his age by the time he left. Perhaps this speaks of the space the groups provide as a place to display difficulties, identify them and receive support to address them.

In the post-group interview, Ana described her son as a much happier boy that enjoyed playing. She said she sometimes struggled with discipline, as Gianni is not a compliant boy. There is a sense in this interview around Ana being happier as well and more confident as a mother, when asked what she gained from the groups.

This time her score this time was a 5, which stands for an ordinary reflective functioning. This is slightly lower than her previous score before starting the groups.

5.3.4. Jack and Kathy

i) Presentation

Jack and Kathy joined the groups when he was just over one year old, and mother was in her mid-forties. She was married to Jack's father and together they had an older school-aged daughter. Kathy and her son were both of White-British heritage, she had a degree and worked before Jack was born. Kathy had a family history involving alcoholic parents and when she gave birth to Jack, she was referred to the Anna Freud Centre's Parent- Infant Psychotherapy (PIP) service.

Mother had developed difficulties with difference, conflict and aggression over the years, possibly in relation to her parents' uncontained affects due to alcoholism. Her perinatal symptoms not only presented as depression but also as an obsessive-compulsive presentation with particular focus on cleanliness and potential danger to her and her child.

When the dyad was referred to the service, Jack was described as a rigid, vigilant baby, who in the course of the treatment was able to start playing more and mother's symptoms also lessened. They were recommended to join the PTG service, to extend the support for Kathy's motherhood and Jack's development, in sight of the approaching stage of toddlerhood. By the time they entered the groups, Kathy was not reported to be taking medication.

They attended for 42 sessions over two years (97%), having only missed one of the planned sessions. In the entry PDI, mother scored 5, presenting as ordinarily reflective.

While participating in the groups, mother remained mostly reflective and sensitive, however some of the challenges associated with toddlerhood, namely, messiness, aggression and ambivalence, seemed triggering for mother and this made it difficult for her to set boundaries for Jack. At the same time, her relationship to the group and the group leader also seemed to bring back representations from her past, as this often shifted from perceiving them as protective, to neglectful.

ii) Analysis of Play Markers

Quality of play

In general, Jack's quality of play did not present any significant difficulties. Initially he showed some inhibition related to being wary of a new space and new people, however he would usually quickly start playing. Similarly, he did not show signs of repetitive play or hyperactivity. There were moments where he would explore different toys and activities rapidly, especially as a young toddler, which can be expected at that age and eventually subsided.

No uncontained affects were identified, as his displays of aggression were considered normative for a toddler his age, although they will be discussed further below.

As per what will be described in the following sections, it is considered Jack's play was not age appropriate, particularly due what was observed in relation to his symbolic and social play.

Content of play

When examining his clinical notes, Jack is more often seen playing in a rudimentary way, using objects instead of imagining or pretending, however there are a few entries where he does show the capacity for symbolisation, but they do not seem to last long or demonstrate much complexity.

After his second year, when symbolic play would ordinarily start to be more present in a child's development, vignettes such as the following were frequent:

> *"Jack was playing to cook the leader some eggs for breakfast at the stove, while another girl played nearby. Jack then drove the red car and after played with the baby doll, taking it for a walk. He spent some time playing outside, driving in the car, and then playing on the swing while mother spoke to a member of staff." (2 years, 1 month)*

As seen in this vignette, Jack engages in symbolic play with others and is able to also share a playing space with peers. It is not clear who initiates play or how involved mother can be in this type of play. What can be seen is that it is somehow more imitative than creative, as there is no story attached to it. Additionally, he appears to quickly move on to a more manipulative type of play that involves a bigger use of his body rather than his mind, and it gives the impression he does not spend big portions of time on each. In this sense, the marker for manipulative play is met.

There were a number of times where Jack brought more imaginative components to his play with the car, which was one of his most common activities:

> *"Jack initiated a play with the red car, coming and going, saying to mother 'I'm back!' and giving her a hug when he got out of the car. Mother said, 'welcome back!'. Jack filled the car with petrol, and a staff member spun the petrol pump. He called for his mum to do it." (2 years, 2 months)*

At some point in his notes, mother is seen introducing the idea of filling up the car with petrol and he incorporated that into his play later. This could be seen as a use of symbols; however, it has an imitative quality to it in that he does not seem to bring his own signature to it and is attached to mother, as he does not accept the involvement of another adult in his play at this point. This suggests that perhaps he needed others in order to more deeply engage using complex symbolic skills in play, therefore this marker is also met. Another aspect worth noticing is the practicing of separation and reunion this game invokes, which would be more commonly seen in younger children. Perhaps Jack still needed to seek such reassurance at this stage in his development and there could be a

relation between this, and the difficulties maternal depression poses to the process of separation-individuation in young children. In this sense, this type of play can be considered age inappropriate.

As he grew up, Jack became more active, more verbal and more able to play away from mother and involve others in his play. However, the symbolic component in his play was still rather basic, as he was often described using the toys and coming close to a 'pretend' scenario, without fully engaging in it:

> *"Jack and mother played with the doctor's kit, and Jack picked up various items with the tongs, looking as though he was in deep concentration." (2 years, 3 months)*

> *"During snack time, the leader spoke about a dyad's absence because of an aunt's illness. Jack went to get the doctor's toy instruments and mother wondered about him thinking about the aunt being unwell." (2 years, 10 months)*

In these two vignettes that happen 7 months apart, it is possible to see how Jack can explore items that are meant for symbolic play and concentrate on them. In this case, he is playing with the doctor's kit and mother thinks he is linking this toy with a real medical situation narrated by the adults. What seems to be absent is the description of narrative, imaginative components, affective aspects, etc. Perhaps Jack, whilst having the capacity for symbolic play, did not have enough encouragement from his environment or did not feel comfortable enough with a type of play that would necessarily involve exploring the contents of his own mind and of his mother's, as possibly these contents could evoke uncomfortable feelings for both. In this sense, the narrative marker is also met.

Social play

Another apparent theme that comes up while examining Jack's record, is that sometimes, and in various ways, he would seek space from the group and either play alone or make others feel unwelcome. Most of the selected vignettes in this section were recorded after he was over 2 years old, when enjoying play with peers and other adults outside of the family would be expected, however even

before this he was already spending progressively less time at the only formally social time in the group, that is the ‘snack time’.

It is not possible to know for sure, but it seems that while he developed awareness of separateness and the existence of a social world, Jack sometimes needed to retreat, almost as if he was going through a late rapprochement phase that could be linked to the difficulties that maternal depression create for a child’s growing independence.

> *“When it was time for snack Jack continued playing in the kitchen corner and came to the table later, when only two people were left. At first mother didn’t join him, but Jack went to bring her over and then sat on her lap. Jack later went to play with the Lego house, filling the car with items then posting them through the letterbox. He seemed determined to make them all fit. He then brought mother a tiger and picked up the book ‘The tiger that came for tea’. A girl approached and took the book from mother, and Jack said ‘no!’ Mother said that she could read the book to both of them.” (2 years, 3 months)*

In this vignette, Jack is seen joining snack late, when most people where not there anymore and therefore having much less of the social experience such an event necessarily offers. Mother was not going to join, which might communicate something about her own occasional need to retreat from the social component of the group, or perhaps just her wish for Jack to manage a social situation by himself. Jack wants to spend time with mother and actively uses his agency to get it. After playing for some time, he seems to need this retreat again in a much more private, intimate way, such as cuddling with mother to read a book in the corner. A girl wants to join them, and he is not happy about this, however mother is able to show Jack that there is space at least for other children in their relationship, which might be related to the fact that mother already had an older daughter.

Whenever Jack needed space from others, he would not always seek mother, as he would often prefer to spend time alone. Additionally, Mother had difficulties with Jack’s displays of aggression and perhaps his need to retreat from the group at times could be linked to this, as it feels rather radical: no protesting, just leaving.

> *"Jack was playing with the bouncing toy and was laughing a lot when the figures jumped out. He later turned around and said to the room he wanted to go home. Mother suggested they go outside for a bit. They played outside for a while, and the group leader spoke to them about needing to get away from the group sometimes and them being the oldest members. When it was snack time Jack and mother were still outside. When they were invited to join by the group leader, they came into the hut, but Jack started playing in the kitchen corner, cutting pizza and playing with Play-Doh. He didn't respond to the leader's attempts to get him to join at the table." (2 years, 5 months)*

In this vignette, Jack appears to be happily playing when suddenly he tells everybody that he wants to leave. This shift feels rather quick and unannounced. Mother is able to find a middle point which is to keep playing but away from everybody else. The group leader is able to verbalise Jack's discomfort and links it to him beginning to outgrow the group. During snack time, Jack did not want to join and preferred to keep playing on his own.

There were moments when Jack seemed to want to play by himself, but he could be rather dismissive of the group or in this case, their staff members:

> *"Jack pushed the cars down the slope in a line and then into the plastic box. A staff member tried to join in, but Jack was concentrating on the cars, continuing to push them in a line. He asked mother if he could go outside to play with water, and she said he could. The leader offered him an apron, but he looked at them and didn't respond, then continued playing with the cars and garage. A girl and her mother arrived, and Kathy greeted them, but Jack was singing and playing without looking at them." (2 years, 6 months)*

It was almost as though he was giving the group the 'silent treatment' and would only speak to mother, as if he was making a remark of his wish not to be part of the group.

Another marker met in this category is that of compliance/opposition. Jack was often seen acting compliantly and avoiding conflict with peers, however at the peak of his anal phase, he would display normative aggression towards mother, which was a challenge for her. Jack's relationship to conflict is a theme that emerges from his records, as well as the progress he makes in this area, possibly

due to the space the group provided. Initially it did not seem easy for him to be around peers. Although he appeared interested, he did not always know how to deal with conflict, which might be related to mother's relationship with aggression.

> *"Jack and his mother approached the table where two boys were sitting. Jack wanted to share the Legos and see what the boys were doing. However, Jack soon lost interest as the boys found it difficult to share at that moment. Jack moved on to play in the kitchen with the pizza and play-doh. He got quite excited by a bowl of eggs and took some out to suck on them. He then climbed up and sat on the big chair and seemed to watch everyone for a while. Today Jack seemed conscious of the observers which we verbalised for him and mother." (1 year, 6 months)*

Here Jack is confronted with the conundrum of conflict in the sense that others might not want the same as him and the way he deals with this scenario is to walk away, avoiding conflict. It is interesting that after this happens, he goes on to suck on some eggs, almost as if he needed oral gratification. After, he feels the need to observe everyone from a high place, which could mean the feeling of being rejected made him silently upset and want to retrieve control by being vigilant.

> *"When a girl and the leader played with the slide, Jack asked to join them and appeared upset when the girl then went to swing instead. He climbed on mother's feet, and they started a game. He was laughing a lot. Jack led the way back into the hut and out again several times, opening and closing the door and bringing out several toys." (2 years, 9 months)*

In this vignette, it is possible to see how Jack interpreted the girl's different wish to do something different as a possible rejection, which made him upset in a way that seems rather passive. He then goes to find comfort in mother, which he finds, and this leads him to be able to play again.

Even though with peers he was often unable to be assertive, with mother it was the opposite. When Jack turned 2, it was more frequent to see in his notes the traces of anality and aggression in his play. As expected for his age, he would sometimes become very frustrated and could change his mood from one moment to the other. This posed certain difficulties for mother, which subsequently might have made obstacles for Jack in terms of identifying his feelings. Perhaps this

could be seen as one of the group's main contributions for this dyad, as the group was able to provide a space for naming these feelings, normalizing them and containing them.

> *"Jack became frustrated, wanting mum to play with him at the Lego house. He then went to the cot, threw all the teddies out and said to mum and me 'stay away!' Mother and the leader said he was frustrated and needed some space. Jack then asked to play outside with the pick-up truck. The leader mentioned it was raining and suggested playing with the cars inside. Jack did this for a while, driving the bus to the door but then went outside barefoot. Mother joined him outside where they played on the cars, swing and climbing frame in the rain. Jack protested a great deal saying he didn't want to tidy and then had a tantrum and hit his mum. The leader said hitting was not allowed and mum held him, he eventually calmed down and said goodbye to everyone at the end." (2 years, 6 months)*

In this vignette it is possible to see Jack going through a very normative phase during toddlerhood, where the conflict between wanting to remain close to mother and seeking independence can become quite overwhelming. Here he can swift from being calm to frustrated in a minute and he also pushes some boundaries, such as going outside barefoot when he was told not to. In this vignette, it is also apparent how mother has some difficulties setting boundaries for him and particularly at the end, when he hits her, it is the group leader who needs to become involved in order to contain Jack, provide boundaries and protect mother from his anger. In this sense, the clinician is playing the role of the paternal figure being another adult who brings the law in, as mother seems to need this support from a third person.

These difficulties were seen a number of times during their participation, and it seems that as Jack's anal phase and his aggressive feelings became more apparent so did mother's struggle to acknowledge and manage them:

> *"Jack came into the hut and was quite aggressive in his play, kicking the ball hard against the observation booth window and setting out the skittles, loudly kicking them down. The leader commented there might be some angry feelings for Jack today about having to wait at the start of the group. The leader said it was good to get some angry feelings out*

through play like banging with the hammer toys. Mother mentioned that Jack was not angry but copying other children at nursery."

"Jack later struggled to share the Lego toys and baskets with another boy. Both mothers and a staff member helped them to share. Jack became angry and went outside. Later he joined for snack and sat on his own chair next to mum, but then suddenly left slamming the door. The leader commented again that Jack seemed angry today and was expressing this through slamming the door. Mother said she thought he felt bored and aimless rather than angry. At tidy up time, the leader helped mother to gather Jack inside to help with tidy up. Jack ran away and then cried when mother carried him inside. He then had a tantrum, screaming, crying, and hitting mother several times hard in the face." (2 years, 6 months)

In this vignette, Jack is seen again displaying what could be considered ordinary aggression for a toddler, and it is the group leader who reads this as such and names it. However, mother interprets it as something different, denying the possibility that her son could be anything other than happy and in particular denying that he could be angry. It is possible mother's history of conflict with aggression within herself and with her own parents, made it hard and painful to recognise this emotion in her son, who might have in that moment reminded her of past, harmful figures in her own life story. It is so hard for her to face Jack's feelings with something other than remaining gentle that the group leader needs to step up as the boundary setter.

iii) Summary of Markers Found

Table 11: Summary of Markers Found for Jack

	Quality of play
Marker	**Presence**
Inhibition/Hyperactivity	Not found
Repetition	Not found
Uncontained Affect	Not found
Age inappropriate	Found
	Total Found: 1/4

Content of play

Marker	Presence
Predominantly manipulative play	Found
Symbolic play present if facilitated by others	Found
Precarious structure and/or narrative	Found
Limited range of emotions	Not Found
	Total Found: 3/4

Social play

Marker	Presence
Proximity to mother: Over-independent or over-dependant in relation to age	Not found
Over-compliance/Opposition	Found
Difficulty engaging with others in play	Found
	Total Found: 2/3

iv) Conclusion

According to the researcher's interpretation of data, Jack's case presented evidence to meet 6 of the 11 set markers, which accounts for 55% of them, supporting the hypothesis that in the presence of maternal depression, most markers are present in children.

It seemed the main areas affected in Jack's play were his capacity to develop complexity in symbolic play, as well as to socialise. Partly due to not knowing how to assert himself with peers and an apparent need to retreat from the group sometimes, Jack did not make the most of the opportunities to engage with peers and other adults that the group offered.

Mother's difficulties with mess and aggression had taken a toll on Jack, firstly, with his vigilant stance as a baby, and then through his toddlerhood when the aggression characterising anality emerged, as he did not know how to navigate these issues in a social context either.

It is possible that Kathy was a ‘good enough’ mother for Jack during the first year of his life, which then allowed him to express his aggressive feelings when he entered the anal phase during his toddlerhood. This brought a new challenge for Kathy’s motherhood that perhaps touched on her own difficulties with aggression. Being able to display these difficulties in the group sessions provided a space where mother could be supported in the task of mentalising and boundary setting, as well as for Jack to bring his own difficulties, explore play and new relationships.

This was not always successful, as often Kathy could not tolerate the group’s suggestions in thinking about Jack’s feelings and behaviours, and perhaps this relates to Jack’s need to isolate. However, by the end of their attendance, mother scored a 6 in her exit PDI, which represents an increase in her reflective capacity.

5.3.5. Harriet and Lucy

i) Presentation

Harriet joined a group when she was 1 year and 4 months. She attended mostly with her mother, Lucy, who was in her mid-thirties. Harriet’s parents came from an English-speaking country and were married. Father was also in his mid-thirties and they both used to work for their government, although now father worked in business and mother in research. Family was of white heritage.

Harriet and her mother attended the groups for 1 year and 9 months, although their attendance was at times inconsistent. By the time they left the group, they had participated in 42 sessions over 1 year and 9 months (62% of attendance). Their inconsistent attendance to the groups was a concern for the staff members and was addressed with mother a couple of times.

The dyad was referred by the Children’s Centre in which Harriet went to nursery, due to her presenting with tantrums and difficult behaviour. Mother had attended Parent Infant Psychotherapy previously at the Anna Freud Centre, as she was diagnosed with depression. According to her notes from the PIP service, Lucy had an abusive father growing up and struggled to express her own aggression. Over the course of the therapy, she disclosed her frustration towards her husband who was not as involved in parenting as she expected. Communicating this to

him was part of the therapeutic work. At the time the dyad entered the group, mother said she was taking medication for her depression.

During the entry PDI interview, Lucy describes Harriet as a child who used to be cautious but has developed into a very explorative little girl. She says this could be hard for herself sometimes as caring for Harriet required a lot of energy. Lucy also says she gets angry with her husband for not getting more involved in Harriet's care but that she did not really get angry at Harriet. When asked about what she expects from the group, she says she is looking for support and reassurance that she is doing a good job parenting and that her child is growing up healthily. Lucy uses a lot of mentalising vocabulary but does not always describe her feelings in depth. This interview was scored with a 4, meaning she is slightly below ordinary mentalising capacity.

During the course of their participation in the group, mother's depressive presentation can be seen particularly in a conflict towards the group, as she was often absent and when attending, often she would prefer for her and her daughter to be separate from others. At the same time, she presented as quite controlling of Harriet's behaviour and as her daughter started developing a more separate mind and expressed more age-appropriate aggression, mother seemed to struggle and a battle for control emerged.

ii) Analysis of Play Markers

Quality of play

Harriet's quality of play presented mostly as expected for a child with no maternal difficulties. She did not seem particularly inhibited, nor aggressive and her play did not show high levels of anxiety or hyperactivity. However, there is one marker identified in this section which is age inappropriateness as she alternated between showing precociousness and precariousness in her play.

In terms of the precociousness, Harriet presented as a girl who had well established routines that she had probably learned from nursery. At the same time, she had a very good vocabulary for her age and enjoyed reading time with

mother. These aspects of her development seemed more appropriate for an older child.

On the other hand, she also demonstrated a proneness to accidents, specially falling. This gives a sense of fragility to Harriet that would be more ordinary for a child who is just starting to walk. In most of these vignettes, Harriet falls and then rapidly becomes upset. Mother picks her up and soothes her. There seems to be a *baby-ish* quality in these moments and given the mother-daughter relationship that the clinical records portray, it is reasonable to speculate that Harriet made use of these baby parts of herself to get in loving contact with mother. A couple of examples follow:

> *"Lucy and Harriet arrived. Harriet was hesitant at first and spent some time looking around. She started to play with the car and the Wendy house, but then tripped over and fell on her knees. Lucy comforted her." (1 year, 9 months).*

> *"Harriet walked over to the kitchen corner where the other families were playing, slipped and fell. She was upset and moaned, and the assistant helped her up. The group leader asked if she was hurt, and she pointed to her leg and said 'leg!' the group leader asked if she wanted to show mummy where she was hurt and she walked over to Lucy to tell her. Lucy comforted her." (1 year, 11 months).*

This coexistence of well-developed capacities in contrast to the described sense of fragility, gave Harriet an interesting quality in which a child who appeared small for her age (as she is described) could do more than her peers and could follow instructions and routines, but at the same time did not have good control of her own body. These falls came as quite a shock to her, leading her to become tearful and to seek mother's comfort. Toddlers are usually impervious to falls and bumps, as they experience them so often in practicing their bodily skills. Therefore, Harriet's response seems rather unusual for her age. In this sense, the marker for uncontained affects is met as her tolerance to frustration was often lower than her peers.

The stressful impact of these accidents for Harriet was notable, as many children would 'walk-off' these moments and continue playing. For Harriet they

represented a big interruption in her experience of play, and perhaps this could be related to an experience of not being ´held´ enough by mother both physically and psychologically, due to mother's mental health difficulties and ambivalence towards her child. Similarly, this might suggest a fragile sense of self, potentially related to mother's depression.

Additionally, although expected for a young child at first, with time children can tolerate separating for longer from mother and so enjoy the presence of others in play; however even at the age of three and when she was soon to leave the groups, Harriet still had some difficulties including others in her world apart from mother. This could be considered as a sign of precariousness that will be further developed in the section below on *Social Play*.

Content of play

In terms of content of play, none of the described markers for this section were identified. Most of Harriet's play included symbolic and fantasy components, she could use play to cope with difficult feelings, and it did not seem like this type of play needed the facilitation of others to occur.

Social play

Some markers are found again under the category of social play. There seems to be a difficulty, even as an older toddler, in being away from mother but also in allowing others into her play and her relationship with mother.

In this sense, two markers co-exist; that of needing proximity with mother even after the age when children do not normally seek it as often; as well as that of the rejection of others.

Additionally, there is an interesting dynamic in relation to the marker of over-compliance. As Harriet starts attending the group, she tends to make attempts to explore and test some boundaries, however she remains quite compliant to the rules and limits provided by her environment and her mother in particular.

With time, Harriet starts to develop a healthy amount of aggression that allows her to claim her own wishes. This presents a challenge for her relationship with

mother, as Lucy seemed to struggle with this new side of her daughter and a competition for who is in control developed.

In terms of the first marker, that of separation from mother, there are two aspects of Harriet's development to observe. One is explicit and the other requires theoretical interpretation:

> *"Harriet and Lucy arrived 15 minutes early and were playing in the garden. A new member of staff and the leader went outside to greet them, and Harriet clung on to her mum and protested at being put down (…) Harriet went to the swings and Lucy pushed her. When the new member tried to help Lucy with the new swings Harriet protested and said 'no, mummy!'." (1 year, 8 months).*

As seen in this vignette, after four months of settling into the group, Harriet still struggled with separating from mother and with including other people in her play. Over time, she did show the capacity to enjoy parallel play with peers, as well as explicit demonstrations of empathy, however, she mostly needed mother near for reassurance, even at an older age. Perhaps their sometimes-inconsistent participation posed an obstacle for Harriet to feel settled more systematically.

> *"Lucy and Harriet were playing by the climbing toy and Lucy began to chat with another mother. Harriet said she wanted to water the plants and asked for mum to help. She had a frowning expression. The assistant said mum was chatting, but she could help her, and she said she wanted her mum to do it." (3 years)*

Secondly, at a more interpretative level, a theme that became rather apparent was the difficulties with bowel movement Harriet showed at times. It was not uncommon for Harriet to feel upset when having to go to the toilet to defecate, or to become tearful when doing it. This could be interpreted as a bodily representation of difficulties to separate and possibly a need for control in the face of a controlling parent. At this stage, children can think of their faeces as parts of their body or as aggressive weapons towards the environment. For a child with difficulties in separating from mother and who at the same time struggles with aggression, this seems coherent.

“Harriet began crying in the toilet. The assistant asked them if everything was ok, and Lucy said it was the first time Harriet did a poo here. ‘That’s good, now you are both okay,’ said the assistant. ‘Yeah’ Lucy replied.” (1 year, 8 months).

“Before snack time, Harriet and Lucy went to the loo. Harriet said she wanted Clifford the dog (toy) to wait for her outside and mum agreed.” (3 years)

In this second vignette, we can see an older Harriet going to the toilet without getting upset like before, however she asks to take a toy which is a dog on a leash. It could be interpreted that this is an attempt for Harriet to become active in a situation where she feels passive and possibly anxious, as the dog represents her as being in control of another creature, just like her mother is in control of Harriet’s body in this moment.

Another interesting behaviour she displayed sometimes was that of kissing toys goodbye at the end of some sessions. This could be thought of a resource she developed to cope with the anxiety of separating from the group, meaning some attachment to this space was experienced by her. Given mother was not reliably attending, perhaps it made it harder for Harriet to trust she would see the toys again soon and she was able to develop her own means to tolerate this.

Another identifiable marker is that of struggling to include others in play. As a dyad, they failed to attend consistently to the group sessions, which might reflect mother’s ambivalence towards the group, while also communicating to Harriet that perhaps the group was not a space to become reliant on. At the same time, it was not uncommon to see them enjoying time together apart from the rest of the group when they would attend., either by staying outside of the room in the garden area or by cuddling together in the corner reading. Staff recorded feeling like they were intruding when trying to join Harriet and her mother at play.

“Harriet sat with mother and played with her. They went to the bathroom before snack and then joined. Harriet ate well, as usual. After snack Harriet and Lucy played catch and skittles in the far corner of the hut. The assistant went to join them and was concerned she might be intruding on their game.” (1 year, 7 months)

Although Harriet was able to enjoy parallel play with peers and show empathy towards them as well, there were moments where others' presence seemed to disturb her as she showed a strong emotional reaction to their interruption in her play.

> *"One of the boys saw Harriet inside and began to shout in the window 'Hello!!'. He did this twice abruptly. Harriet began to cry and said with a shaky voice 'I don't like this boy'. The assistant said: 'Maybe you don't like the way he is playing Harriet; you got a bit scared'. Lucy said: 'Harriet, don't talk like this'. At this moment, there were two bugs near the Wendy house and Harriet began to cry and point to the bugs." (2 years, 11 months)*

At the beginning of their participation, Harriet used to follow the proposed routines in the group better than other children her age. She would happily tidy up with her mother's help at the end of sessions, which most toddlers struggled with as it meant they had to stop playing. A moment in which it was common for children to protest, did not seem to bother Harriet very much in the initial stages. Her mother was very diligent in setting boundaries and at times she could be controlling of her child, as well as a little aggressive towards her. In this sense, initially Harriet presented as quite compliant towards her mother, therefore this marker was met.

> *"At one point Lucy began to tease Harriet in her play and Harriet became quite cross. 'It's too much for Harriet,' said the leader. Then mum stopped. Mother took her to use the potty before snack. We also chatted about potty training leading to more aggression in toddlers which is normal and part of becoming independent." (1 year, 7 months)*

At this point, Harriet was more able to show some aggression, which might have represented a difficulty for mother, who might have unconsciously been seeking to reposition some of that aggression back into Harriet when she provokes her in this vignette. The group staff helped mother become aware of what she was doing and allowed Harriet's feelings to be acknowledged.

With time, Harriet became much more able to express her anger and wishes overtly, perhaps due to the facilitation of the group as a safe environment to practice this and to support mother when she did so. However even near the end

of their participation, mother still sometimes struggled to cope with her daughter's aggression.

> *"They entered the hut and Harriet told her mum she wanted to play with the Legos. Mum followed her, and they remained playing by themselves. Harriet was protesting more and bossing mum around in her play. At snack time, Harriet joined the table and enjoyed her snack while mum chatted with the other mums. She was looking around and said that nobody was playing outside. Mum said it was snack time and she could play later. She looked at mum and said: 'Sit properly'. Mother replied 'you sit properly' slightly embarrassed. Everybody giggled and the group leader said Harriet liked to boss mum around sometimes." (2 years, 11 months)*

iii) Summary of Markers Found

Table 12: Summary of Markers Found for Harriet

Quality of play

Marker	Presence
Inhibition/Hyperactivity	Not found
Repetition	Not found
Uncontained Affect	Found
Age inappropriate	Found
	Total Found: 2/4

Content of play

Marker	Presence
Predominantly manipulative play	Not found
Symbolic play present if facilitated by others	Not found
Precarious structure and/or narrative	Not found
Limited range of emotions	Not Found
	Total Found: 0/4

Social play	
Marker	**Presence**
Proximity to mother: Over-independent or over-dependant in relation to age	Found
Over-Compliance/Opposition	Found
Difficulty engaging with others in play	Found
	Total Found: 3/3

iv) Conclusion

According to the researcher's interpretation of data, 5 out of the 11 markers were found, accounting for 45% of them. Harriet does not strictly meet the criteria to confirm the hypothesis that in the presence of maternal depression, most markers are present in children and her difficulties seem to be particularly concentrated in the area of social play.

In general, Harriet had the capacity for spontaneous play at a symbolic level and she sought to share this experience, mainly with mother, as her main type of play. Mother often was able to follow Harriet's lead in play, however it is not apparent mother initiated much play herself. Harriet's markers give the impression that psychic separation was not an easy task for mother to facilitate, possibly due to her depression.

It is reasonable to speculate that the support mother received from PIP when Harriet was a baby, helped her become a 'good enough' mother for Harriet's babyhood and that this allowed the child to mostly develop in a healthy manner, although some difficulties started presenting when Harriet's aggression increased in order to separate. At the same time, the reminiscent possible effects of mother's depression became visible as the present markers came to light in the group sessions.

Harriet was already attending nursery before she joined the group, therefore physical separation was already in place, perhaps prematurely. However, when

the signs of psychological separation and accompanying aggression started to emerge, it created a conflict in their relationship.

One of the main expressions of individuation in a toddler is their aggressive behaviour but this aspect of development presented a big difficulty for mother, since her own father could not control his own anger. This could possibly relate to her depressive presentation and her own misplacement of aggression, i.e., turning it against herself and becoming depressed. It could be speculated that Harriet's normative toddler aggression might have reminded Lucy of her father. Additionally, this means mother possibly did not trust parental figures which is what the group and in particular, its leader, represents.

Finally, it is apparent that by the end of their participation in the group, Harriet still showed some of the markers described but these were much less prevalent than in the beginning. Overall, Harriet was a good deal more confident, and mother was more able to mentalise both for herself and for Harriet. When mother had the exit PDI, her score increased to a 5, which stands for ordinary mentalising capacity and represents an increase in mother's RF.

Additionally, it is worth mentioning that her capacity to mentalise as measured by the PDI, oscillated between below ordinary and ordinary, even after being seen by two different services, PIP and the PTG.

5.4. Theoretical replication: cases of five children of mothers without depression

5.4.1. Daisy and Molly

i) Presentation

Daisy was the second child of Molly and Jack who both work in the field of arts. The couple was in their mid-thirties, married and had an older child who attended the Parent-Toddler group when he was younger, so Daisy had been familiar with the space since she was a baby. Mother was of White-British heritage while father was of Mixed White British and Iranian heritage.

As both parents worked in the realm of arts, they had flexible schedules and took turns to care for their children. Even though Daisy did come with her father several time to the group, it was mainly her mother who would participate with her.

The dyad's participation in the group was a self-referral from her parents who knew the work carried out at the group from when they brought their son, who had recently started school.

Daisy was 1 year and 2 months when she started coming to the group with her mother and they attended for 42 number of sessions over the course of 27 months (67%).

When mother attended the entry PDI interview, she scored a 6, meaning her mentalizing skills were above ordinary.

ii) Analysis of Play Markers

Quality of play

In Daisy's case, there is no evidence for any of the markers under this section. She does not present as inhibited or hyperactive in her play, there are no signs of repetitive play or uncontained emotions. Similarly, all the vignettes found in her records describe a child who is developing age appropriately.

> *"Daisy had been playing in the kitchen with the group leader, who was sitting next to her. Daisy gave her a plate of pretend food and the leader thanked her for this. The leader stood up and went to the back of the hut (…) the group leader came back to the main room and Daisy went rapidly towards her and pretended to put some sprinkles on her plate. Daisy went back to the kitchen and asked her mother if she wanted one, to what her mother responded, 'I'd love some'. Daisy gave a plate with pretend food to her mother and then served one to herself and pretended to eat it. Daisy then went to the kitchen to fetch some sprinkles to put on her mother's pretend food." (2 years and 6 months)*

As seen in this vignette, Daisy was able to play spontaneously, using role play and symbols in a social context that included mother as well as others, without any apparent difficulties.

Content of play

In this category, no evidence was found for any of the markers. Daisy was able to play mostly symbolically without needing facilitation, she presented a structure and narrative in her play that was age appropriate and was able to express a broad range of emotions. This can be seen partly in the previous vignette belonging to the above category. Here is another example:

> *"Daisy and her mum opened the medical kit and Daisy started exploring its little tools (…) Daisy begins by checking her mother's ears with a toy otoscope (…) the leader stood up and went to pick up Teddy (big stuffed bear). She grabbed him by the ears and carried him as if he was walking towards the snack table. She put Teddy standing in front of Daisy and said, in a playful voice and as he was speaking, that he wasn't well. Daisy starts taking rapidly every tool there is in the kit each by each, and she puts them first on one of Teddy's ears and then the other. Molly told the leader she thinks Daisy is putting the objects on his ears because his brother just had an ear infection." (2 years and 8 months)*

In this vignette, it is possible that Daisy was replicating something that she saw at home. Perhaps mother caring for her brother and therefore it may be the case that she was experiencing some identification with her. Similarly, Daisy may have been also identifying with her brother. Possibly she might have seen him in pain or discomfort, which could have brought some anxiety for her due to empathy or because it made her feel concerned for herself as it is usual in toddlers, due to their investment on their own bodies. If this was the case, then I think it could be possible that by pretending to be the one who takes care of someone instead of the one who is being taken care of, Daisy could be gaining some sense of mastery in a situation that in real life she could not control. This sense of mastery might have soothed some anxieties regarding her preoccupation with illness and pain.

Social play

No markers were found in Daisy's case under this category. Daisy was able to separate and reunite in relation to mother in an age-appropriate manner. Similarly, and as seen in previous vignettes, she was able to engage others in her play. These were mostly adults as it is expected for her age, however peers

were often involved in her play in a more parallel way, and she showed interest and joy in sharing play spaces with them. Lastly, she did not behave in any particularly compliant or oppositional fashion that could be interpreted as a variation of normative toddler development.

> *"Daisy came into the hut on her mother's arms. Her mother sat down on one of the chairs next to the window and Daisy remained with her, sitting on her legs and facing to her mother's chest. After a while Daisy stood on the floor putting her head on her mother's legs. Her face looks red, and her eyes were hazy. Daisy went to the middle of the room and watched towards the rug where another older girl was playing. Daisy went back to her mother and took her hand before going back to the rug. Her mother went with her." (2 years and 5 months)*

This vignette illustrates the progression of transiting from a need to be close to her mother, to being able to separate for a few moments and show sufficient curiosity about the environment to break away from the limits of the mother-child dyad. From the look on her face, it seems that Daisy had been sleeping before entering the hut with her mother. She found herself in a new place when she woke up, which can be scary for a child. Fortunately, as she started became aware of her situation her mother was with her, and this made the transition to play easier. Daisy begins by being fully in touch with her mother's body (sitting facing mother's chest), then slowly starts to make contact with the space still maintaining her body close to mother (standing with head on mother's legs). Eventually she manages to take a few steps away from her and appears to find interest in what the other girl is doing. Still at this point she needed to fetch her mother to feel safe enough to approach this girl and have a new experience. This can be considered as age appropriate since it is around the third year of life when toddlers are expected to manage their body, thoughts and feeling by themselves, without the constant presence of a significant adult.

> *"Daisy said she wanted to wash the dishes, to what the leader responded that she could but had to wear an apron not to get wet and then helped her choose one. Daisy said she wanted a pink one but there was no pink one. Daisy showed discomfort when the leader lifted her sleeves so they would not get wet. Daisy took off the apron saying that he did not want one. The leader told her that the rules for everyone were that to do the washing up, they had to wear an apron and if she did not want one, she*

could not do it. Daisy insisted a couple of times, receiving the same response from the leader. Daisy then gently hit the tap, the leader said 'oh!' in a friendly way. Daisy laughed and got off the bench saying she did not want to so the washing up." (2 years and 10 months)

This vignette shows how Daisy was able to show some aggression with no signs of emotional dysregulation or excessive discomfort.

"Daisy was having an early snack at the table. Another toddler was being held by his mother and he started crying. Daisy stopped eating, she stared at him and showed a worried look wrinkling her forehead. She asked why he was crying, and the leader explained that he was waking up and needed his mother to cuddle him. Daisy then said that once she hurt her knee, her mother cuddled her, and she felt better." (2 years, 10 months)

According to her records, Daisy was often interested in the emotional reactions of other children and felt quite curious about them. The look on her face that could be interpreted as worry or a puzzled expression. This might communicate Daisy felt concern and empathy. At this age, it is possible Daisy knew what crying meant generally, so she could have had an idea around the fact that the younger boy was upset because of something. Her curiosity allowed her to ask and receive a satisfactory response that made sense to her, since she could relate to it with her own experience. By remembering that soothing experience with her mother, she is not only saying she understands, in some ways, what the boy is going through, but she is also demonstrating she is gaining object constancy and the stable inner image of her mother as a caring good object, which at the same time can work as a soothing resource for herself when her mother is not physically present.

"Daisy goes up to the little pool where a younger girl is also naked and playing. Each of them gets one pink watering can, identical to each other. Molly takes the girl's watering can and goes a few steps back to the house where a little outdoor tap is found (…) Daisy looked at the girl and lifted back the hand that was holding her watering can, as if she was going to hit her with it (…) Molly then took Daisy's watering can fill it up with water. The girl extended the hand that's holding her watering can towards Daisy, as if she was offering it to her. Daisy took the girl's watering can and dropped it in the pool. Molly came back with Daisy's watering can filled with water. The girl let all the water from her watering

can fall into the pool and both mothers celebrated this. Daisy saw this and imitated the girl's action, enjoying the same reaction from the adults. She laughed." (3 years old)

Daisy was the only girl in the group for a while, until a new younger girl arrived. Additionally, Daisy's time in the group was soon to be over because of her age, so perhaps what this vignette is showing is some sense of rivalry towards this little girl who could stay. At the same time, Daisy had to share her mother in the pool game they were having, and since her only sibling is a boy, perhaps Daisy was not used to sharing much with other girls. However, at the end, Daisy seemed to understand that the girl was being admired by the adult women and by sharing the game with her she could also profit from the enjoyment of that small mother-daughter group full of feminine referents.

iii) Summary of Markers Found

Table 13: Summary of Markers Found for Daisy

Quality of play	
Marker	**Presence**
Inhibition/Hyperactivity	Not found
Repetition	Not found
Uncontained Affect	Not found
Age inappropriate	Not found
	Total Found: 0/4

Content of play	
Marker	**Presence**
Predominantly manipulative play	Not found
Symbolic play present if facilitated by others	Not found
Precarious structure and/or narrative	Not found
Limited range of emotions	Not Found
	Total Found: 0/4

Social play

Marker	Presence
Proximity to mother: Over-independent or over-dependant in relation to age	Not found
Over-Compliance/Opposition	Not found
Difficulty engaging with others in play	Not found
	Total Found: 0/3

iv) Conclusion

According to the researcher's interpretation of data, Daisy presented 0 out of the 11 markers described, which accounts for 0% of the set markers, supporting the hypothesis that in the absence of maternal depression, the majority of these play markers are not present.

Daisy had creative parents who were able to be present and reflective. Similarly, the couple had the experience of an older child, perhaps allowing for less anxieties to unfold around Daisy's development. All these factors seemed to have served as facilitators for Daisy's development to take its course without apparent difficulties.

Her participation with mother in the groups is portrayed as running smoothly and mainly as an experience that permitted mother and daughter to spend some time together apart from the rest of the family, to play and connect, as neither did mother bring any significant concerns to the group. Perhaps the family's main aim was to provide their daughter with a space that had helped their older son in the past, and fortunately they had the time and the resources to prioritise this.

When Molly attended the exit PDI interview, she scored a 5, which stands for ordinary reflective functioning. This is a slightly lower score than her previous interview.

5.4.2. Amy and Elly

i) Presentation

Amy and her mother Elly joined the groups when the child was a year and ten months old. Amy was an only child and lived with both her parents who were of Asian heritage. Mother had been brought up in her country of origin, while father was UK born. Both parents had an education to postgraduate level, working in science. At the time of their entry, mother was in her early thirties, while father was in his early forties.

The parents self-referred to the groups because Amy was showing some aggressive behaviour towards other children in nursery and adults as well as her own parents. These included biting and hitting, as well as some clinginess. Mother was also still breastfeeding at the time, and she wanted some guidance in terms of how to best wean and set boundaries. They attended for 33 sessions during a year (72%) with a consistent participation and left due to an organisational decision to close the group.

Mother described her culture of origin as quite rigid and authoritarian, where adults did not reach out to their parents when they are struggling but only to share good news. Elly expressed the wish for Amy that she would always know that her parents were a safe base for her even as an adult. This conflict seems to leave Elly a little confused in terms of when and how to set necessary boundaries for her child. Mother said she is often left following what Amy wants because she does not want to hurt her child, and it seems like her fantasy of being a good mother is to care for her daughter without any conflict.

Mother also commented on the fact that when Amy was a baby, breastfeeding was difficult, and she feels she has been more able to engage with her daughter as she has grown older and when some exchange such as smiles, or words started to take place.

In her entry PDI, Elly reached a 5, meaning at the time she started attending the group she demonstrated an ordinary level of reflective functioning.

ii) Analysis of Play Markers

Quality of play

In general, it is observed that Amy presented normative development for a child her age. In this category, no markers were found as there were no traits of inhibition or hyperactivity in her play, nor uncontained affects or age-inappropriate behaviours.

> *"Amy was done playing with water and came back to the kitchen area. She was looking at the breads and another girl and her mother were also sitting on the table and joined everyone. Amy took the wooden cake and cut it, giving pieces to everybody. Elly suggested 'what about a tea party'. 'Sounds lovely!' said the group assistant. Amy gave cups and pretended to serve tea for everyone. Soon after 'tidy up' time came up and Amy was able to stop playing and tidy with the help of her mother." (2 years)*

This vignette serves as an example to illustrate how kitchen play was an opportunity for Amy to interact with others, adults and peers, particularly of the same gender. Here Amy allows the presence of others and makes them a part of her play. Mother helps to facilitate this group experience by announcing the party, which possibly reassures Amy about the safety of having others in the dyadic space. In this vignette, Amy is able to finish her play and follow the norm of tidying up before leaving. Her ability to follow the rules might be particularly good for a child her age, due to her attendance at nursery.

This is a vignette that was registered soon after Amy and her mother joined their group. As seen here, by age 2 Amy was able to initiate play, include others and present some role play and symbolism in her play.

Content of play

Under this category, Amy again presents as normal for her age. She is able to play both manipulatively and symbolically, showing spontaneous symbolic play with a structure and narrative that were appropriate for her age and an appropriate range of emotions.

During their participation in the groups, it seemed like mother was progressively more able to find strategies to deal with small daily moments of conflict with Amy. However, there was one boundary in particular that mother was more resistant about. As read in the notes written by the group leader, a lot of thought was given to how to best help mother get the confidence to wean Amy, as the clinician sensed Amy was ready and mother did not spontaneously talk about the matter with the therapist or other parents in the group.

> *"Amy and Elly were playing with the baby doll near the book area. Amy was holding the baby and supporting him on her chest. 'Are you giving milk to the baby?' asked the group assistant. 'Yes' she said. Mum laughed and looked at her. Amy then went to the kitchen area and began to cut vegetables in half with the aid of mum. Mum said she really enjoyed helping around the kitchen at home. Amy began to distribute toy vegetables to the adults around the hut. Everybody thanked her. At tidy up time, all the toddlers helped apart from Amy who was breastfeeding." (2 years, 4 months)*

In this vignette, Amy seems to fully embrace an identification with a female caring figure in that she pretends to feed her baby in the way mother feeds her and after, she goes on to feed everyone in the room. There seems to be a sort of coming and going in Amy's mind, where in this session she moves from becoming the carer and the feeder, to then being actually breastfed by mother. There is no detailed information regarding how the breastfeeding came to be, who proposed it or who needed it. Nevertheless, perhaps both mother and daughter need to make sure they could still come together in the way that is known and protected, after Amy practices being a big girl.

> *"We entered the hut and Amy said she wanted snack. 'Oh, are you thinking about snack time?' said the assistant while looking at the clock. 'Yeah' replied Amy. 'It is almost time, but meanwhile you can prepare the baby a snack while you wait' she suggested. Amy nodded and headed to the kitchen area. Mum was observing her from the chair. Amy said the baby was hungry. The assistant asked her: 'Is the baby having a snack or milk?' 'Just snack' she said. 'Is it a big baby? It does not need milk anymore?' I asked. 'Yeah, just the snack' she said. Mum giggled. She opened the oven and said she was going to prepare the bread for the baby." (2 years, 5 months).*

In this vignette it is possible to see how the clinician facilitates some gratification delay for Amy, making use of a play interest of hers. Amy is able to follow this and to displace her wish to be fed into play with the baby doll, where she is once again the feeder and carer. When the clinician sees Amy's play, she starts a conversation that thematises the issue of breastfeeding, in the displacement of the play, hence making it less threatening for the child. Amy is able to engage in this small conversation, saying this baby does not need the breast and will be satisfied by a regular snack. The clinician states that this baby is big enough not to need the breast and therefore communicates to Amy there is a part of her that is a big girl and does not need her mother's breast either.

> *"Amy was removing the pieces of the cylindrical toy. She grabbed a long part and said: 'It's a lipstick'. She laughed and pretended she was putting on her lips. Mum and the assistant giggled. 'A lipstick?' the assistant asked. 'Yeah, pretend' she said and handed it to her. The assistant pretended to put on her lips, and Amy giggled. Mum had her turn too. 'I don't know where she learns these things' mum said laughing. 'They always surprise us' the assistant said. Mum nodded and gave Amy a cuddle." (2 years, 5 months)*

Here it is possible to see Amy presenting a much more developed vocabulary and conversational skills, as she invites a group female experience around a piece of her imaginative play. A lipstick could be considered as something that is linked to feminine aspects as well as more adult ones, so it is possible that Amy was wishing at that moment, to be part of the 'big girls' in the room, therefore wanting to share this with her mother and one of the clinicians.

Social play

Mother's difficulty in weaning Amy and both parents' struggle to set clear boundaries might have been linked to Amy's initial difficulties in letting go of mother at times. Amy appears to have started nursery before she turned two and perhaps this might have felt as early for her, so now she want to keep mother close in the PTG because here, unlike at nursery, mother or father could stay.

> *"Amy and her father were the first to arrive at the Toddler Group. Dad was carrying Amy and we both greeted them inside. Dad put Amy on the floor, and she said: 'Daddy, daddy'. 'Yes, sweetie' he replied. 'Daddy,*

daddy' she said. The group leader said that daddy was just there. She said 'daddy, daddy' again while putting her hands in the air. Dad picked her up and her gazed turned to the staff members. The leader said she was getting warmed up. 'Yes' daddy said. 'You are the first to arrive, you can choose what do you want to play. Shall we give a high five to (assistant)?'. She nodded. They high fived and fist bumped. Amy then did the same with the group leader encouraged by her dad. Amy looked at father and he placed her on the floor. She looked around and began to remove her jacket. 'Do you need help?' asked dad. 'No' she said. 'You want to do it by yourself' I said. 'Yeah' she said. She managed to take her jacket out and handed it to her dad. 'You made it!' said the assistant. Amy smiled and then entered the room and dad followed her." (2 years old)

Although Amy normally attended the group with mother, this scene was quite common at the early stages of their participation. All adults involved try and reassure Amy by saying dad is not leaving her and that she now has the chance to have the room for herself. Father goes a step further and tries to encourage his daughter to engage playfully with the clinicians, transmitting to Amy that these are people she can relate to. This illustrates how this family introduces the social world to this child, as one that can be friendly. This exchange allows father to sense that Amy is ready to be put on the floor, which shows him as a parent that is able to wait until his child is ready. Amy then proceeds to display some assertive and autonomous behaviour which is age appropriate, receiving praise from the clinician afterwards and she then goes off to play. This is an interesting example of how time to gain confidence and a sensitive transition facilitated by significant adults, can give space to Amy's sense of empowerment.

Amy's reluctance to separate soon passed, so it is not considered pervasive enough to meet the marker of proximity.

Amy did not meet criteria for any of the other markers, as she did not behave in a particularly compliant nor oppositional manner that would be considered a variation of normative development.

In terms of engaging others in play, as seen before, she could easily play with other adults and as the following vignettes will show, this was also the case with peers.

“After snack Amy and another girl played together with the cars. They said they were in an adventure and that they were going to the park together. Their parents watched them with smiles on their faces. The group assistant said, ‘You guys are having so much fun together!’. They looked at her and Amy repeated that they were going to the park together. They said ‘bye bye’ to their parents and began to ride across the toddler hut. After that, both girls played catch alongside with their parents.” (2 years, 2 months)

This vignette shows how Amy has developed the capacity to show interest in peers and find joy in sharing experience with this one girl. It is also likely that girls, as they develop an identification with femininity, would want to play with other girls who might show similar interests. Furthermore, the game described in the vignette is not collaborative, which is developmentally normative, however it does involve some togetherness, so it might represent a stage where play is not just parallel anymore. There is also verbal language in this game, which provides a narrative and use of imagination. Parents on their part, seem to enjoy this scene, possibly feeling reassured that playing a little way away from them and with other children is safe and desirable.

“Another girl started crying and Amy changed her facial expression. She looked at her dad and had a frowning expression. ‘Are you worried about her, Amy?’ said the leader. ‘Yeah’ she said. ‘She sounds upset but her mum is helping her. Mum and dad help us when we are upset.’ Amy continued to look at the girl. ‘Do you want to check if she is ok?’ the leader asked. ‘Yeah’ she said. They got closer and the leader said: ‘Amy wanted to check if you were ok. She was a bit worried because you cried’. The girl looked at them and said, ‘I bumped my head’. ‘Oh, it makes sense now’ the leader said. ‘Are you feeling ok now?’ the leader asked. ‘Yeah’. Amy’s expression was lighter, and she smiled while touching her head. ‘I bump my head too’ Amy said. ‘Oh, you have also bumped your head once?’ the leader added. ‘Yeah’ she said.” (2 years, 3 months)

In this vignette, Amy shows preoccupation when another girl is upset. This might have been related to her being Amy’s friend or regular playmate, although it is also possible to consider that at this stage, it is common for toddler’s sense of individuality to be forming and therefore, the me-not-me limits are still unclear. This can sometimes lead to a child feeling concern about a peer’s pain, because

it feels like a very close and almost personal experience. The clinician is able to read Amy's need to make sense of what might have happened and when she gets a response, she seems content and contained. Additionally, she is able to relate her peer's experience to her own in the past. This shows that Amy has developed some mentalisation capacities, although incipient and age appropriate.

iii) Summary of Markers Found

Table 14: Summary of Markers Found for Amy

Quality of play	
Marker	**Presence**
Inhibition/Hyperactivity	Not found
Repetition	Not found
Uncontained Affect	Not found
Age inappropriate	Not found
	Total Found: 0/4

Content of play	
Marker	**Presence**
Predominantly manipulative play	Not found
Symbolic play present if facilitated by others	Not found
Precarious structure and/or narrative	Not found
Limited range of emotions	Not Found
	Total Found: 0/4

Social play	
Marker	**Presence**
Proximity to mother: Over-independent or over-dependant in relation to age	Not found
Over-Compliance/Opposition	Not found
Difficulty engaging with others in play	Not found
	Total Found: 0/3

iv) Conclusion

According to the researcher's interpretation of data, Amy presented 0 out of the 11 markers described, which accounts for 0% of the set markers, supporting the hypothesis that in the absence of maternal depression, the majority of these play markers are not present.

As described in this case, Amy displayed a very normative development for a toddler. The group seemed to have provided some needed support for Amy's parents and in particular Amy's mother who had some resistance to starting the process of weaning Amy. Because of mother's general difficulty with these issues, she was offered a session with the service's consultant child analyst more than once. Initially she did not take the offer, until the group was about to end. Towards the end of their membership, Amy's parents took up the offer of attending a session with the service's consultant. In that meeting, the child analyst helped the parents explore their issues around boundary setting and mother's difficulties with weaning. In this session, mother commented that it was hard for her to let go of Amy and perhaps this would be easier when they had a second baby.

By the time their participation ended, Amy was able to play quite independently and enjoyed pretending to take care of a baby doll. She was being a 'big girl' and she might have felt ready to let go of mother's breast. Sadly, this conflict was not completely elaborated during their participation in the group due to its closing.

In the exit PDI, mother scored a 7, which stands for a superior capacity to mentalise. This is an important improvement in comparison to the score she reached before she started her participation in the group.

5.4.3. Aisha and Manira

i) Presentation

Aisha started attending the groups when she was 15 months, along with mother Manira. She lived with both her parents and her older 5-year-old sister. Both parents were solicitors in their mid- to late thirties, however mother was a full-

time parent while they participated in the group. The family was of South Asian heritage, having family in the UK. According to Manira, her own mother supported them with caring for the children. Aisha and her mother attended the groups for 22 months with an 85% rate of attendance. The exact number of sessions attended was not available in the data.

Manira self-referred due to concerns related to how she had parented her first daughter, saying that when Aisha was born, Hina had real difficulties coping with the arrival of her baby sister. Mother thought Hina's suffering was related to the way she was parented and so she explains she does not want to make 'the same mistakes' with Aisha. Manira hoped the toddler group would support her parenting of both daughters.

According to protocol, mother attended the pre-entry PDI interview. This interview was transcribed, coded and scored 5 in the RF scale, which means mother presented at the time with an ordinary capacity to mentalise.

ii) Analysis of Play Markers

Quality of play

In Aisha's records, there are no signs of inhibition, hyperactivity, repetition or uncontained affect in her play. However, after her second birthday mother became pregnant and this seemed to have an impact on Aisha's psyche and development.

> *"Aisha smiled at the group leader and took a wooden ball. She took a second wooden ball and then knocked the two together, looking at the leader intermittently and smiling. After about ten minutes, she left her mother's lap, but stayed very close to her. She gradually moved further from her mother, interacting and smiling with the group assistant, and playing with the helical ball toy. Manira remained close to Aisha during the afternoon. She sometimes stopped Aisha from dropping all the wooden balls on the floor and praised her when she 'tidied'. Manira also encouraged Aisha to say 'thank you' to the leader." (15 months)*

This vignette was recorded on Aisha's first visit to the group. Aisha seems comfortable exploring not only the material surrounding such as toys and the

space, but also to explore interactions with other adults. Initially, this is done while remaining physically close to mother, which is expected for her age. Eventually Aisha might have understood that mother was staying in the group with her, hence she felt the safety to move away a little. The sort of activities described by the clinician in this vignette, give a picture of a girl who is able to play and communicate along the lines of what would be considered typical development.

Regarding mother, Manira seems preoccupied with her daughter being messy and appearing impolite, which can also be expected in the first few sessions, as mothers might want to show themselves as 'good' parents. Another reason for mother's preoccupation with tidiness and politeness is that Mother does not know what is expected/allowed in the group. She does not yet know what the group 'rules' are, so to speak. Mother was also able to interact with her peers, which is considered one of the main aims for parents attending the group.

The following vignette was recorded sometime after the birth of her new baby sister:

> *"Aisha sat in the book corner with the group leader. She took a dolls' bottle and placed the teat in her mouth (not pretending but trying to drink from it). The leader commented on her wanting to be a baby. Aisha gave the leader a bottle and suggested she drank from it. The leader took a stuffed animal from the cot and pretended to give it some milk. Aisha took the animal and threw it to the centre of the room. The leader took another animal and pretended to give it some milk. Aisha did the same again. They repeated this sequence with every soft toy in the cot until the cot was empty. The leader talked about her anger with baby and her mum, and said it was all right to be angry and even when she felt angry, her mum still loved her and wanted to play with her. Aisha said she did not want to play with her mum. The leader said that to Aisha she was so angry with her mum that she did not want to play with her now, but she might feel like it in a little while. The leader looked up and saw that Manira was watching the entire sequence of events. The leader asked Aisha again if she wanted to play with her mum and she said yes. The leader said she would go and tell her mum. The leader went to Manira and offered to take the baby. Manira said 'I saw all that. At least she is getting it out'. The leader agreed with Manira and said that Aisha wanted to play with her. Manira and Aisha spent the rest of the group playing together, mostly outside." (2 years, 10 months)*

In this vignette, Aisha was able to play out what her wish was: to be the baby and to get rid of her baby sister. There is some symbolic nature to it, where the toys represent the actual baby and there is no real harm done in this display of aggression, however her pretending skills and use of toys could be considered quite concrete for her age, even after the adult suggests a more elaborated use of symbols. In this sense, her play can be considered age inappropriate and thus this marker is found.

The role of the group here seems fundamental in that the therapist facilitates an understanding of her actions, provides reassurance and helps with the care of the baby. Additionally, mother is able to witness this exchange between her daughter and the therapist and is able to understand it and interpret it as healthy, which speaks of her capacity to mentalise.

Content of play

As seen in the previous section, Aisha seemed to be following a normative development until her mother announced her pregnancy. The idea that she could be displaced by another child took a significant toll on Aisha such that the development of her play seems to have got stuck, which is interesting in regard to how her older sister also was reportedly so impacted by her own birth.

Aisha was able to symbolise, as she was starting to use more words as she approached her second birthday and she was also using toys in pretend play.

> *"Aisha gave the leader some toy pizza to eat and at the snack table pointed her finger at the leader. When the leader mirrored this, Aisha smiled. Aisha took a sip of her drink and then handed her cup to the leader saying 'water'. The leader gave her a little water. Aisha drank it and then handed the leader her cup saying 'juice'. She gave her a little juice. Aisha repeated this many times, alternating between wanting water and juice and seemed to enjoy commanding me about." (2 years 5 months).*

This vignette illustrates a child who is now passed her second year of life and who is able to do some pretend play where there is some social reciprocity and use of language. In this bit of play, it is interesting to think about the theme of food and how Aisha demands to be fed by the therapist, perhaps placing her in a

maternal role. The therapist also notes that Aisha is making more eye contact with her, which could be interpreted as the child being more immersed in the social world, which comes as a result of growing separation from mother.

Even though Aisha was displaying very good language skills, her play did not meet the expectations for a child her age in terms of symbols and narrative.

> *"Aisha chatted to me about the inflatable toy microphone that she had brought. She kept trying to blow it up and when it deflated, she said 'it keeps going down'. She did this many times and seemed to have much fun. Later in the afternoon, Aisha said to me 'now I want to blow bubbles'. I held the bubble pot for her, and she managed to blow bubbles very well. She played happily with me and another child who was also blowing bubbles, while her mum changed the baby's nappy." (2 years, 11 months)*

In this sense, all the markers in this section are met except for limited range of emotions. These are a predominance of manipulative play over symbolic play; symbolic play needs the facilitation of others and; a precarious structure and/or narrative in play.

Social play

None of the markers under this section are found in the case of Aisha. As seen from previous vignettes, in general she did not behave as over dependent or too unattached from mother, she did not present as overly compliant or oppositional and she enjoyed playing with others. In terms of this last marker, she mostly played with other adults and there are some mentions of parallel play with peers. Perhaps peer play could have been more developed by the time she left the group, however maternal reports on her adjustment to nursery were always positive.

As Aisha was dealing with the arrival of her new baby sister, leaving the group and starting nursery, she sometimes displayed some conflicting feelings towards mother and the group leader, however these moments were not frequent or problematic enough to meet a marker.

“Aisha went up the slide. The group leader saw her and waved at her as she was at the top of the slide. Aisha looked at the leader with some surprise and then stretched her arms out to indicate she wanted to be lifted off the slide, which her mum did. Aisha hid behind her mum and when the leader opened the door to say hello Aisha said to her ‘go outside’ and ‘go away’ afterwards. The leader went outside and Manira encouraged Aisha to look for her. Aisha was reluctant and said ‘no’ when she reappeared. Manira said Aisha had been so excited to come to play with (Leader) and yet did not want to when she arrived. The leader wondered aloud if Aisha felt a loyalty conflict, which Manira thought might be the case. Manira also said that there were now more adults with whom Aisha interacted at her Nursery and that perhaps she got a little confused or overwhelmed.” (2 years, 8 months)

Aisha had never expressed any open rejection of the group space or the therapist before, therefore there might have been something different happening this time. As the therapist suggests to Aisha, the birth of the new baby might have made Aisha feel she had to be more careful of her relationship with her mother and really make the most out of her alone moments with her. Aisha was enjoying the space and was playing but stopped once she saw the group leader who was about to join them. Aisha might have felt like she needed to push this other adult away in order to keep mother close and once the group leader verbalised this, mother agreed, which means she is able to think about her daughter’s possible feelings and thoughts, even when these might be potentially quite complex. Similarly, it is possible Aisha knew she would be leaving the group soon. Perhaps she felt this as a rejection from the group and so she defensively rejected it as well.

iii) Summary of Markers Found

Table 15: Summary of Markers Found for Aisha

Quality of play	
Marker	**Presence**
Inhibition/Hyperactivity	Not found
Repetition	Not found
Uncontained Affect	Not found
Age inappropriate	Found
	Total Found: 1/4

Content of play	
Marker	**Presence**
Predominantly manipulative play	Found
Symbolic play present if facilitated by others	Found
Precarious structure and/or narrative	Found
Limited range of emotions	Not Found
	Total Found: 3/4

Social play	
Marker	**Presence**
Proximity to mother: Over-independent or over-dependant in relation to age	Not found
Over-Compliance/Opposition	Not found
Difficulty engaging with others in play	Not found
	Total Found: 0/3

iv) Conclusion

According to the researcher's interpretation of data, Aisha presented 4 markers out of 11, accounting for 36% of them, supporting the hypothesis that in the absence of maternal depression, the majority of these play markers are not present.

As discussed, Aisha's development seemed to be following a normative path for a toddler her age up until the point where her mother became pregnant again. Even though Aisha did not show the marker in relationship to her proximity to mother, it is worth noting that she became quite conflicted with the arrival of the baby, perhaps suggesting that Aisha did not feel her relationship with mother was safe enough. Additionally, her parents reported that Aisha was prone to sickness and skin afflictions, which could, on an interpretative level, speak of bodily and unconscious mechanisms aimed to secure mother's care.

The fact that mother started their participation in the group with a good enough capacity to reflect, poses a question in terms of the history of her two daughters fearing and manifesting such unrest when facing the arrival of a new sibling. Apart from some initial tendency on Manira's part to control Aisha, there were no signs of any significant relationship disturbances. Perhaps the response to this phenomenon, i.e., of a disturbance in relation to the imminent birth of a subsequent sibling, could be embedded in the family history as a transgenerational issue.

Lastly, Manira scored a 5 again in her PDI exit interview, remaining at an ordinary mentalising capacity; this score does not indicate an improvement in mother's reflective functioning.

5.4.4. Marco and Caitlin

i) Presentation

Caitlin and Marco joined the Parent-Toddler Groups when he was one year and four months old and she was in her late thirties. Marco's parents self-referred to the service, seeking support with his '*tantrums, breastfeeding, intense separation anxiety and sleeping'.* Marco's mother was of Asian and white heritage and his father was Mediterranean. Marco was the only child of this couple who were together and both professionals involved in the field of arts. Caitlin held a master's degree and father an undergraduate degree. At the time she was working part-time and both parents took turns to look after Marco. The family had a support

system, as their extended families lived in the country and helped with Marco's care.

Caitlin and Marco attended the groups for 26 sessions over 10 months (87%) and left due to the closure of the group in the context of a restructuring of the hosting organisation (the Anna Freud Centre). The closure meant that Marco left the group after just turning 2 years old.

According to the protocol, Caitlin attended the entry PDI interview. From this interview it was possible to gather that after his first birthday, Marco had been having more tantrums than usual. She was finding herself wondering how to address this new stage of her son's life, since it seemed that he was particularly challenging with her and less so with other members of the family. Additionally, she informed the interviewer that she still breastfed Marco and was worrying about it currently being more of a way to manage his behaviour rather than meeting a need.

This interview was transcribed and coded with the RF scale achieving a score of 6, which is above ordinary reflective functioning.

ii) Analysis of Play Markers

Quality of play

Because of the closure of the program, Marco was not able to attend the groups for the length that was initially planned (18 to 24 months). Therefore, his play can only be assessed in relation to his second year of life. From the record that does exist however, there was no evidence for Inhibited, hyperactive or repetitive play. The following is a vignette from his first session, when he was only 14 months:

> *"Marco and Caitlin played with the play-doh and the group leader joined them. He was sitting on mum's lap, and she asked if it was ok for him to be like that. The leader said it was fine and that it was good for him to stay on mummy's lap. He grabbed the rolling pin and began to hit it on the table. 'Oh, you are making noises Marco'. He looked at the leader and smiled. He handed her another rolling pin and she thanked him. He then handed the leader his rolling pin and she said: 'Oh look, now I have two'. He smiled. Marco turned around and began to make loud noises*

while holding his mum. The leader said, 'Oh I know, I am taking all of mummy's attention from you'. Mother giggled. The leader made a moon shaped play-doh and showed it to Marco. 'It's a moon' the assistant said. 'Mooon' replied Marco. 'Yes, it is a moon!' the assistant told him." (14 months).

In this vignette, it is possible to see that as long as he is feeling safe in contact with his mother, Marco is able to interact with strangers in a playful way and even share some words. Mother is a little worried about how rules are established for members to be in the group, however the therapist reassures her about the natural need of Marco at this stage to remain close to mother, thereby helping mother to further understand her child and potentially let go of any pressure to push him quickly into independence. It is also possible to see how the clinical assistant here picks up on Marco's wish to remain at the centre of the conversation, verbalising for him and bringing that into mother's mind. This piece of information could also indicate that Marco is not yet at a place to share mother completely, possibly because so far, he has been her central concern. In this sense, part of introducing children to the social sphere, means helping them face the reality that there are other people in the world with needs, and that, in order to enjoy the benefits of different relationships, it is necessary to learn how to think of others and not just oneself. In terms of his age, this vignette demonstrates an example of normative development and age-appropriate behaviour for a young toddler.

In terms of affect, there were no signs to conclude Marco had difficulties regulating his emotions or that there were any moments where he was over aroused:

"At tidy-up Marco found it hard to stop playing. He began to cry and the leader encouraged Caitlin to provide physical containment by putting on his jacket to help him accept it was home time, which worked, and he quickly recovered." (15 months)

Here it is also possible to see how Marco is starting to be in contact with the reality of social norms when the end of the session is near, as he struggles to stop playing and needs comfort from mother. She is able to soothe him, which also provides information about their history as a dyad. If the child is easily

comforted by the parent, it is likely they have had a mostly attuned relationship in the past. Here the clinician guides mother to help them manage this new experience, helping mother to introduce limits for her son, in a loving way.

Content of play

Assessing this category is a difficult task as Marco left before he was able to develop many of the play skills that would be expected for a child over the age of two. For example, his play was mostly manipulative, however this was age appropriate at the time. He was also able to present symbolism in his play, sometimes facilitated by others, even early on during his second year of life, which at this stage would also be considered age appropriate.

Similarly, at the age he was whilst participating in the group, he would not have been expected to present very complex play narratives, therefore it is not possible to conclude he was not age appropriate in this aspect of development either. Therefore, these markers are considered absent.

Additionally, Marco was able to express different emotions in his play as the vignettes below will show.

> *"Marco and his mother began to play with the animals. The group leader arrived and said: 'Look, it is Marco's Zoo!'. Marco giggled and showed her a cow toy. 'What is this, Marco?' mother added. 'Cow' said Marco. Mum mentioned that he is saying more words now. Marco grabbed the sheep toy and said: 'Sheep!' 'Look at you, so chatty Marco!' said the leader. He continued to name the animals and mother giggled." (18 months).*

In this vignette, Marco is able to show his growing verbal skills, meaning his capacity to symbolise in play and in life in general is developing at good pace for his age. The more a child is able to separate from mother and gain awareness of themselves as an individual, the more they can start to use symbols to relate to the world, allowing more social encounters like this one.

> *"Marco played at the kitchen today making play-doh balls and putting them in the oven with the group assistant and another toddler, while his mother chatted to another mother. Marco was happy to play with the*

assistant while his mum chatted. Later he spent some time playing at the garage with his mother and another boy, pushing the cars down the ramp and then filling the container with toy cars again." (23 months)

As seen in this vignette, near his second birthday Marco was showing growing capacity to separate from mother, show interest in playing with others as well as exploring some basic forms of symbolism such as pretending to cook play-dough. However, his play remained mostly manipulative as can be observed in his car play, as there is no record of there being an imaginative component.

Social play

Even though mother's initial concerns were related to the process of weaning, after approximately three months of attending the groups, she was on a steady path towards achieving this. This can be considered an important step in the process of mother-child separation. In this sense, Marco did not present any of the markers in relationship to his dependency towards mother.

"Marco was trying to get in in the red toy car. He entered the car and mother advised him to move his legs in order to propel the car forward. He began to move them, and the car slightly moved too. 'There you go,' said mother. She gave him a little push and he continued moving his legs. He stopped in the middle of the room. He looked at his mum and grabbed the telephone that was inside the car. He took it and the group leader handed the other mobile toy phone to mother. She said 'I think Marco wants to check on you'. 'Of course,' she replied and said 'Hi Marco, are you okay? How is the driving going?' Marco looked at her and continued with the phone by his ear. Mum said, 'bye-bye then' and Marco put the phone inside the car. He resumed his driving." (17 months)

This vignette shows that Marco was feeling more settled in the group space and could move away from mother a little more in order to explore and play. Here it is possible to see that Marco is in the middle of this transition, trying new things but still needing mother's support through her voice and gaze, and he literally stops to check on mother's presence in order to continue his play. However, in this case he does it in a more symbolic way, through playing with the phone, instead of actually needing contact with her, which could be considered a maturational step. Mother, on the other hand, remains present and encourages him to explore, with

the support of the staff member who verbalises Marco's needs to help him and mother understand what might be happening in his mind.

In terms of the marker of Compliance/Opposition, it could be said that he did not present in either manner that could be considered unusual for a toddler. He certainly did not show compliance and in a typical way for a toddler, he showed healthy and normative aggression in the form of assertiveness towards peers. At 18 months mother started noticing that he would claim things as 'mine' and would not let others have them. This is an indication of his growing awareness of himself as an individual.

> *"Another toddler joined Marco by the toy cars. Marco protested and pushed him. Caitlin said 'No, Marco! We don't push, we have to share with others'. The group leader said it was hard to share sometimes, but mum was trying to help him do it. Another mother and Caitlin began to talk about sharing and toddlerhood. Caitlin commented it was hard for her to see him push other children and protest like this. The other mother replied that it was good for him to be able to protect himself and that being passive was worse. The therapist nodded in agreement, emphasising how ordinary it was to protest at this age. The assistant mentioned that Marco was learning, and Caitlin agreed. Both boys were running to and from each other and their mums commented that they looked excited and happy." (23 months)*

This vignette confirms the behavioural changes that Marco was starting to show in relation to his aggression. Mother notices this new element in his development and seems a little overwhelmed and to be trying to control it. The therapist allows mother to understand the root of this behaviour and normalise it, which she is able to appreciate. At the same time, the conversation with a peer mother also seemed to have helped, where the other mother provides a different perspective, a third view, that allows mother to feel there is nothing wrong with her child and that this is part of the process of growing. In the end it is possible to see how these toddlers can easily shift from aggression to companionship, which brings back a sense of joy for the group.

When this vignette was recorded, Marco was nearly two years old and close to the group closing. His assertiveness although healthy, also posed an obstacle to forming peer relationships. This is something the group could have helped with if

they had had another year as most other toddlers in the history of the groups had. This difficulty in allowing peers to play alongside him is the only marker that could be identified, as even for his age it seemed to be a struggle for him.

> *"A girl stood next to Marco and the group assistant commented that the girl also wanted to play with water, so they would have to share the water toys. Marco looked at the group assistant with a puzzled expression and she mentioned that even though it was really hard to share, there were toys for the both of them. Mother emphasised from a distance that he needed to share. The assistant asked him if he could give them a duck and a bucket, and he handed the girl one. The assistant said that was very nice of him and he smiled. They took turns with the tap and by the end of their play the assistant commented that they share really nicely". (24 months)*

This last vignette was recorded on his last session. As seen, Marco still needed some support for socialising with peers, but he was starting to achieve it with the help of the group and his mother, who encouraged him. He was now able to speak more, separate more easily from mother and assert himself. It is possible to imagine that if the dyad had been able to keep participating for another year, Marco would have been ready to start nursery in terms of his socio-emotional development.

iii) Summary of Markers Found

Table 16: Summary of Markers Found for Marco

Quality of play	
Marker	**Presence**
Inhibition/Hyperactivity	Not found
Repetition	Not found
Uncontained Affect	Not found
Age inappropriate	Not found
	Total Found: 0/4

Content of play

Marker	Presence
Predominantly manipulative play	Not found
Symbolic play present if facilitated by others	Not found
Precarious structure and/or narrative	Not found
Limited range of emotions	Not Found
	Total Found: 0/4

Social play

Marker	Presence
Proximity to mother: Over-independent or over-dependant in relation to age	Not found
Over-Compliance/Opposition	Not found
Difficulty engaging with others in play	Found
	Total Found: 1/3

iv) Conclusion

According to the researcher's interpretation of data, Marco presented 1 of the 11 described play markers, which accounts for 9% of them, supporting the hypothesis that in absence of maternal depression, the majority of these play markers are not present.

Marco presented normative development for a toddler. This is possibly linked to mother's initial reflective capacity at the moment they started attending the groups, as this might be a representation of her mentalising skills in the past and during the first year of her child's life. At the same time, their attendance was very consistent, and mother made good use of the group in terms of speaking openly about her fears as a mother.

In the exit PDI interview, mother scored 7, meaning she shows mentalising skills above the ordinary. This is slightly higher than her previous interview, suggesting an enhancement in her reflective functioning.

5.4.5. Daniel and Lorna

i) Presentation

Daniel and his mother Lorna first came to the group when he was 1 year and 7 months and mother was in her mid-thirties. Both parents came from a Latin-American country and were in the UK due to work. Both parents had reached a postgraduate level of education and had professions, as well as an older son who had recently entered school. Mother was at the time a full-time parent as Daniel had not entered nursery yet. They self-referred to the groups looking for a space for Daniel to make friends. They attended the group for about 18 months with over 60% of attendance, until Daniel was attending nursery for some days a week and was about to start attending more frequently, as he had reached the age of three. The exact number of sessions in this case was not available in the data.

According to the protocol, mother attended the pre-entry PDI interview. In this interview, mother reported that she was still breastfeeding Daniel: *"it's been so difficult to stop. It wasn't like that with (older son). Sometimes I think it is because (Daniel) is not demonstrative with his affections. But when he's close, He just opens himself and he's like a baby again".* Mother is aware Daniel is likely to be her last child, so letting go of his babyhood feels like a loss.

Mother also communicates her concerns about Daniel's behaviour. She thought he found it hard to share attention and often tried to bring the attention back to him by getting expressively frustrated, biting and hitting, which has meant mother is not very confident with taking him to friends' houses or groups. She also feels she can sometimes socially isolate and does not want that for Daniel, which is partly the reason they seek to join the group.

This interview was transcribed and coded, scoring 5 which indicates ordinary mentalising, which means mother is able to think about her and her child's behaviours, thoughts and feelings.

ii) Analysis of Play Markers

Quality of play

In Daniel's case, there was no evidence of Inhibition or hyperactivity in play. Given mother's description of his frustrated behaviour, there might be an indication of uncontained affect, however this was not observed in the group, so it is possible to deduce it subsided with time. This could also be considered as part of the normative spectrum of development in toddlerhood. In general, his play was age appropriate, therefore this marker is not found either. The main issue causing concern, which will be discussed further below, is Daniel's difficulty with letting go of his wish to own his mother and grow up.

Here is an example of his first time at the group:

> *"At first, he remained close to his mum, sometimes hiding behind her. During the 20 min period that the leader chatted to his mum, he gradually moved away from her. Occasionally he seemed to play 'peek a boo' vaguely with the leader. Eventually, he tossed his hat to the leader. The leader caught it and tossed it to land on the chair in front of him. He tossed his mum's hat and the leader tossed it back. This became a game and he smiled and laughed. He explored toys and looked at others playing. He remained quite close to his mum but was able to move away from her at times." (1 year, 7 months).*

In this first illustration of Daniel, it is possible to infer that he is able to enjoy a new social environment when mother is present as he is able to go back and forth from her, while he adventures himself into what is an unknown social space. As expected for his age, he still needs mother to make sure she is still there, that he is safe and for emotional refuelling. The entry into the social world is a developmental achievement for young children and its success depends largely on their earlier experiences with their carers. The fact that Daniel is able to interact with a stranger in a playful way and in the presence of mother, might say something about his understanding of adults and in particular, about the relationship with his mother and father.

Content of play

Under this section, no markers were found. According to his clinical records, Daniel could oscillate between manipulative play and symbolic play:

> *"Daniel spent a lot of time playing with the watering can. He poured some water on the concrete surface and watched it run. He did this for a long time, apparently fascinated by the water. Lorna and I commented on his curiosity and on how absorbed he was. Soon after, he went inside and played with the drums, with his mum." (2 years old).*

> *"Daniel played with his mum at the doll's house. The group leader sat nearby. Daniel placed the 'papa' in a single bed and then placed the dog with the father in bed. He placed the 'mamma' and the little boy in a bed together. Lorna smiled at the leader and said, 'he wishes' and they both smiled. This enabled the leader to speak about Daniel's oedipal wishes and struggles." (2 years, 1 month).*

The first vignette shows a piece of manipulative play. It has been described that in toddlerhood, water play becomes an interest, as children in the process of recognising their own bodily sensations associated with sphincter control, are drawn towards in-and-out and causality games, as well as mess. The second vignette shows a piece of symbolic play, in which Daniel presented a coherent structure and narrative and so expressed his internal conflicts.

This illustration was recorded after Daniel had recently started sleeping in his own bed. Here, he is able to communicate through his play, what occupies his mind at the moment. Daniel is looking to remain close to mother instead of playing with others in the group, and he expresses his wish to be the man in mother's bed and mother is able to read this perfectly, as well as recognizing with humour that this is not possible. What also seems relevant is the developmental achievement that involves the use of symbolic play to communicate his desires or fears, being able to access a transitional space instead of staying with the concreteness of remaining physically close to mother and acting out. It is mother, through her loving, yet not merged care, that has provided him with the resources to fantasise, which is fundamental for the development of imagination and other cognitive capacities.

Social play

In this section, two markers are found. Daniel struggles to let go of his mother and this subsequently creates an obstacle to showing more interest in other adults and peers. In fact, very little is said in his records about interactions with other members of the group. This is also something that mother described as a worry in herself.

> *"Lorna told me that she had partially weaned Daniel as he had fallen asleep without his evening feed and she wanted to know the leader's opinion. She got tears in her eyes as she said that she realised that Daniel was fine with the changes, but she was struggling with the loss of closeness. She said he was her last child and acknowledged how hard it was to let him go." (1 year, 10 months).*

This vignette allows some access into mother's mind and how she imagines her relationship with her son, as one that can survive some physical distance. It is not mentioned whether mother was planning to wean her son, however it seems like an event might have brought the question to her mind of "if he managed to fall asleep without the breast, does he still need it? Does he still need me?" Mother not only questions the need for her and her breast, but also allows others such as the father and the group leader to think with her about this matter, acknowledging maybe that she is not omnipotent herself and that she needs support in her maternity.

Another relevant piece of information that can be retrieved from this illustration is the fact that she is able to notice ambivalent feelings in herself about weaning her son. On the one hand, she understands it is something that needs to happen at some point and that moment might be now, while on the other hand, she can also access the feelings of loss and sorrow that this new physical distance will bring. Not only she can access these feelings within herself, but she is also able to communicate them to the group leader. This speaks of her capacity to mentalise.

> *"Lorna reported that Daniel has become far clingier and demanding. She said that since he stopped breastfeeding, he sometimes put his cheek on her tummy in the evenings and enjoyed the closeness. Recently he*

tried to get at her stomach to put his cheek on, but in a rough manner and in inappropriate places like the park. He became very angry if she stopped him. She felt invaded and did not know how to respond. Lorna and the group leader talked about the push and pull of toddlerhood. She seemed very relieved that the leader normalised his struggle for her." (2 years, 1 month).

As expected for a two-year-old, anality brings with it a sense of power and control for children, as they gain an increasing ownership of their bodies and its by-products. This vignette shows Daniel's wish to return to a stage where he felt omnipotent and his mother's first and only priority, as he seeks contact with that part of mother that was his shelter as an unborn baby. He pushes a boundary that mother had established, and she feels this as an intrusion to her body. Mother is able to allow some aggression from her part to remark that boundary and prohibit Daniel's incestuous desires to possess mother's body for his pleasure. Mother is also able, again, to bring this to the group leader and use her as a container, showing her own vulnerability and seeking support. The therapist listens, contains, normalises, and sometimes draws in other parents who have undergone the same difficulties.

"Daniel arrived with his mum and ran into the outside dolls' house. Both he and his mum looked relaxed and well. Lorna said that 3 days ago there was a big change, he suddenly was less clingy, more cooperative, more able to play on his own etc. She said he was a different boy, and she was greatly enjoying him. He has made a developmental leap. Daniel played quite independently of his mum at times. He interacted well with the group leader during which time he was chatty and expressive. It was a pleasure to see his enjoyment and exuberance in his play." (2 years and 4 moths).

This conflict between mother and son subsided for some months, however towards his last sessions in the group and as he was starting nursery near his third birthday, it returned. Perhaps the leap into full-time nursery and loss of the group activated some anxieties for Daniel about growing up, wanting once more to go back to mother's tummy and feel safe.

Nursery had been a concern for Lorna as Daniel still struggled to relate to peers as his third birthday was approaching.

"Mother spoke about Daniel and nursery school and voiced considerable concern. She said she had friends whose son of Daniel's age was already attending nursery school. She said that she did not think Daniel was ready. Lorna said that although Daniel was fine in the toddler group, he was different in other settings. He did not share as well, tended to be impulsive, lash out or throw things. Lorna said that he was enrolled to start nursery in January. She said that he could start gradually with her present." (2 years, 6 months).

Despite mother's wish for her son to become independent and sociable, she is able to see that he might need a little more time to get there and is able to stay thinking about what his needs are and that these are not necessarily the same as her own. What this illustration is also suggesting, is that there is something about an unfamiliar context that is anxiety-provoking for Daniel, meaning he still needs some more time to strengthen his capacity to self-regulate and carry mother with him in his mind instead of needing her body.

Soon after this mother arranged for Daniel to start nursery two mornings per week, with her being able to stay as long as necessary to help him settle. She reported that he was fine at the very beginning but then needed more support during the second week and had started acting out more at home.

Toddlerhood involves constant processes of progression and regression. The new practicing toddler moves away from mother with his first steps and finds excitement in his exploration only to then realise that this necessarily means he is a separate and small being, which can create anxiety for the young child. Perhaps Daniel faced this new separation from mother and home as a joyful change, however later he might have felt overwhelmed, and this could explain his more frustrated mood at home.

"Lorna said that Daniel was managing better at nursery school. She was being more matter of fact about leaving him and telling him she would be back, and he was responding well. Lorna talked about telling Daniel that when he was sad or needing his mum, he could close his eyes and make a picture of her. She said it worked well. Daniel apparently told his mum a few times that he had closed his eyes and thought of her'" (3 years old).

This vignette allows some insight into what might be a developmental leap for Daniel, which is his capacity for holding mother in mind. This is known as object constancy and it is normally acquired around the third year of life, when the experience of being with mother has been good enough for a child. At the same time, mother is able to state that she will be leaving and gives her child an alternative that feels quite sensitive and reflective in terms of understanding what her child might need to help calm himself. In a way, Lorna appears as a mother that is able to regulate her own anxiety about separating and believe in both her own resources and in the work, she has done as a mother over Daniel's first three years, and these together allow Daniel to bear her absence for a certain period of time and open up to a new stage that welcomes other people, learning and norms into his life.

iii) Summary of Markers Found

Table 17: Summary of Markers Found for Daniel

Quality of play

Marker	Presence
Inhibition/Hyperactivity	Not found
Repetition	Not found
Uncontained Affect	Not found
Age inappropriate	Not found
	Total Found: 0/4

Content of Play

Marker	Presence
Predominantly manipulative play	Not found
Symbolic play present if facilitated by others	Not found
Precarious structure and/or narrative	Not found
Limited range of emotions	Not Found
	Total Found: 0/4

Social Play

Marker	Presence
Proximity to mother: Over-independent or over-dependant in relation to age	Found
Over-Compliance/Opposition	Not found
Difficulty engaging with others in play	Found
	Total Found: 2/3

iv) Conclusion

According to the researcher's interpretation of data, Daniel presented 2 of the 11 described play markers, which accounts for 18% of them, supporting the hypothesis that in absence of maternal depression, the majority of these play markers are not present.

Daniel presented a mostly normative development for a toddler, with a marked difficulty in the process of letting go of mother. Throughout their participation in the group, mother's reflective capacity was permanently present, which is possibly linked to Daniel's overall healthy presentation. Even though Daniel's struggles were marked, this type of conflict is considered typical for toddlerhood. Perhaps it could be hypothesised that it was heightened due to mother's unconscious conflicting feelings with loss, in the context of having left her home country.

Their attendance was fairly consistent, and mother made good use of the group in terms of speaking openly about her fears as a mother. In the exit PDI interview, mother scored 6, which is a slight improvement in mother's reflective capacity in comparison with the beginning of her participation in the groups.

5.5. Results: cross-case analysis

5.5.1. Literal replication: cases with the presence of maternal depression

i) Play Markers

As a group, the average (4.8) and median (5) of maternal reflective capacity did not change from time 1 to time 2, which is consistent with the findings from the first study, having a group of mothers that oscillated between ordinary skills and just below ordinary. However, most of the depressed mothers presented an ordinary or above capacity to reflect at time 1 and/or 2, suggesting depression in these cases did not significantly compromise maternal reflective capacity.

The children of this group, whose mothers had depression presented with, on average, 7.4 of the play markers (67% of the total), with a median of 7. From these figures, this group of children present a pattern that is consistent with the hypothesis that toddlers of mothers with depression will present with at least half of the proposed markers investigated in this study.

One child did not meet the criteria for confirmation of this hypothesis. Harriet, the only girl in the group, presented 5 of the 11 markers (45%). Even though their attendance was not very consistent, as mentioned before, Lucy and Kathy were the only mothers who increased their PDI scores from T1 to T2, and they were also the mothers of the two children with least number of markers present. Both Lucy and Kathy had a good socio-educational level and had received Parent-Infant Psychotherapy before joining the PTGs. Perhaps previous treatment helped lessen the depressive symptoms and acted as a protective factor in the children's development, therefore the markers seen in the groups could be residual effects from those early days when the dyads were misattuned, as well as a product of the current difficulties these mothers were having with adjusting to their child's toddler-like aggressive and conflicting behaviour.

In terms of the relationship between play markers and maternal reflective functioning, a clear association could not be found. The three mothers with the lowest mean average from T1 to T2 were Beth, Hina and Lucy. Beth and Hina's children were the ones with the highest number of markers, however Lucy's

daughter was the child with the lowest number of markers and also the only one who did not meet the criteria to validate the initial hypothesis.

Regarding the specificity of the markers, in terms of quality of play, none of the children presented inhibition, meaning that in one way or another, they all sought to play. Two children presented hyperactivity, two of them presented repetitive play, three of them presented some form of uncontained affect and they were all considered to present aspects in their play that were considered inappropriate for their age. In the case of Rohan he presented as delayed, Harriet as occasionally precocious and Gianni oscillated between some developmental delay and appearing too independent for his age.

Repetitive play was only identified in the two boys with the greatest number of markers, i.e., Rohan and Eric, whose mothers had the most complex presentations. Eric was also the only one to present a limited range of emotions. As discussed in chapter 5, these two markers communicate a particular level of disturbance in play.

Regarding content of play, most children (4) presented with the first three markers: predominance of manipulative play over symbolic play, needing others to facilitate symbolic play and a precarious structure and/or narrative. This would suggest symbolic play is one of the most disturbed aspects of play in children of mothers with depression.

In relation to social play, the three markers were present in most children. Four children struggled to find an age-appropriate level of proximity to mother, however with some variance. Rohan and Harriet manifested some level of overdependence towards mother, while Eric and Gianni did the opposite. This would suggest that mothers who are more controlling and intrusive such as Hina and Lucy, might facilitate an overdependent relationship with their children, whereas more disengaged mothers such as Ana and Beth, might produce children who become disengaged from their mothers as well.

None of the children presented as oppositional in a way that could be considered unusual for a toddler, however they all manifested some level of compliance

whether it was towards mother or peers. This suggests that children of depressed mothers might need extra support in building up their confidence and asserting themselves.

Lastly, all children except for Gianni, who sought others when he appeared to feel displaced from mother, met the criteria for the marker of difficulties engaging others in play. This could often occur as a product of a difficulty in separating from mother and a need to over rely on her, therefore it is congruent that both Harriet and Rohan met this criterion as well as presenting as overdependent on mother.

In this sense, social play could also be considered to be an area of play development in toddlers that is strongly affected by the presence of maternal depression.

Table 18: Play Markers in the Cases Where Maternal Depression is Present

Marker	**Quality**				**Content**				**Social**		
	Hyp	**Rep**	**Aff**	**Agg**	**Man**	**Sym**	**Nar**	**E**	**Mo**	**Co**	**Oth**
Frequency	2	2	3	5	4	4	4	1	4	5	4
Child*	R-G	E-R	R-G H	E-R G-J H	E-R G-J	E-R G-J	E-R G-J	E	E-R G-H	E-R G-J H	E-R J-H

**(E) Eric; (R) Rohan; (G) Gianni; (J) Jack; (H) Harriet.*

ii) Attendance to the Groups

In terms of the children who were part of the data for this study, there were four boys and one girl with an average age at entry of 15 months. All participants were members of a group for a period of between 20 and 24 months. The consistency of their participation varies depending on the case. On the one hand there are the number of sessions each dyad attended overall and on the other, the consistency of their attendance, meaning the number of sessions they attended from the total number of sessions they were expected to attend within their time

as members. As a group, children attended 42 sessions on average with a median of 43, with a consistency of 69% and a median of 63%.

The child who attended the least number of sessions as well as the one who had the lowest consistency was Eric, with 36 sessions and a consistency of 53%. Eric was also one of the children who presented the second highest number of markers after Rohan. Eric's mother had one of the more complex mental health presentations amongst the participant mothers and she scored a 4 at both entry and exit, meaning her reflective capacity was bellow ordinary after two different interventions: PIP and the PTG. Similarly to Beth, Hina had a complex and very current mental health history as she experienced the trauma of being raped, which led to the birth of Rohan and her depressive presentation, while also managing her asylum inquiry. Rohan met 10 of the 11 proposed markers (90%). These two cases might indicate a possible correlation between the complexity and timing of the maternal depression, potential co-morbidities and the child's diminished capacity to play. Additionally, it is worth mentioning that these mothers were the two with the lowest socio-educational level.

The cases with the higher number of sessions and higher percentage of consistency in attendance are two different ones. Whilst Gianni attended the most sessions (49) his consistency was the second highest (72%) after Jack (97%). Gianni was the child with the third highest number of markers present (7/64%). Even though he attended consistently, it seems relevant to mention he did not always come with his main carer, as mother sent him with a nanny on 6 occasions. Gianni's mother presented a good capacity to reflect both in her entry and exit PDIs, however she decreased her score from a 6 to a 5 from time 1 to time 2. In this case, a parallel cannot be drawn between Gianni's number of markers and his mother's reflective capacity as measured by the PDI, at the time they participated in the groups. However, a link between his capacity to play and her depression history is likely to exist, as the effects of depression on his play development precede their membership at the groups.

What can perhaps be concluded from looking at these two cases, is that two children that met more than 60% of the markers had mothers who, although scoring very differently in their PDIs, did not seem to fully engage with the work

at the group. In the case of Beth, she was clear about feeling uncomfortable in the group setting, hence her poor attendance. In the case of Ana, she might have seen the group as a space for Gianni rather than for her or their relationship, as she decided to send him off with an alternative carer, the nanny, on several occasions. When adjusting the number of sessions attended with mother, their attendance percentage goes down to 63% which is in line with the rest of the members.

The highest attender was Jack and his mother Kathy with 42 sessions and a 97% of consistency in attendance, having only missed one session. Jack is the second child with the lowest number of markers present (6/55%) after Harriet (5/45%) and his mother scored a 5 on her entry PDI and a 6 on her exit one. Kathy along with Lucy were the only mothers who went up in their PDI scores from time 1 to time 2. While these cases alone might suggest a relationship between attendance and child outcomes, but Harriet and Lucy's cases could suggest an alternative correlation, where the child had the least number of present markers, yet their attendance was in line with the group's average.

When introducing the variable of maternal reflective functioning, conflicting tendencies are found, as both Ana and Kathy had an ordinary or above mentalising capacity from beginning to end of treatment, however their children's outcomes differ significantly.

Table 19: Attendance in the Cases Where Maternal Depression is Present

Child	Age at entry (months)	Length of participation (months)	Sessions	Attendance (%)	Number of markers
Eric	15	24	36	53%	9
Rohan	13	24	43	63%	10
Gianni	19	20	49	72%	7
Jack	13	24	42	97%	6
Harriet	16	21	42	62%	5

In conclusion, with this data it is not possible to establish a clear link between attendance, maternal reflective capacity and child's play markers. However, it is possible to observe that all mothers except for Caitlin, were absent for at least 30% of their expected number of sessions. This might relate to some conflicting feelings about the need for support. Similarly, Lucy and Beth tended to isolate from other members when they attended, therefore their use of the groups was rather disengaged.

5.5.2. Theoretical replication: cases with an absence of maternal depression

i) Play Markers

As a group, the mean (5.4) and median (5) of maternal reflective capacity increased from time 1 to time 2, where the mean and median were both 6. This is consistent with the findings from the first study, having a group of mothers that oscillated between ordinary and superior reflectivity.

The children on the other hand, presented on average 1.2 of the play markers for children of mothers with depression (12.7%), with a median of 1. In this sense, this group of children present a pattern that is consistent with the hypothesis that toddlers of mothers without depression will present less than half of the proposed markers for this study. In contrast to the previous group, the child who presents the greatest number of markers in this group is a girl, and so are the only two children who did not present any markers, therefore no assumptions can be made in terms of this variable.

In terms of the relationship between maternal reflective functioning and play markers, all mothers obtained a normative mean score between entry and exit, and all children presented quite a low percentage of markers, which could be considered as expected variation of ordinary toddler development.

Regarding the specificity of the markers, it can be observed that under the section of quality of play, none of the children in this group presented any disturbances. Only Aisha presented as age inappropriate, mainly due to the markers she presented in the following section on content. In content of play, Aisha is the only

child who presented mostly manipulative play instead of symbolic and therefore she was also considered to have a poor narrative and structure. None of the other children presented any markers in this section.

Two boys presented markers under social play. Daniel was considered to have both an overdependency on mother and also a difficulty in engaging others that were not mother in play, whereas Marco solely presented this last marker since he mostly played by himself.

Table 20: Play Markers in the Cases Where Maternal Depression is Absent

Marker	Quality				Content				Social		
	Hyp	**Rep**	**Aff**	**Agg**	**Man**	**Sym**	**Nar**	**E**	**Mo**	**Co**	**Oth**
Frequency	0	0	0	1	1	0	1	0	1	0	2
Child*	-	-	-	A	A	-	A	-	D	-	M-D

**(A) Aisha; (M) Marco; (D) Daniel.*

ii) Attendance to the Groups

This group of children was formed by 3 girls and 2 boys. They were 16 months of age on average at the time of entry into the groups and attended for an average of 16 months. This mean is affected by a couple of cases that were forced to end their participation sooner than planned, due to the institutional decision to close the service. These are the cases of Amy and Marco who were part of the last cohort of the program. The other members attended for periods between 18 and 22 months. Given the variances in length of attendance and some breaches in the data, the number of sessions each member attended will not be considered, however the consistency of attendance was of 74% with a median of 72%. This indicates this group of mothers were more consistent in their attendance than mother with depression. Similarly, most non-depressed mothers were able to share their anxieties and use the group for support.

Table 21: Attendance in the Cases Where Maternal Depression is Absent

Child	Age at entry (months)	Length of participation (months)	Number of sessions	Attendance (%)	Number of markers	Markers (%)
Daisy	14	17	42	67%	0	0%
Amy	22	12	33	72%	0	0%
Aisha	15	22	-	85%	3	27%
Marco	13	10	26	87%	1	9%
Daniel	19	18	-	61%	2	11%
Daisy	14	17	42	67%	0	0%

The child who presented the greatest number of markers (3) was also the one with the highest consistency in their attendance (85%), perhaps reflecting mother's wish to engage in the treatment to help her child. However, this mother did not seem to increase her reflective capacity as measured by the PDI, returning a score of 5 both times. On the other hand, the child who attended with the least consistency (60%) presented with 2 markers (11%) and mother scored a 5 at time 1 and a 6 at time 2. When looking into this data, it is therefore difficult to draw conclusions that potentially correlate the variables of attendance, maternal reflectivity and the child's capacity to play.

5.6. Discussion

The findings of this study suggest that children of mothers with depression tend to present a decreased capacity to play in comparison to their peers. In this sense, the hypothesis for this study is met as it is concluded that children of mothers with depression present variation from ordinary play in comparison to their peers. In response to this study's research questions, the main affected areas of play were symbolic and social play. Additionally, it was found that what seems to relate to the level of impairment in toddler play is the acuteness of maternal symptoms which does not necessarily relate to a significantly impoverished maternal RF. Similarly, it was found that mothers with depression attended less than their non-depressed counterparts.

According to Winnicott (1951, 1971) in order for a child to develop the capacity to play and symbolise, as a baby he needs to experience the illusion of omnipotence facilitated by the environment and later experience a sense of lack that emerges when his environment starts allowing some separation and presenting reality. According to Mahler et al. (1975), a measure of aggression in both the toddler and the mother towards each other is necessary for separation to occur. For the toddler, this aggression is linked to anality and ambivalent feelings related to dependence to mother and for the mother, their toddler can awaken unresolved issues with anality, sexuality and aggression, challenging her adult infantile repression (Furman, 1992).

Maternal depression has been linked to unintegrated aggression (Bleichmar, 1996) as well as complicating the task of separation (Halberstadt-Freud, 1993), which could explain why children of mothers with depression struggle to play. Similarly, the capacity to symbolise is closely related to the social realm, as language emerges to provide a new way for toddlers and their parents to relate in the face of physical separateness (Bergman & Harpaz-Rotem, 2004). Additionally, when there is separation, space is available for the child to relate to others different from mother.

Symbolic play is also related to imagination and exploring both one´s own and other minds (Fonagy & Target, 1996). This exploration of thoughts and feelings can be frightening for a child as differentiating between fantasy and reality is not yet possible at this stage and it is through play with adults that these fears can be contained, allowing imaginative play to be safe (Stoker, 2011). Depressed mothers have been observed to play less with their children than non-depressed mothers (Tingley, 1994; Sohr-Preston & Scaramella, 2006) and when this is met by a maternal impoverished ability to mentalise for herself and/or her child, it is likely children might not engage in imaginative play, staying at a more concrete level as the cases examined in this study.

Furthermore, social play and therefore social skills are initiated in the family environment (Sroufe, 2005; Panksepp, 2007) as well as group interactions, peer relationships and siblings (Music, 2017). In this sense, a depressed mother not only might struggle to accept her child’s and her own aggression as well as to

allow separation, but she might also isolate from social spaces and in this sample, several depressed mothers attended the groups inconsistently, in comparison to non-depressed mothers were not only more present in the groups but were also able to share their anxieties and use the group for support. A potential explanation for this could relate to depressed mothers struggling with dependency as well as having a strong super-ego (Blatt, 1974; Beebe et al., 2007; Blum, 2007). The relationship to a therapist might be experienced as a threat by a mother with depression, as in the transference the therapist can represent parental figures that were experienced as not good enough, therefore engaging in a relationship with them and depending on them may bring back feelings of vulnerability which combined with a harsh super-ego, can create feeling of extreme inadequacy for a mother. This can often result in abandonment of treatment (Cattaruzza, 2014). Furthermore, the group setting might also propose a difficulty for depressed mothers. Halberstadt-Freud (1993) proposes that women who present PND are still merged with their own internal imaginary mother, remaining at a dyadic level of relating as opposed to a triadic one. This means a depressed mother struggles to facilitate the separation and individuation of her child in relation to her, and so allowing others into that dyadic space can be very challenging. When this is the case, a child might be unable to play and present an impoverished capacity to experience the cultural field (Winnicott, 1971).

In this sense, the findings of a meta- analysis conducted by Cooper & Conklin (2019) on drop-out rates for individual treatment for depression might be relevant. These authors concluded that longer treatments and a comorbidity with a personality disorder were associated with higher drop-out rates. Similarly, ethnic minorities were likely to drop-out more which the authors related to these groups having more contextual barriers to access treatment. Furthermore, educating and guiding clients' expectations, attending to their preferences, and fostering the therapeutic alliance were variables associated with higher treatment engagement. This last aspect is relevant as mothers with depression in this sample showed lower levels of education in comparison to their non-depressed peers. A systematic review conducted by Dennis & Chung-Lee (2006) on the barriers women with PND faced when seeking treatment, concluded that this group of women tend not to seek help due to both maternal and professional

aspects. Stigma around the diagnosis was a contributing factor and the authors suggest that education on PND as well as a therapeutic alliance with the health professional are facilitators for starting treatment.

Additionally, a particular aspect of social play that was observed across all cases was the presence of compliant behaviour towards mother and/others (peers and other adults). A potential consequence of a maternal depression in a child is that due to a non-integrated relationship with aggression on the part of the mother the child might feel she is not able to survive his aggressive feelings, needing to repress a part of his true self (Winnicott, 1971). Similarly, a child might take it upon themselves to enliven a depressed mother, leading to over-dependency of the mother on her child and a reversal of the caregiver's role (Emanuel, 2006). In this sense the child puts mother´s needs over his own which does not allow him to develop his authenticity. In this sense it was observed that mothers with depression who relate towards their children in a controlling manner may facilitate an overdependency from their children towards them, while children of mothers with depression who disengage from them, might seem disengaged as well. This finding is consistent with what has been described in the literature (Blatt, 2004; Schechter, 2004; Emanuel, 2006; Beebe et al., 2007; Salomonsson, 2013).

Based on this study's findings, it is thought that the severity of the compromise in the child's capacity to play is likely to be more related to the acuteness of the maternal symptomatology rather than her capacity to reflect. Unfortunately, because this study did not intend to measure maternal depression, it is not possible to stablish at this point what aspects of these mothers' symptoms affect child play the most. The two children with the greatest number of markers, as well as the only two who presented markers related to an interference in the socialising role of play, were those whose mothers presented the most complex mental health difficulties, whereas the relationship between the amount and severity of markers and RF was less clear. These two boys were the only ones who presented repetition in their play. According to Singletary (2015) repetitive behaviour can be an attempt to self-regulate in the face of hyperarousal, where instead of turning to others for social support, there is a desire for predictability and stability in the form of repetition and sameness. Perhaps an unavailability of

containment from a more severely depressed mother challenges the child when it comes to needing and depending on others, leading to a cycle of repetitive sense of disappointment where the trauma of deprivation is re-enacted (Coates, 2016).

Furthermore, infants can develop ‘second skin defences’ (Bick, 1968) as a way of holding themselves together in the absence of maternal containment. A child who cannot bear to be in touch with feelings of dependency may reject other adults or a mother-like figure who may have something to offer, as a reminder of what they do not have themselves. This could be related as well to a tendency observed in a couple of children from this sample who seemingly presented as independent from their mothers for their age.

In this sense, another aspect observed in these children was the fact that in opposition to their peers, their development seemed more uneven or ‘inharmonious’, as it was the case for Gianni and Harriet. For example, children who might have developed second skin defences had a supposed easiness to separate from mother, while manifesting many other developmental delays. According to Anna Freud (1945) moderate disharmony is part of the many variations of normality, however gross disharmony could be a precursor of psychopathology. Anna Freud (1963) believed a mother's interest and predilection can act as a stimulant for infants, meaning the infant concentrates on developing along the lines that they feel elicit the mother's love and approval. This seemed to be the case for those children in this sample who had controlling mothers who possibly behaved in this manner to prevent the child from separating and differentiating from her, thus preventing conflict. These children seemed to be entangled in this dynamic and remained over-dependent instead of moving away in order to grow.

Finally, an interesting finding of this study that was not thought of in the initial research questions is that that depressed mothers tended to have lower levels of education and potentially less social support as they were all full-time parents at the time. The existing literature has described these as risk factors for depression in mothers (O’Hara & Swaine, 2009; Yim et al. 2015; Ghaedrahmati et al., 2017; Silverman et al., 2017; Hutchens & Keraney, 2020). These social circumstances

could also be influencing maternal attendance as well as RF, given that stress is known to be an obstacle for mentalising (Luyten & Fonagy, 2018). In terms of these findings' implications, supporting depressed mothers might be a multifactorial effort in which reasons for disengagement and lower RF could be both psychological and contextual.

5.7. Conclusion

This study aimed at testing theories about play in the children of depressed mothers by identifying potential markers and their presentation in toddlers who participated in the Parent-Toddler Groups at the Anna Freud Centre.

This study's findings suggest children of depressed mothers in this study presented with more marked difficulties in relation to finding an age-appropriate dependency to mother, asserting themselves, establishing new relationships and developing symbolisation. Similarly, the findings suggest that children of depressed mothers in this sample tend to present a more disharmonic development than their peers. This also means these children tend to have some delays in their development or that different aspects of their development might not be congruent with other aspects. On the contrary, children of mothers without depression in this study did not present any of the above-mentioned more pervasive difficulties. Similarly, none of these children were considered to have difficulties with asserting themselves. Additionally, most of them were able to play symbolically and use this type of play to explore wishes and conflicts expected for their age. These findings concur with this study's initial hypothesis.

5.8. Limitations

The first limitation with any qualitative study is that due to practical issues they are normally not conducted at a large scale in terms of data as well as the difficulties to replicate the specific contexts in which they are conducted, therefore generalisations cannot be made to a wider context than the one studied with confidence. In the case of this study, only 10 cases were considered, and these were divided into 2 groups of 5. Similarly, even though all cases were part of the same intervention, and they were put into these two groups due to clinical

similarities, many other personal and contextual variables are most likely to be present in each case that cannot be sufficiently accounted for or effectively replicated in the future.

Another issue when analysing qualitative data is the potential influence of the researcher's bias. In this case for example, the researcher was aware of what group each case belonged to when analysing their data and the wish to meet the initial hypothesis can always be present and impact the results even when efforts to triangulate the analysis were made.

Finally, given the fact that the presence of depression was a core factor in this study, the absence of measures to confirm the presence and perhaps severity of depression once the mothers entered the groups, regardless of their referral, would have strengthen the available data.

5.9. Future research

This study focused on the presentation of children who have mothers with depression in terms of their play development, however research on this field is still quite scarce. Future research could further examine the relationship between child play development and maternal depression as well as the presentation of play in these children. This could contribute to the understanding of the impact of maternal depression in child development and to make this impact recognisable in child play. This could be done through both quantitative and qualitative research using existing or creating standardized observational measures for child play in under-fives population.

Secondly, future research could also explore the potential therapeutic factors of a space such as the PTGs in order to help a child develop their play capacity as this would theoretically help develop other areas such as language, imagination, socialising, etc., by assessing different intervention models and considering investigating the mediating and moderating factors that influence the relationship between maternal depression and children's play. Factors such as parental mental health, attachment quality, socio-economic status, and access to supportive resources may interact with maternal depression to shape children's

developmental outcomes. Future research could employ statistical analyses and qualitative methodologies to explore these relationships in greater depth.

Finally, some of the suggested findings in this study could be better assessed in future research as this study was not able to address them all thoroughly. For example, potential difficulties for mothers with depression to attend spaces such as the PTGs could be explored in an intersectional manner by examining how multiple dimensions of identity intersect to shape therapy attendance experiences for mothers with depression. Intersectional analyses help identify disparities, privilege, and unique challenges faced by diverse subgroups within this population. Similarly, future research could or the relationship between quality of the maternal depressive symptoms and the child's level of severity in their impaired capacity to play. For example, further research could stablish the level of severity of maternal depression and their child's play and compare both variables within a different range of depressive presentations.

Chapter 6. Conclusion

In terms of the research questions that guided this project, the first study focused on the presentation of maternal reflective functioning in mothers with depression when compared to their non-depressed counterparts in the context of their attendance to the PTGs. The first study in this project suggests that before attending the PTGs, RF of depressed mothers did not differ significantly from non-depressed mothers in this sample. Similarly in the second study, the RF of depressed mothers was found to be mostly ordinary. These finding suggest that depression alone as a factor might not always compromise RF. Similarly, depressed mothers in this study were less responsive to treatment in comparison to their non-depressed peers. This suggests a model such as the PTGs could be helpful in contexts where RF is at risk but depression is not present. This result is then complemented by some finding from the second study where it is suggested that depressed mothers attended the groups less than their non-depressed counterparts. Different plausible explanations are explored in relation to the decreased response to treatment on the part of depressed mothers. This could be related to dependency and self-criticism issues linked to depression as well as tendencies to isolate from groups, however, other contextual factors not necessarily related to mental health such as such as high life stress and lack of social support could also impact on a mother's capacity to mentalise as well as their attendance to an intervention such as this one.

The PTGs have several components that are considered helpful in previous literature, such as their theoretical framework, time length, its aims, practices and setting, however these components might be insufficient when it comes to working with mothers with depression, especially if there are other intersectional variables adjacent to their mental health difficulties. It is therefore suggested an intervention such as the PTG would see better results with this type of users by networking with other agencies that could support mothers with contextual vulnerabilities. Another potential improvement could be targeting maternal mental health explicitly within the group or offering a parallel individual therapeutic space, whilst considering the heterogeneity of depression, therefore being able to provide appropriate interventions for different presentations.

Furthermore, it was observed that the depressed mothers in the second study had lower levels of education and potentially less social support, which have been described in the literature as risk factors for depression in mothers (O'Hara & Swaine, 2009; Yim et al. 2015; Ghaedrahmati et al., 2017; Silverman et al., 2017; Hutchens & Keraney, 2020). These social circumstances could also be influencing maternal attendance as well as RF, given that stress is known to be an obstacle for mentalising (Luyten & Fonagy, 2018).

In terms of these findings' implications, supporting depressed mothers might be a multifactorial effort in which reasons for disengagement and lower RF could be both psychological and contextual.

The second study aimed at testing theories about play in the children of depressed mothers by identifying potential markers and their presentation in toddlers who participated in the Parent-Toddler Groups at the Anna Freud Centre. In this sense, it is suggested that children of mothers with depression in this sample tend to present a decreased capacity to play in comparison to their peers, where the mainly affected areas of play were symbolic and social play. According to the second study, children of depressed mothers in this sample present more marked difficulties when it comes to finding an age-appropriate dependency to mother, asserting themselves, establishing new relationships and developing symbolisation. Similarly, the findings in the second study suggest children of depressed mothers tend to present a more disharmonic development than their peers. A tendency was observed, where children who presented the most hindered play capacity were also the children whose mothers presented the most acute mental health presentation. As it has been previously stated that depression might not be determinant for low RF, this suggests it might be maternal symptomatology rather than RF that has a greater influence on the child's capacity to play. It was also observed in the second study, that mothers with depression who relate towards their children in a controlling manner may facilitate an over-dependency from their children towards them, while children of mothers with depression who disengage from them, might act disengaged themselves. These findings can potentially be explained by maternal difficulties with aggression and socialisation, and it is suggested it is the acuteness of

maternal symptoms rather than RF that would be linked to a more severe impingement on child play development.

6.1. Summary of limitations

There were several limitations to this research project, particularly when it comes to the possibility of generalising its findings. Firstly, the small sample size of both studies proposes a barrier to the assumption of representation in the population. Similarly, the lack of a control group in randomised circumstances means it is not possible to attribute its findings to the variables considered in this project, meaning it is not possible to completely assert its hypothesis. When this project's findings are not generalisable due to the design of this research, its applicability to other cultural contexts cannot be assumed, as the theoretical framework supporting the findings of this project are specific to a westernised and industrialised culture. In terms of the quantitative part of this study, correlational research can establish whether there is a relationship between variables, in the case of this project, these were RF and its relationship to mother's demographic information, in particular depression and their participation in the PTGs. However, this type of research does not provide a reason for that connection between these variables, nor it can establish causality. Furthermore, even when some correlations were drawn, it is not possible to guarantee that other variables not accounted for were not part of the equation.

In terms of the qualitative part of this study, limitations are mostly found in the risk of potential bias on the side of the researcher's framework. Furthermore, the data used for both studies have a qualitative nature. The statistical study used PDI interviews which were coded by different certified coders including the researcher. This can always mean some minor differences in the criteria of each coder and as previously stated, the PDI as an instrument might not reflect the participants' reflective functioning in all its complexity and intra-case diversity. Similarly, the data used for the second study were mainly observations registered by the clinicians who worked with the participating dyads and so these clinical notes possibly contained some of the clinician's personal impressions as well. Other limitations related to the use of the PDI and the RF scale are that the measure may be insensitive to treatment change in samples of distressed

mothers seeking emotional support (Sleed et al., 2013), and qualitative changes are not measured by this scale (Fonagy et al., 2016).

Finally, given the pivotal role of depression in this study, the sole reliance on referrals and self-report for determining the clinical category of each case could have been supported by having depression-oriented measures included in both studies.

6.2. Summary of suggestions for future research

Further research is needed to expand our knowledge regarding the influence of depression on a mother's capacity to mentalise for herself and her child. Measures could be used to determine the acuteness of the depressive symptoms and its relationship to RF or perhaps a distinction between types of depression and its relationship to RF. In terms of the non-significant change in RF in depressed mothers at Time 2, further research would be needed in order to assess potential qualitative changes in maternal representations as well as a better understanding of what constitutes a helpful intervention for supporting the mentalising capacity of depressed mothers.

Similarly, the existing research on child play and its link to maternal depression is still quite insufficient and further research could help narrow this gap in knowledge. This study was only focused on the presentation of play in toddlers who had experienced a mother with depression, however further research could also focus on whether interventions such as the PTGs can contribute to a child's play development and reduce the impact of maternal depression. Similarly, some of the suggested findings in this study could be better assessed in future research. For example, potential difficulties for mothers with depression to attend spaces such as the PTGs or the quality of the maternal depressive symptoms and the child's level of severity in their impaired capacity to play.

Finally, further research may be needed to fully understand the extent to which the PDI can be used to measure the RF of parents regardless of their context as well as its capacity to capture change in RF in a certain amount of time.

6.3. Clinical implications

This research's findings contribute to the understanding of maternal depression and its impact on child development, more particularly toddler play.

Maternal depression is related to social vulnerability, affecting 10% to 20% of women as well as their children, becoming a public health issue and a collective responsibility.

This piece of research shows the PTG model can be a valuable and cost-effective intervention to enhance RF where maternal depression is not present and it proposes improvements to this model which has historically worked with many depressed mothers and their toddlers, in order to better serve this specific population. It is hoped these findings can also inform the clinical practices of other similar models and/or practitioners working with mothers with depression.

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Appendix

Data Processing Impact Assessment (DPIA) form

The GDPR requires that a DPIA is completed before any processing of data that is likely to present a high risk[1] to the interests of the data subject(s). The ICO recommend that all data processing is reviewed with a DPIA before processing begins. The intended processing should be assessed to identify any risks and the appropriate mitigation for the risk(s) identified and approved.

The existing Privacy Impact Assessment (PIA) form, has been revised, based on the ICO suggested format, to meet GDPR requirements.

If you intend to start processing personal data for a new service or activity (research or training) at the Centre you must complete a DPIA at the planning stage and have it approved by the IGLG. The identified risks must be logged and monitored once the activity starts.

If you, as the Data Controller, are intending to work with external partners (as Data Processor(s) they may need to contribute to your DPIA, and if you are an intended Processor for an external Controller they may require you to use their DPIA process.

Is a DPIA necessary?

1. Will you be using personal data for your new service/activity (project)?

Yes – complete the DPIA and send it to the IG Manager

Parent Toddler service data: • Video recordings of PTG and/or children's files to illustrate and support certain cases. • Parent Development Interview at Time 1 and 2 • Demographic information about the families

Applicant: Inge Pretorius

Date: 18/5/18

[1] High risk could result from either a high probability of some harm, or a lower possibility of serious harm. (https://ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr/accountability-and-governance/data-protection-impact-assessments/)

DPIA Form

Step 1: Identify the need for a DPIA

Explain broadly what the project aims to achieve and what type of processing it involves. You may find it helpful to refer or link to other documents, such as a project proposal. Summarise why you identified the need for a DPIA.

Please see the PhD proposal of Fernanda Ruiz-Tagle Gonzales. Fernanda is a PhD student at the Unit of Psychoanalysis at UCL.

The project aims to investigate the efficacy of the AFC Parent Toddler Groups. In particular it aims to investigate whether attending the group has an impact on the parent-child attachment relationship and on the child's capacity to play.

The existing data on the PDI interviews will be used. Additionally, as complementary data the analysis of interactions within the PTG sessions thought the video-tape recordings and/or observations in the files

Step 2: Describe the processing

Describe the nature of the processing: how will you collect, use, store and delete data? What is the source of the data? Will you be sharing data with anyone? You might find it useful to refer to a flow diagram or another way of describing data flows. What types of processing identified as likely *high risk* are involved?

The study will be a qualitative analysis of PTG data that has already been collected, including

1. Notes in the children's files (observations, demographic data)
2. DVD recording of group sessions
3. The data from measures collected on families attending the PTG (Parent Development Interview, Ages and Stages Questionnaires, feedback forms).

All families attending the PTG have given written consent for their DVD and other data to be used for research purposes.

The data is currently stored int the PTG archive boxes in the loft of house 12. When not being accessed, the data will be locked securely at the AFC.

All extracted data will be anonymised (case 1, case 2 etc) when extracting notes from the case files and a key will be kept while access to the case files is required and will there after be destroyed so the children and families will not be easily identifiable and will be anonymised in the final published research.

Describe the scope of the processing: what is the nature of the data, and does it include special category or criminal offence data? How much

data will you be collecting and using? How often? How long will you keep it? How many individuals are affected? What geographical area does it cover?

Race, ethnicity and health data will be included in the research (Art 9 (2) (j) New data will not be collected, only existing data from approximately 15 families will be used in the research The data is currently being kept at the AFC according to IG guidelines and case files will not be removed from the Centre

Describe the context of the processing: what is the nature of your relationship with the individuals? How much control will they have? Would they expect you to use their data in this way? Do they include children or other vulnerable groups? Are there prior concerns over this type of processing or security flaws? Is it novel in any way? What is the current state of technology in this area? Are there any current issues of public concern that you should factor in? Are you signed up to any approved code of conduct or certification scheme (once any have been approved)?

All families – parents and toddlers - attending the PTG have given written consent for their DVD and other data to be used for research purposes. They would expect their data to be used to investigate the benefits of attending an AFC PTG.

Describe the purposes of the processing: what do you want to achieve? What is the intended effect on individuals? What are the benefits of the processing for you, and more broadly?

The research hopes to gain a better understanding of the impact on the parent-child relationship and on the child's capacity to play, of families attending the PTG. The research will have no effect on those families included in the study. The benefit to the AFC is that the research will contribute to the evidence-base of the PTG.

Step 3: Consultation process

Consider how to consult with relevant stakeholders: describe when and how you will seek individuals' views – or justify why it's not appropriate to do so. Who else do you need to involve within your organisation? Do you need to ask your processors to assist? Do you plan to consult information security experts, or any other experts?

N/A. The families were asked at the start of their attendance if they would be willing to allow their data to be used for such research purposes.

Step 4: Assess necessity and proportionality

Describe compliance and proportionality measures, in particular: what is your lawful basis for processing? Does the processing achieve your purpose? Is there another way to achieve the same outcome? How will you prevent function creep? How will you ensure data quality and data minimisation? What information will you give individuals? How will you help to support their rights? What measures do you take to ensure processors comply? How do you safeguard any international transfers?

It is proposed to use this data under Legitimate Interest (Art 6(1)(f), the families gave permission at the time for the use of their data for research purposes but have not given explicit consent for this particular use, which we consider does not infringe their rights or freedoms and would use their data in ways they would expect and have agreed to in principal. The families are not current users of the PTG but a note will be placed on their file so if they make a SAR we will include this use of their data. This will ensure their rights are upheld, including the right to object to this processing. The data will not be amended in any way so data quality remains unaffected by the proposed analysis. Identifiable data will not be used unnecessarily. Any publications or papers would not identify individuals and would be used to improve the service delivered to future Parent Toddler Group attendees. The Researcher will have a named staff member responsible for their use of this data and clear instructions about access and use, for a specified period only.

Step 5: Identify and assess risks

Describe the source of risk and nature of potential impact on individuals. Include associated compliance and corporate risks as necessary. (Number each risk identified)	**Likelihood of harm** Remote, possible or probable	**Severity of harm** Minimal, significant or severe	**Overall risk** Low, medium or high
1. Unauthorised access to or mis-use of data	**Possible**	**Significant**	**medium**
2. Data not held securely	**possible**	**significant**	**medium**
3. Family not told of use when making subject access request	**possible**	**significant**	**low**

Step 6: Identify measures to reduce risk

Identify additional measures you could take to reduce or eliminate risks identified as medium or high risk in step 5				
Risk	Options to reduce or eliminate risk	Effect on risk Eliminated, reduced or accepted	Residual risk[2] Low, medium or high	Measure approved Yes/no
1	Clear guidance on access (any limits such as at Centre only) and use off site) no public viewing of video etc), NDA specifying how data can/cannot be used	reduced		Yes
2	Need to de-identify as early as possible to reduce risk of identification.	reduced		Yes
3	All records used in initial scoping and subsequently used for research to be marked accordingly, so if data subjects asks we can inform them of use and uphold their rights as applicable.	eliminated		Yes

[2] A high residual risk is one that cannot be sufficiently addressed by the measures put in place to protect the rights of the data subjects

Step 7: Sign off and record outcomes

Item	Name/Date	Notes
Measures approved by:	**IG Manager**	Integrate actions back into project plan, with date and responsibility for completion
Residual risks approved by:	**N/A**	If accepting any residual high risk, consult the ICO before going ahead
DPO advice provided: 18/5/18	Need clear guidance on access to and use of material at start of project, included in NDA. Discussed with Inge 18/5/18	DPO should advise on compliance, step 6 measures and whether processing can proceed
Summary of DPO advice:		
DPO advice accepted or overruled by:		If overruled, you must explain your reasons
Comments:		
Consultation responses reviewed by:		If your decision departs from individuals' views, you must explain your reasons
Comments:		
This DPIA will be kept under review by:	Inge Pretorius and IGLG	The DPO should also review ongoing compliance with DPIA

Date Approved: 7.6.2018

Anna Freud
National Centre for
Children and Families

Non-disclosure and Confidentiality Agreement (Individual)

This agreement relates to requirements of the Data Protection Act 1998, the Human Rights Act 1998 and the 'common law duty of confidentiality' and is an agreement between

Fernanda P. Ruiz-Tagle G., 42A Cavendish Road, London N4 1RT.

And

Anna Freud National Centre for Children and Families ("AFNCCF") whose registered head office is at 12 Maresfield Gardens, London NW3 5SU

1. The following terms apply where you may gain access to, or have provided to you, personal identifiable information (defined within the terms of the Data Protection Act 1998) when working for, or with the AFNCCF, (the 'data controller'). It also applies where you are privilege to or access commercially sensitive information, research data, security related information or any intellectual property of the AFNCCF. A named AFNCCF staff member will be responsible for your access to data and will be a signatory to this agreement
2. Access you may have to AFNCCF data may include:
   - Access to or sharing of information held in any electronic format or on paper or other hardcopy
   - Information that is part of verbal discussions, both that you are a party to or that you may overhear.

3. Any information (personal or organisational) will only be used for purposes agreed between you and the AFNCCF. Information will be accessed or retained for an agreed period and then returned or destroyed as agreed and by an approved method, as set out below.

Data to be accessed: Parent-toddler service data: audio recording of Parent Development Interviews (PDI) and Clinical Records. All families have given consent for these interviews to be used for research purposes.

Agreed purposes are: the PDIs will be transcribed and analysed as part of and MSc research project and by Early years research assistant. Copies of the transcripts will be given to the PTG clinical administrator. Copies of the clinical records of selected cases will be held by the main researcher to be analysed in the frame of PhD research.

Agreed access or retention period: from January 2019 until September 2021

Agreed return/destruction method: the student will delete any copies of PDIs and/or clinical notes that she has used for her research after she has submitted the research dissertation and after she has submitted manuscripts for publication in peer reviewed journals. The student will let her research supervisor know that she has done so.

4. Information containing a unique identifier and/or a combination of items from the following list is personal identifiable data and must be accessed and handled with due care:

Name, Address, Postcode, Date of Birth, Gender, Ethnic Group, therapeutic and or medical history.

5. All personal identifiable information will be treated as confidential and will not be disclosed to any other persons outside the requirements of the above agreed purpose(s), without agreement of the 'data controller'. All research material will be treated as confidential and will not be disclosed to any other persons outside the requirements of the above agreed purpose(s). Any organisational information marked as 'commercial' or 'sensitive' or which by implication of the subject could prejudice the commercial interests of the AFNCCF will be treated as confidential.

6. Any use by you of AFNCCF IT equipment or IT systems will be as instructed by a member of AFNCCF staff and may include any or all of the following provisions:

- Abiding by the Acceptable Use of IT policy, a copy of which will be provided
- Not retaining copies of any material you may have access to, unless authorised
- Not emailing or otherwise sending copies of any material you may have access to, unless authorised
- Use of encrypted and approved USB devices only when authorised

7. Where your activities do not require you to process information but you become party to it by overseeing or overhearing, you will be required to keep such information confidential indefinitely or until it is in the public domain by legitimate means.

8. Any breach of the terms of this agreement may result in termination of arrangements (including formal contracts) and legal action may be taken.

9. The AFNCCF is responsible for ensuring all sub-contractors and consultants adhere to the terms of this agreement and the member of staff named below has particular responsibility for your access to our data and systems.

Name Fernanda P. Ruiz-Tagle G.

Position PhD. Student UCL

I confirm that I have received and read the following Centre policies:

Acceptable Use of IT Systems Policy

Premises Security Policy

Health and Safety Policy

Code of Conduct

Confidentiality Code of Conduct

I understand and agree to the above terms and conditions (Recipient)

Signed [redacted]

Print Name: Fernanda P. Ruiz-Tagle G.

Organisation: Unit of Psychoanalysis UCL

Date: 6/3/2020

Representative of the Anna Freud National Centre For Children and Families (Data Controller and Disclosing party)

Signed: [redacted]

Print Name: DR IM PRETORIUS

Date: 13·3·2020