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Literature Review  
Empirical Research Project  
Reflective Commentary

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Families)

## **DECLARATION**

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

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## Part 1: Literature Review

Title: Atypical Parental Behaviours Associated with the  
Development of Disorganised Attachment in Infants

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## Abstract

Research has identified atypical parental behaviours that are associated with the development of disorganised attachment in infants. This paper reviews the literature on the different types of these atypical parental behaviours, their nature and theories regarding their aetiology. In particular, research into the mechanisms through which specific parental behaviours may lead to infants developing a disorganised attachment is considered. Within this, the research on parental unresolved childhood attachment traumas and how these may be repeated and transmitted within the parent-infant relationships are explored. This includes the research on the impact of this on infants in terms of risk of later psychopathology. Given the mental health and thus clinical implications, the literature on the ways in which parent-infant psychoanalytic psychotherapy addresses these parental behaviours, preventing these potential difficulties, is explored. Using the research to inform clinical practice, this review considers the important implications for how early disturbance in the mother-baby relationship can be addressed within this treatment modality and the importance of early intervention in promoting a more positive attachment between infant and parent.

*Keywords:* Atypical parental behaviours, disorganised attachment, parent-infant psychoanalytic psychotherapy

## **Introduction**

This literature review looks at the research on atypical parental behaviours that have been associated with the development of disorganised attachment in infants. The focus of this review is on parental behaviours that are not considered blatantly abusive, but which are thought to be traumatic for young infants, predispose them to developing a disorganised attachment and are, potentially, associated with serious mental health difficulties later in life. This review looks at the different types of atypical parental behaviours, their nature and aetiology, and how they may lead to infants going on to develop a maladjusted attachment to their parents. Particular attention is paid to the research on parental unresolved childhood attachment traumas that are thought to be repeated and transmitted in the way that the parent behaves towards their infant, especially in response to the infant's attachment behaviours. The research on how these behaviours are embedded within a wide range of miscommunication between parent and infant, as past attachment traumas prevent the parent from being able to effectively recognise and respond appropriately to their infant's attachment needs, is considered.

In terms of clinical practice, understanding how best to address these parental behaviours has led to a consideration of early intervention in the form of psychoanalytic parent-infant psychotherapy and the importance of preventing later mental health problems for the infant by promoting a more positive attachment between infant and parent in treatment. However, there is, by comparison, less written on how atypical parental behaviours can be effectively addressed clinically. Using the research to inform clinical practice, this review also considers the important implications for how early disturbance in the mother-baby relationship can be addressed in psychoanalytic parent-infant psychotherapy.

## **Attachment theory and disorganised attachment**

The study of attachment began with the work of Bowlby who claimed that the relationship between child and caregiver was born out of and powerfully influenced by the young infant's absolute dependence on their caregivers for survival (Bowlby, 1969). Central to this theory is the idea that when infants feel fear and need to re-establish a sense of safety they seek proximity with their caregiver to ensure this (Bowlby, 1969). Caregivers are thought to be biologically programmed to respond to their infant's signals or 'attachment cues' of distress (Bowlby, 1969). Research in this area has found there to be differences in the way caregivers respond to their infant's cues and that the quality of responsiveness impacts greatly on how comfortable the infant feels about approaching their caregiver in moments of need (Ainsworth & Bell, 1970; Bretherton, 1985). This was demonstrated in the Strange Situation Test (SST), which was a laboratory experiment that looked at the interaction between an eighteen-month-old and their mother through a series of short separations and reunions in the presence of a stranger. This experiment categorised the different kinds of interaction into attachment categories (Ainsworth & Bell, 1970). Two main categories were found, 'secure' and 'insecure', with the latter having two sub-sets of attachment, 'ambivalent' and 'avoidant' (Ainsworth & Bell, 1970). The experiment revealed that in a 'secure' attachment the infant showed an expectation that their mother would be able to soothe them effectively, whereas in an 'insecure' attachment, the infant showed reluctance or an avoidance of using their mother as source of comfort as though they would be unable to find sufficient reassurance from them (Ainsworth & Bell, 1970).

Further studies have found that the nature of early attachments have significant implications for development in later childhood (Cicchetti, Cummings, Greenberg & Marvin, 1990; Marvin & Britner, 1999; Sroufe, 2005). For instance, it has been shown that a securely attached toddler who feels that their mother is reliable and available when they need her are



more able to use her as a secure base from which to confidently explore their environment outside of their relationship (Ainsworth, 1985). Further studies have shed light on how secure attachment is a predictor of curiosity, effective entry into peer groups in preschool, close friendships, and coordination of friendship and group functioning in middle childhood, as well as identity, intimacy, and self-reflection in late adolescence (Sroufe, 2005). Concomitant neurological implications have also been found in relation to how the parent and child interact and the impact of attachment on how the infant is able to regulate their emotions as their brain develops (Schoore & Schoore, 2008).

### **Disorganised attachment**

Later research has found there to be another attachment type termed ‘disorganised attachment’ (Main & Solomon, 1986). This type of attachment was used to describe a category of infants whose behaviour did not fit in neatly with the main categories of secure or insecure attachment because they did not adopt a consistent way of approaching their parent during the SST (Main & Solomon, 1986). These infants displayed unusual behaviour when they were reunited with their mother, such as freezing or moving and making sounds in a disjointed way, moving forward and then turning back, which made it look as though they were in conflict about approaching their parent (Main & Solomon, 1986). Additionally, these children have been observed to include a broad range of out of sync ways of relating to others that have been seen to change quite rapidly from moment to moment (Main & Solomon, 1986). Disorganised children have been observed to show conflicting impulses to approach their parent and at the same time to keep away from them (Main & Solomon, 1986). They have shown impulses to fight, flight or freeze or to try to ‘tend and be friend’ their parent, as well as reversing the roles of the child-parent dynamic as though their parent is the one in need (David & Lyons-Ruth, 2005). These infants have also been seen to sequentially display

strong attachment one moment and then quite suddenly becoming avoidant the next, to hold certain positions, to seem dazed and confused and often moving and making sounds in an undirected way (Lyons-Ruth, Dutra, Schuder, & Bianchi, 2006).

It has been hypothesised that this unusual behaviour reflected the infant's dilemma of being dependent on a parent who sometimes frightened them and made them feel unsure about whether it is safe or not to approach their parent for comfort (Main & Hesse, 1990). Due to this uncertainty, children's coping strategies to manage fear were thought to breakdown and cause them to display contradictory patterns of behaviour (Main & Hesse, 1990).

The prognosis for children with this attachment type has been considered. Research has found that as children grow up and their capacity to understand others' states of mind increases, these disorganised behaviours in toddlerhood often develop into controlling ones or role-reversing ones later on in childhood (Solomon & George, 2011). Just as with disorganised attachment behaviours, these controlling strategies have been understood as a way that the child manages their distress of being dependent on a parent that frightens them (Solomon & George, 2011). This involves the child taking the initiative in the interaction with their parent, trying hard to maintain the parent's involvement by displaying care-giving and punitive behaviour themselves so as to keep their parent under their control and behaving on their terms (Solomon & George, 2011).

Additionally, there is evidence that disorganised attachment in infancy may have significant repercussions for psychopathology later in life (Lyons Ruth & Jakobvitz, 1999; Cassidy & Mohr, 2001; Sroufe, 2005). It is generally understood that early attachment relationships are internalised and thus the behavioural and emotional regulatory patterns that exist between parent and child inform how children interpret and express themselves in other areas of their lives, especially when they are under stress. This means that the disorganised

way that children relate to their parents translates into maladaptive coping strategies in other areas (Groh, Roisman, van IJzendoorn, Bakermans-Kranenburg & Fearon, 2010). For instance, disorganised attachment has been shown to be a predictor of children being more likely to display aggressive behaviour (Greenberg, 1999) and coercive peer interaction (Lyons-Ruth, Alpern & Repacholi, 1993) as well as a predictor of externalising mental health problems in childhood (van IJzendoorn, Scheungel & Bakermans-Kranenburg, 1999) and in adolescence (Carlson, 1998). This has been found to be particularly the case for boys (Fearon, Bakermans-Kranenburg, van IJzendoorn, Lapsley & Roisman, 2010). Although less association has been found with internalising symptoms (Groh et al., 2010), due to the extent of the above difficulties, disorganised attachment presentations are thought to be often seen clinically (Lyons-Ruth & Spielman, 2004).

However, although there is robust evidence that supports the notion that attachment plays an important role in the evolution of children's behavioural problems, the findings of a more recent study question the extent to which disorganised attachment specifically increases the risk of externalising problems (Fearon et al., 2010). Though not denying the association between disorganisation and later mental health difficulties for children with this attachment type, there is some debate whether disorganised attachment reliably predicts pathology (Granqvist, Sroufe, Dozier, Hesse, Steele, van IJzendoorn et al., 2017) and an argument has been put forward for a more nuanced understanding of the trajectory of disorganised attachment that takes into consideration the child's genetic and temperamental susceptibility, the impact of repeated or major separations as well as other causal factors (Granqvist et al., 2017).

## **The development of disorganised attachment**

Given the significant mental health repercussions, research tried to understand in more detail why infants may develop this attachment style. Notably, it has been most commonly observed in families where there has been high risk of parental abuse and neglect towards the children (van Ijzendoorn et al., 1999). In terms of these families, the development of disorganised attachment makes sense as infants would naturally be extremely fearful about interaction with an abusive parent who can be unpredictable and inconsistent (Carlson, Cicchetti, Barnett & Braunwald, 1989). In a moment of distress, when the child needs to seek comfort from a parent, they understandably will be in two minds about whether or not they want to turn to their parent as they cannot be sure how their parent will react. The terrible dilemma for a child about whether to seek comfort from a parent who has the potential to be abusive is clear and how children may then go on to develop a disorganised way of relating to their parents is also clear.

Alongside disorganised attachment developing within high-risk families, other causal factors have been considered. A meta-analytic study found that children who are exposed to the impact of cumulative socio-economic risks are almost as likely to develop a disorganised attachment as maltreated children, which suggests that, for instance, extensive socio-economic stressors such as low household income and parents substance abuse are also detrimental to children developing a secure attachment (Cyr, Euser, Bakermans-Kranenburg & van Ijzendoorn, 2010).

Notwithstanding the importance of these factors, disorganised attachment is also routinely observed, though to a lesser extent, in families where there is low risk of abuse and neglect (van Ijzendoorn et al., 1999) and an alternate developmental path to disorganised attachment that does not feature maltreatment or socio-economic risks has had to be understood.

## **Parental understanding of their childhood attachments**

To gain further understanding of this, various avenues of research have been pursued. One has been exploring parental representations of their own attachment histories; that is, it has focused on how parents think about their childhood relationships with their own parents and investigated whether this has an effect on the quality of their attachment to their own infant (Main, Kaplan & Cassidy, 1985). The method that was used to consider this was the Adult Attachment Interview (AAI: George, Kaplan & Main, 1985). These interviews enabled researchers to look closely at the different ways parents talked about their childhood attachments and their attachments to their own children during semi-structured interviews. Importantly, research found a category of parents who, when discussing their childhood experiences of attachment loss and trauma, had a state of mind that could be characterised as ‘unresolved’ (George et al., 1985). Unresolved narratives had unique qualities to them such as frequent lapses in reasoning, missing links, and with the parents generally describing themselves and their childhoods in inconsistent and incoherent ways (George et al., 1985). These qualities were thought to imply that the parents had not yet processed and recovered from their experiences of attachment trauma, they remained ‘unresolved’, and beyond a clear description. Due to this, parents were thought to be preoccupied by troubling feelings and memories from the past which impacted detrimentally on how they viewed their relationship with their infant in the present (George et al., 1985).

In terms of how this is linked to infants developing a disorganised attachment, it was thought that the intrusion of memories and feelings associated with past attachment trauma into the parent’s mind significantly impacted on the way they interacted with their infant. It was thought that it caused certain parental behaviours that disposed the infant towards being very uncertain about approaching their parents when they were in need of comfort (Hess & Main, 1990 & 1999).

## **Parental behaviour**

Another avenue of research to understand how disorganised attachment developed was pursued, which focused on the role of parental behaviour. Research that observed parental behaviour during interaction between mothers and infants in the SST found that there were three main categories of behaviour regularly seen to occur between mothers and infants who had disorganised attachments. These were frightened, frightening or withdrawing parental behaviours (Main & Hesse, 1990). A coding scheme to capture these behaviours was developed (Main & Hesse, 1990) and using this it was confirmed that there was a link between parents who had an unresolved state of mind in the AAI, exhibited these types of behaviours, and had children who developed a disorganised attachment to them (Main & Hesse, 1990; Schuengel, Bakermans-Kranenburg & van Ijzendoorn, 1999).

Importantly, research using video footage from the SST categorised different types of frightening, frightened and withdrawing behaviours and in this way offered a description of what these behaviours might look like for an infant (Main & Solomon, 1990). Frightening behaviour was said to involve, for instance, the mother suddenly ‘looming’ into the head or eye area of the infant when the infant was not expecting it or wanting this attention. Another example of frightening behaviour was when the mother’s body position was seen to assume an ‘attack’ position or take a threatening stance. Frightened parental behaviour, on the other hand, was characterised by the mother showing signs of hesitation and fear. She used facial expressions or made vocalisations when talking to the infant that were unnerving and awkward. Additionally, withdrawing parental behaviours were defined by their dissociative or trance-like quality; the mother used eerie ‘haunted’ vocal tones, spoke in a detached way and had inexplicable shifts in her mood. Finally, the mother showing sexual or spousal affectionate behaviours towards the child by indulging in extended sexualized kissing or fondling was also considered significant (Main & Solomon, 1990). All four categories of

these behaviours were thought to be deeply unsettling for the infant and linked to disorganised attachments in infants.

In terms of frightening parental behaviour, it was argued that when the infant is confronted extensively with interactions where their parent behaves in a frightening way, they infer that it is unsafe to approach their parent or signal their need for comfort and they become fearful themselves (Main & Solomon, 1990). Similarly, in the case of being in the presence of a parent who behaves in a frightened way, it has been found that with the parent who communicates apprehension when interacting, the infant, on sensing their parent's fear, will demonstrate conflict about approaching them for comfort (Lyons-Ruth et al., 2006). Of note is that both of these scenarios cause a paradox for the infant: even though the infant needs to turn to their parent because they are distressed, if the parent seems frightened or too frightening, the child will be conflicted about approaching them (Main & Solomon, 1990), a conundrum that has been termed "fright without solution" (Main & Hesse, 1990).

### **Parental disrupted affective communication errors**

Research further developed the understanding of the role of parental behaviour in infants going on to develop a disorganised attachment. Integrating the research on the significance of parental unresolved attachment trauma, it was posited that parents who had unresolved attachment traumas particularly provoked fear in their infant because they were unable to respond adequately to their infant's communications (Lyons-Ruth, Bronfman & Parsons, 1999). It was argued that because these parents were so caught up in their own past trauma there were frequent breakdowns in communication wherein the parent continually missed or misinterpreted their infant's cues. This was because they were so consumed by their own thoughts and feeling that they had a tendency to read into their infant's behaviours their own difficulties (Lyons-Ruth et al., 1999). Notably, this suggested that problematic

parental behaviours were embedded within a wider range of miscommunication between parent and infant where the parent's past attachment traumas prevented them from being able to effectively recognise and respond appropriately to their infant's attachment needs. These breakdowns in communication were called 'disrupted affective communication errors' and were seen as traumatic and frightening for the child (Lyons-Ruth et al., 1999).

To capture a more detailed picture of these 'disrupted' communications, Lyons-Ruth et al. (1999) developed a coding scheme which elaborated on Main & Hesse's (1990) categories. This was the Atypical Maternal Behaviour Instrument for Assessment and Classification (AMBIANCE). The AMBIANCE included frightening/disorientated and withdrawn behaviour, and developed the new category of 'disrupted affective communication errors', as well as 'role/boundary confusion' and 'negative/intrusive behaviours'. Descriptions of these additional categories included the following- in terms of 'affective communication errors', these were behaviours where the parents displayed miscommunications, giving non-responses, inappropriate responses or simultaneous conflicting communicative cues, such as suggesting that they want the infant to approach but then distancing themselves as the infant starts to respond. Role-confused responses were described as being to do with the way the mother understood her position as the parent and the infant as her baby; she may elicit comfort from the infant as though she had been the distressed one or else, for example, speak to the infant in hushed sexualized tones as though the infant were her partner. Negative-intrusive responses were described to include verbal or physical behaviours such as mocking or teasing the infant or inappropriately pulling them by the wrist as though they were in trouble even though they had not misbehaved. Importantly, the addition of these categories allowed for an analysis of a wider range of behaviours parents showed towards their infant (Lyons-Ruth et al., 1999). It also suggested that parental behaviours towards infants are just as contradictory and confusing as the infant's disorganized



attachment behaviours toward the parent (Lyons-Ruth et al., 1999). Thus, the AMBIANCE listed minute and subtle parental behaviours which when combined and exposed to the infant on a prolonged and extensive basis, were thought to be frightening for the infant and leave them unsure whether to approach the parent for comfort when their attachment needs were activated.

In a study that used the AMBIANCE coding system to look at videotapes of sixty-five mother-infant-dyads going through the SST, it was found that the frequency of these types of parental AMBIANCE behaviours could be observed at a significantly higher rate for infants with disorganised attachment than for those without (Lyons-Ruth et al., 1999). A central finding from this study was that of the five kinds of atypical behaviours coded, disrupted affective communication errors were particularly strongly related to infant disorganised behaviours (Lyons-Ruth et al., 1999). Communication errors also predicted increased infant distress, with infants crying more often and exhibiting proximity-seeking behaviour. It was thus confirmed that the breakdown of communication between infant and parent is a highly important aspect of atypical parental behaviour contributing to disorganised attachment (Lyons-Ruth et al., 1999).

As a result of this finding, a broader theory was put forward that stated that parent's general ability to respond appropriately to their infant's communications and attachment needs was more important than specific frightened or frightening behaviours (Lyons-Ruth et al., 1999; Schuengel et al., 1999). In this view, the parent's failure to respond to the infant's emotional and communicative cues was seen as the key frightening experience and linked to infants displaying disorganised attachment behaviour (Lyons-Ruth, Bronfman & Atwood, 1999). A study of video-recorded microanalysis of infants interacting with their parents has supported this hypothesis (Beebe, Lachmann, Markese & Bahrisk, 2012). Findings have shown that communication marked by difficulty, discrepancy and conflict between a parent

and infant aged four months consistently predicts infant disorganised attachment at twelve months (Beebe et al., 2012).

The reason for why it is traumatic and frightening for infants when parent-infant communication patterns are mistimed, breakdown or their emotional cues are continually met with an inappropriate or a lack of response is thought to be due to the fact that the young infant with limited behavioural and cognitive coping capacities will not be able to gauge the level of actual threat to themselves (Lyons-Ruth et al., 2006). This has led to the claim that in disorganised attachment there must be an interpersonal account of trauma; the traumas of infancy are often 'hidden traumas' of maternal unavailability and disrupted communication (Hesse & Main, 2006). Linking affective communication errors in dyadic communication to the aetiology of disorganised attachment has therefore meant that the the future disorganised infant has a particular kind of difficulty, the of difficulty feeling known by his mother, the difficulty knowing his mother's mind and the difficulty of knowing himself (Beebe et al., 2012).

### **Parental states of mind and behavioural profiles**

Additionally, as a result of coding for these disrupted parental behaviours using the AMBIANCE, a further development was made in research. This was that there were two very different types of behavioural profiles of mothers with disorganised infants, correlating to two types of states of mind. These profiles were labelled 'hostile/self-referential' and 'helpless/fearful' and were found to correspond to sub-categories of infant disorganised behaviour, disorganised-insecure and disorganised-secure respectively, based on the type of organized attachment strategy the infant's behaviour most resembled (Lyons-Ruth, 2003).

Firstly, it was found that mothers who displayed more frightening, role-confused and negative-intrusive behaviours fit a hostile/self-referential profile (Lyons-Ruth, 2003). In this

profile, the mother may seek attention from her infant as though she needs comfort and will thereby ignore and override the infant's attachment signals. She may also take her own initiative and attribute feeling states to the infant which could have little to do with the infant's actual experience. At the same time, the mother may also show hostile, avoidant and resistant behaviours that are rejecting of the infant (Lyons-Ruth, 2003). Correspondingly, infants in this group have been found to show a complex mix of insecure attachment behaviour, such as calling for their mother yet avoiding her and resisting her invitations for interaction by turning away and remaining unresponsive, and thus have been classified as having an insecure-disorganised attachment (Lyons-Ruth, 2003).

In contrast, mothers who fit into the helpless/fearful profile were found to show more fearful and withdrawing AMBIANCE behaviours and have infants with a disorganised-secure attachment (Lyons-Ruth, 2003). These mothers are said to appear loving and timid with their infant, often submitting to their infant's attempts to make contact with them. However, these mothers often fail to take the initiative in greeting or approaching their infant and regularly hesitate, move away, or deflect the infant's requests for proximity before giving in (Lyons-Ruth, 2003). Significantly, these mothers also are said to show higher rates of withdrawing behaviour, combining their responses with an underlying anxiety or tension, wherein they often disengage and seem preoccupied with whatever is on their mind and so miss their infant's attachment cues and thus show a high rate of disrupted affective communication errors (Lyons-Ruth et al., 1999). Importantly, the infant's experience of being with a mother who withdraws and who is emotionally inaccessible is said to be itself frightening. This is because it leads to the paradox of infants needing their mothers for their survival yet finding her state of mind and behaviour distressing as they cannot reach her in her thoughts and so she cannot see and therefore tend to their needs (Lyons-Ruth, 2003).

Notably, research has argued that identifying this helpless/fearful profile of maternal behaviour is more difficult than recognizing a hostile/self-referential one (Dutra & Lyons-Ruth, 2005). This is because whereas hostile behaviours are relatively straightforward to identify as maladaptive, intrusive and disagreeable, the helpless/fearful profile, on the other hand, requires very close and sensitive observation of the mother and infant for it to become apparent (Dutra & Lyons-Ruth, 2005). This is because mothers can appear caring and their helplessness can easily go unnoticed. However, a very significant finding from videotaped and AMBIANCE coded mother-baby interactions show that the subtle experiences of 'helpless' mothering are traumatic and frightening for babies, potentially as much as explicitly hostile parental behaviours (Dutra & Lyons-Ruth, 2005).

### **Intergenerational transmission of attachment trauma**

The discovery of these different parental profiles encouraged an understanding of how they relate to parents' experiences of their own childhood attachment trauma. Using the AAIs, parental unresolved states of mind linked to childhood attachment trauma were shown to correspond to parental hostile/self-referential and helpless/fearful states of mind (Lyons-Ruth, Yellin, Melnick & Atwood, 2005). For instance, in cases of parents who have not experienced specific incidences of abuse in their past, their unresolved trauma has been thought to stem from their own experiences of being with an attachment figure who withdrew from them or was hostile in their interaction with them in their childhood (Lyons-Ruth et al., 2005). For parents who have experienced childhood abuse it has been shown that different forms of trauma can be associated with different states of mind (Lyons-Ruth et al., 2005). For example, mothers who have a history of physical abuse or witnessed violence in their childhoods have been shown to be more likely to identify with their aggressive parent and display a more hostile profile towards their children, presumably as an attempt to master their

unbearable feelings of vulnerability and fear (Lyons-Ruth et al., 2005). On the other hand, mothers who have been the victim of sexual abuse or parental loss have been found to be more likely to withdraw from interactions with their children and to manage their negative feelings by becoming passive and showing a helpless profile (Lyons-Ruth & Block, 1997).

The finding that hostile/self-referential or helpless/fearful parenting profiles emerge from a disturbed and traumatic attachment history is important as it suggests that the attachment needs of the parent which have not have been consistently met or appropriately responded to in the past can lead to a repetition of this with their own infant (Lyons-Ruth et al., 2005) and several studies have confirmed this link between unresolved states of mind and the intergenerational transmission of attachment (Lyons-Ruth et al., 2005; Kelly, Slade & Grienenberger, 2005; Madigan, Bakermans-Kranenburg, Van Ijzendoorn, Moran, Pederson & Benoit, 2006).

Research has considered the ‘second generation effect’ of parental experience of maltreatment, attachment loss or trauma (Hesse & Main, 2006). It is thought that attachment trauma may be repeated and transmitted through the parent’s state of mind and the way they behave during interactions with their infant (Lyons-Ruth et al., 2005). This might be in the way that the parent attributes feelings and thoughts to the infant that reflect their own unconscious and unprocessed state and which may not be indicative of the infant’s actual experience (Hesse & Main, 2006). In this way, the parent profoundly influences how the child sees itself and their relationship as whatever the parent does not recognise in her child, the child will be unlikely to recognise in themselves and thus the infant may not develop a coherent sense of themselves as a person in their own right (Lyons-Ruth et al., 2005), Furthermore, the infant may internalise the characteristics attributed to them by the parent, which may not truly reflect their experience but could be an unacknowledged feeling of the parent’s from the past (Lieberman, 1997). Thus, parental behaviour linked to infant

disorganization could be seen as a result of the parent's own continuing unresolved responses to trauma, which become part of the infant's early experience.

### **Neurological and mental health implications**

The experience of this type of 'relational trauma' has been explored in neuro-developmental research and it has been shown that the way parents and their infants relate to one another affects the development of the infant's brain (Schore, 2010). There is evidence that hyper or hypo-regulation of stress responses in the infant's brain are influenced by how able the parent is to regulate the infant's emotional life and meet their attachment needs (Schore, 2010). This means that when the infant is consistently exposed to frightening or frightened parental behaviours or hostile/helpless states of mind in which their attachment cues go unnoticed or are misinterpreted, fear is triggered in the infant and this results in high levels of the stress hormone, cortisol, potentially impeding right brain development (Schore, 2010).

A notable finding of this research is that during times when the infant feels fear, the infant is essentially matching their parent's fearful state as it is the parent's state of mind that interferes with their meeting their infant's attachment needs (Schore, 2010). In this way, the parent, by not soothing the infant when distressed and by being preoccupied by their own needs and feelings, influences the transmission of their own physiological stress to their child (Schore, 2010). Thus, it would seem that parental unresolved trauma with its concomitant frightened, frightening and hostile and helpless states of mind is itself transferred and imprinted onto the developing brain of the infant. This, therefore, may make the repetition of relational trauma in the future likely as it becomes part of the 'hard-wiring' in the infant's brain (Schore, 2010).

These advancements in the research have also been accompanied by a consideration of the mental health repercussions of these parental behaviours for infants later on. Significantly, it has been found that the incapacity of parents to behave and respond appropriately to their infant's communications has serious consequences for later psychopathology (Barach, 1991; Liotti, 1992; Dutra & Lyons-Ruth, 2005; Ogawa, Sroufe, Weinfield, Carlson & Egeland, 1997). It has been hypothesised that infants whose communications and emotional states repeatedly go unnoticed or else are picked up on but are misunderstood by their parent, have an increased likelihood of developing a tendency to dissociate in adulthood (Ogawa et al., 1997). Evidence for this has been found in a longitudinal study that investigated a sample of 56 mother-infant dyad at social risk (Dutra & Lyons-Ruth, 2005). Results showed that disorganised attachment, maternal lack of involvement with the infant at 12 months and, notably, disrupted maternal affective communication errors at 18 months, contributed significantly to the prediction of dissociative symptoms at 19 years of age (Dutra & Lyons-Ruth, 2005). Importantly, the reasons for this vulnerability to dissociate later in life have been described in the literature as being the result of the infant's internalisation of the conflict around showing attachment needs to their parent and lack of integration around basic strategies for seeking comfort when they feel distress (Dutra & Lyons-Ruth, 2005). Additionally, because the infant experiences states of mind, interactions and fragments of relating that the mother does not pick up on, they remain unintegrated in the child's experience and in this way a part of their experience becomes cut off and is left unacknowledged. Thus, when the mother continually misses cues or responds to her infant in way that is changeable and unpredictable, large pieces of the infant's experience are missed and create breaks in the infant's experience. It is these breaks that are said to be the likely precursors to dissociative symptoms in adulthood (Barach, 1991; Liotti, 1992; Dutra & Lyons-Ruth, 2005).

Additionally, infants who are excessively exposed to parental behaviour that is frightening are at more risk of developing borderline or anti-social personality disorders in adolescence (Lyons-Ruth, Bureau, Holmes, Easterbrooks & Brooks, 2013).

### **Psychoanalytic parent-infant psychotherapy**

Given the serious mental health risks and the observation that disorganised attachment presentations are often seen clinically (Lyons-Ruth & Spielman, 2004), prevention is clearly of great therapeutic importance. Parent-infant psychoanalytic psychotherapy is an early intervention that addresses disturbance between parent and infant. It is a treatment that draws on attachment-based research, neuroscience, developmental theory and psychoanalytic thought. It hopes to prevent relational trauma from being repeated, to prevent the infant developing a disorganised attachment and to address the difficulties between mother and infant that may be compromising the infant's emotional and physiological development (Lieberman, Silverman & Pawl, 2000; Baradon & Bronfman, 2010). The literature on parent-infant psychotherapy speaks broadly to treatment's ability to enhance parents' understanding of their relationship to their infant and place the infant on the path towards healthy development using various clinical techniques within a psychoanalytic framework.

### **Psychoanalytic theory**

In the psychoanalytic literature underpinning clinical practice, theory pays particular attention to how parents who have an unresolved attachment trauma in their backgrounds need to be supported to have insight into how the past has been unhelpfully interfering in their present relationship to their infant (Fraiberg, Adelson & Shapiro, 1975). The central psychoanalytic hypothesis states that negative and painful feelings from the parent's past attachment traumas may be transferred into the relationship with the infant through



projections and the attributing of qualities and feelings from the parent's unconscious mind that distort how the infant is seen (Baradon, 2010; Biseo, 2016; Fraiberg et al., 1975). These feelings in the parent are seen to be triggered by the infant's attachment needs. The experience of being with a young infant is thought to be evocative of infantile feelings, experiences and sensations that re-invoke latent memories of early traumatic attachment experiences from the parent's childhoods (Baradon, 2010; Biseo, 2016; Fraiberg et al., 1975). In this way, a parent who has experienced their own disorganised attachments in infancy, when faced with the care and responsibility of a new born infant, is impeded in their responses to their infant's distress by their own memories (Lyons-Ruth & Spielman, 2004). A clinical example of this is of a mother who in her childhood experienced punitive attacks and abandonment from her own parents. As a result of this early trauma, she may be caught in a conflict about becoming the uncaring, overbearing parent of her own childhood or otherwise may see her child as the emotionally abusive parental figure from the past. This may result in the mother's confused and disorganised responses to the infant's attachment needs whereby she projects her own memories and experiences, unconsciously, onto her baby, leaving the baby's experience unacknowledged (Lyons-Ruth & Spielman, 2004). Importantly, in this scenario, the mother and infant are not present as figures in their own right but are rather 'ghosts' of the mother's previous experiences (Fraiberg et al., 1975).

### **Clinical technique**

In translating this theory into clinical practice, the literature on psychoanalytic parent-infant psychotherapy (PIIP) has explained that this form of treatment tries to shed light on the ways that the mother is being hindered by her past attachment traumas in her relationship with the baby. In particular, the treatment tries to speak to the parent's unresolved past trauma by shedding light on the parent's preoccupied and dissociated states of mind that occur when they feel emotionally overwhelmed while in the presence of their infant

(Baradon, 2010; Biseo, 2016; Fraiberg et al., 1975). Specifically, it is claimed that the therapist aims to help the parent differentiate the infant's attachment needs from their own feelings so as to prevent the tendency of the parent to read into their infant's behaviour their own difficulties (Lyons-Ruth & Spielman, 2004). The writing on clinical technique explains how PPIP facilitates this by providing a safe environment where the meaning of the parent's interactions can be explored and their underpinning emotions, memories and unconscious phantasies about their relationship to their baby can be understood (Baradon & Joyce, 2016).

Notably, one important aspect of the work is to help the parent remember, process and work through their unresolved attachment trauma and in that way, avoid an unconscious repetition of their difficult early relationships (Fraiberg et al., 1975). It therefore becomes important to highlight that it is not about the quality of the childhood experiences, but their 'intra-psychic representation' which is essential to resolve (Stern, Sander, Nahum, Harrison, Lyons-Ruth, Morgan & Tronick, 1998). That is, in treatment it is vital that the parent think and talk about their difficult experiences, so that they can be accepted into part of their memory and identity, and understood, rather than left unconscious and acted out in their relationship with their own infant to the detriment of both parent and infant well-being.

Clinicians have written about different 'ports of entry' into this kind of therapeutic work (Stern, 1995; Lieberman et al., 2000). In starting the work with the parent, it has been argued that one aim is to help the parent move from being disconnected with their experiences and feelings to a position of being able to represent and think about their difficult childhood attachments and emotions in a way that is helpful in enhancing their bond to their baby (Baradon, 2010). A result of this psychic work is said to be that the parent will become increasingly sensitive to forms of 'intimate relational knowing' (Stern, 2004), where the visceral aspects of their interaction with their infant will take on different meaning (Baradon, 2010).

In this vein, the process of working through past memories and integrating previously unintegrated emotions and experiences is said to occur primarily within the therapeutic relationship (Fonagy, 1998; Lieberman et al., 2000). The parent's way of relating, or 'transference', to the therapist is thus very important as it brings the parent's expectations and internal model of relationships to the forefront of exploration (Baradon, 2010). In the writing on clinical practice, this is said to be important as it reveals to the parent some perspective on how they are with others and it also introduces new helpful experiences of being with someone who responds appropriately and thoughtfully (Baradon, 2010). This means that the therapist helps transform how the parent relates to the other, and the new experience is said to lay down new ground work for being with someone without unhelpfully projecting past feelings or memories (Baradon, 2010).

Additionally, in this line of thought, the therapist is thought to help the parent to develop new ways of balancing the needs of the baby and herself (Lyons-Ruth & Spielman, 2004). It is thought that with the parent's own needs likely having been unseen by their own parents in their past attachment relationships, they probably have little sense of knowing themselves as a person in their own right, free from the projections of the past (Lyons-Ruth & Spielman, 2004). Psychoanalytic parent-infant psychotherapy is thus said to provide the parent an experience of coming to know themselves and feeling valued, allowing the development of new ways of relating to others (Lyons-Ruth & Spielman, 2004).

Another port of entry is to help 'contain' the baby's experience. This involves the therapist acting as a 'container' for the baby's raw emotions and sensations, which the mother, due to her own difficulties, may find hard to think about and to process. Drawing on Bion's (1962) theories of early infant development, the baby's unbearable emotions and anxiety-producing experiences that may be 'split-off', left unacknowledged, due to their overwhelming nature. In a situation, where the mother is attuned to the emotional states in

her baby, she will, in her state of 'reverie', be able to empathise and process her infant's experiences, make sense of them and then feed this back to her infant so that its challenging experiences are more manageable and understandable. However, in situations where this does not happen, the therapist is thought to fulfil a similar role in treatment. The therapist is receptive to the baby's emotional, and physical experiences and in their state of reverie is able to process them. Thus, in treatment, the therapist transforms the baby's unthinkable, difficult emotions and sensitively communicates back to the baby their feelings and experiences. This provides comfort and meaning so that unmanageable states can become manageable. In this process, the therapist not only models for the mother a new way of making sense of the baby's experiences but also, it is hoped, gives the baby new experiences, setting the basis for first feelings and prototype for all thinking and creativity (Bion, 1962).

Although these techniques and descriptions of PPIP are extremely informative, how parental behaviour that is linked to the development of disorganised attachment in infants might be addressed in treatment must be inferred from these descriptions. This is because there is little written on how the specific disturbance between parent and infant where the parent presents with disorganised and disorganising behaviours that cause the infant distress can be addressed in treatment.

In specific reference to disorganised attachment, the literature on the topic states that a parent who has experienced trauma and a difficult attachment in their childhood experiences a particular kind of conflict that needs to be addressed in treatment- the fear both of giving the child a similar experience to their own, yet also fearing what it would mean to respond to the infant's attachment cues (Lyons-Ruth & Spielman, 2004). In this scenario, within the treatment it clearly remains important that the therapist helps the parent differentiate the infant's attachment needs from their own feelings so as to prevent unnecessary projecting onto the infant of the parent's own difficulties (Lyons-Ruth & Spielman, 2004). However, in

addition to this, clinicians have written about how by using their relationship to the parent, they are able to talk about difficult emotions that would have otherwise remained detached from the parent's conscious emotional life (Lyons-Ruth et al., 2006). This is important as past communication patterns with attachment figures tend to be subtle and implicit. Therefore, they can be difficult to identify and articulate until they surface in the therapeutic relationship and are explored openly in the treatment (Lyons-Ruth et al., 2006).

Similarly, in cases of impaired attachment, therapists are said to need to show the parent the difference between the infant's attachment cues and their other emotional communication so that the parent can adjust their behaviour to respond appropriately to the infant when they are in need of comfort or are displaying other kinds of emotion (Lyons-Ruth & Spielman, 2004). This is said to alleviate the difficulty for parents with disturbed attachment histories who often misread the attachment cues of their children and whose own confusing and disturbed idea of parenting causes confusion about responding to her child's attachment and understanding what the infant might be feeling.

Correspondingly, for the infant, the result of the parent's working through of painful and conflictual psychic material is that, crucially, the baby discards the parent's attributions and projections (Baradon, 2010). Part of this is how the therapist becomes a new 'live attachment object' for the infant and gives space for the infant that allows for new experiences (Baradon, 2005). Here therapeutic work is said to address aspects of the infant's experience where there may have been a lack of adult attention, such as of having their attachment needs appropriately or consistently met. It is argued that by giving the infant new experiences of being reflected on and responded to, the baby begins to develop an image of themselves in relation to another who is able to think about them as vulnerable and dependent but also as a person in their own right, rather than a 'ghost' from the parent's own childhood (Baradon, 2010). In time, following PPIP, the infant is believed to be able to transfer this

experience to its parents. Importantly, this is thought to allow for a new way of relating, with the infant as a strong participant (Baradon, 2010) and, hopefully, potentially avoiding an impaired or disorganised attachment.

## **Conclusion**

In conclusion, the literature on clinical work has stated that psychoanalytic parent-infant psychotherapy can address attachment difficulties between parent and infant where parental behaviour and states of mind are impeding secure attachment and infant well-being. This literature review has discussed these parental behaviours, their aetiology and expression, and it has shown how these behaviours reveal a confused and disorganised parenting model, a repetition of interactions and attachments styles from the past. This is related to how past traumas in relationships and unintegrated states of mind in the parent are transmitted to the infant in both emotional and physiological terms, through behaviours which prevent the infant feeling able to turn to their parent for comfort and thus preventing the infant's attachment cues being met, leaving the infant in a traumatized state and at risk of developing a disorganised attachment and mental health problems later in life. A number of clinical implications of this has been discussed. However, as there is far less written on clinical work with disorganised parent-infant dyads than there is on disorganised attachment in general, there is scope for further research on the clinical implications of working with disorganised attachment. Both attachment theory and the practice of psychoanalytic parent-infant psychotherapy emphasize the intergenerational transmission of relationship patterns. In this way, treatment can attend to parental behaviours linked to infant disorganization and it would therefore seem to make sense that more clinical examples and vignettes could be added to this research topic.

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Part 2: Empirical Research Project

Title: Patterns of Disrupted Maternal Behaviour within  
Psychoanalytic Parent-Infant Psychotherapy: A Case Study

Student number: 1027205

Word Count: 9072



## Abstract

Topic: Atypical ‘disrupted’ maternal behaviours are associated with infants developing disorganised attachments and psychopathology later in life. This study considers whether these disrupted maternal behaviours can be observed in treatment during psychoanalytic parent-infant psychotherapy and, if so, how these behaviours manifest in the sessions and are addressed therapeutically by the clinician. Method: This is a qualitative study using video footage of two sessions from a single psychoanalytic parent-infant psychotherapy case. The two sessions are from different time points in the treatment. The first is a middle session and the second is the last treatment session. The two sessions are explored in two separate ways. Firstly, the AMBIANCE coding instrument is used as a basis for identifying disrupted maternal behaviours. Secondly, using a qualitative explorative approach, the events preceding disrupted maternal behaviour and the therapist’s interventions in response to these behaviours are thematically organised. The findings from the two sessions are then compared. Results: The results of this study reveal that behaviour as outlined by the AMBIANCE coding instrument was observed in the sessions. In particular, in this case, the mother exhibited a high frequency of ‘frightened/disorientation’, ‘affective communication errors’ and ‘withdrawing’ behaviours. Maternal disrupted behaviour was found to be mainly preceded by instances of distress and withdrawing behaviour in the baby as well as by the therapist’s responses to the baby’s behaviour. The therapist was found to respond consistently to maternal disrupted behaviour using specific technique. A comparison between the two sessions shows that there were considerably fewer disrupted maternal behaviours at the end of treatment. Discussion: Overall, it is concluded that disrupted maternal behaviours are observable in treatment and may be addressed in psychoanalytic parent-infant psychotherapy. Using the AMBIANCE coding scheme allowed for insight into the therapeutic process and revealed a clear pattern of interaction between the mother, baby and therapist.

*Keywords:* Disorganised Attachment, Maternal Disrupted Behaviours, Psychoanalytic parent-Infant Psychotherapy

## Impact Statement

This study has implications for further research and clinical practice. Firstly, in terms of clinical practice, this study shows that by looking at minute aspects of interaction between mother and baby a very thorough understanding of disrupted communication can be achieved. Particularly, this study shows that even types of maternal behaviours associated with a ‘helpless/fearful’ profile, which are considered very difficult to detect clinically, can be observed. This is important as understanding the ‘transmission loop’ of miscommunication between mother and baby sheds light on the process of therapy and how mothers maybe helped to understand the difference between infant’s attachment cues and their own emotional difficulties which prevented her from responding meaningfully to them, which has been argued to be a central aim of parent-infant psychoanalytic psychotherapy. This relates to another clinical implication of this study, the refinement of clinical technique. This study potentially offers a more nuanced way of understanding how therapists address maternal disrupted behaviours within parent-infant psychoanalytic psychotherapy. The findings of the study, which reflect a dramatic reduction in maternal disrupted behaviours over the course of treatment, suggests that the therapist’s techniques were effective in treating the disrupted communication and could be considered an encouraging example of what may be achieved in treatment.

In terms of research, this study has another implication. At present, the AMBIANCE scales have been used predominantly in laboratory settings and in quantitative research. This study proposes that it could be a useful tool to help both clinicians recognise disrupted behaviour as well as researchers who are working in a treatment context. The AMBIANCE scales may also be a good measure of treatment outcome in parent-infant psychotherapy as it can be used to reflect the frequency of disrupted behaviour and whether or not it reduces from the start to end of treatment. Moreover, as has been noted by others, the detailed descriptions

of disrupted behaviours in the AMBIANCE can show very clearly what needs to be noticed and addressed clinically and therefore enhance the therapist's formulation and practice.

## **Introduction**

‘Disrupted’ parental behaviours are atypical; they are subtle and difficult to detect in everyday situations as well as in clinical settings. They occur within a range of miscommunication and unclear, mistimed interaction between parent and infant. They include minute behaviours in the parent such as gaze avoidance, sudden changes in tone of voice, holding infants awkwardly or not responding to infants’ vocalisations. Though not considered blatantly abusive, when extensively exhibited over a prolonged period of time, they are thought to be traumatic as it means that the infant’s communications are not being meaningfully acknowledged by their parent. Importantly, there are serious consequences for infants who have been exposed to these types of behaviours; these infants are thought to be at risk of developing a disorganised attachment and potentially severe mental health difficulties later on in life.

This study explores video recorded material of a mother and her baby daughter, aged three months old, in psychoanalytic parent-infant psychotherapy (PIIP) treatment. Using a coding instrument specially designed to capture these subtle behaviours, two treatment sessions are examined. The patterns of these types of disrupted interaction between the mother and the baby are explored. It is investigated how these behaviours are addressed by the therapist and, by comparing the two sessions, whether the treatment was successful in reducing these disrupted behaviours over time. This study highlights the importance of understanding whether these behaviours can be observed in treatment and how they can be effectively addressed clinically, potentially enhancing a closer bond between parent and baby and preventing later psychopathology.

## **Background Literature**

The study of attachment began with the work of Bowlby who claimed that the strong and ubiquitous motivation for infants to form attachment bonds with caregivers resulted from the need for survival (Bowlby, 1969). Central to this theory was the idea that when infants felt fear and needed to re-establish a sense of safety they sought proximity with their caregiver to ensure this (Bowlby, 1969). Correspondingly, caregivers were said to read their infant's signals or 'attachment cues' of distress and to respond to their infant's needs accordingly (Bowlby, 1969). Research in this area has shown that there are differences in the way caregivers responded to their infant's cues and that the quality of responsiveness impacted greatly on how comfortable the infant felt about approaching their caregiver in moments of need (Ainsworth & Bell, 1970). This was demonstrated in the Strange Situation Test (SST), which was a laboratory experiment that looked at the interaction between an eighteen-month-old and their mother through a series of short separations and reunions while in the presence of a stranger. This experiment categorised the different kinds of interaction into attachment categories (Ainsworth & Bell, 1970). Two main categories were found, 'secure' and 'insecure', with the latter having two sub-sets of attachment, 'ambivalent' and 'avoidant' (Ainsworth & Bell, 1970). The experiment revealed that in a 'secure' attachment the infant showed an expectation that their mother would be able to soothe them effectively, whereas in an 'insecure' attachment, the infant showed reluctance or an avoidance of using their mother as source of comfort as though they would be unable to find sufficient reassurance from them (Ainsworth & Bell, 1970).

Later research found there to be another attachment type termed 'disorganised attachment' (Main & Solomon, 1986). This type of attachment was applied to a category of infants whose behaviour did not fit in neatly with the main categories of attachment because they did not adopt a consistent way of approaching their parent during the SST (Main &

Solomon, 1986). These infants displayed unusual behaviour when they were reunited with their mother, such as freezing or moving and making sounds in a disjointed way, which made it look as though the infant was in a conflict about whether they wanted to approach them for comfort (Main & Solomon, 1986). It was hypothesised that the infant was dependent on a parent who frightens them, leading them to feel unsure whether it is safe or not to approach their parent for comfort (Main & Hesse, 1990). Due to the uncertainty of being with a frightening parent, children's coping strategies to manage fear were thought to breakdown and cause them to display the contradictory and unusual patterns of behaviour as seen in the SST and this conflict was deemed the defining feature of disorganised attachment (Main & Hesse, 1990).

Significantly, disorganised attachment was later shown to be a predictor of children being more likely to display aggressive behaviour (Greenberg, 1999) and coercive peer interaction (Lyons-Ruth, Alpern & Repacholi, 1993) as well as a predictor of internalising and externalising mental health problems in childhood (van Ijzendoorn, Scheungel & Bakermans-Kranenburg, 1999) and in adolescence (Carlson, 1998).

Given these significant mental health repercussions, research tried to understand in more detail how this attachment style develops in infants. Although it has been routinely observed in both families where there is high risk of abuse and neglect, it has also been found in families where there is low risk, though to a lesser extent (van Ijzendoorn, Scheungel & Bakermans-Kranenburg, 1999). In terms of high-risk families, the development of disorganised attachment makes sense as, understandably, infants are extremely fearful about interaction with an abusive parent and unsure whether they should approach them for comfort (Carlson, Cicchetti, Barnett & Braunwald, 1989). However, research has had to work out why disorganised attachment also appears in families where there is low risk and an alternate

developmental path to disorganised attachment that does not feature abuse has had to be suggested.

To gain further understanding of this, various avenues of research have been pursued. One of those has been exploring how parents think about their own childhood attachments, and investigating whether this has an effect on the quality of their attachment to their own infant (Main, Kaplan & Cassidy, 1985). This involved using the Adult Attachment Interview (AAI: George, Kaplan & Main, 1996). By looking closely at the different way parents talked about their childhood attachments to their parents and their attachments to their own children during semi-structured interviews, a category of parents was found who, when discussing their childhood experiences of loss and trauma in their attachment relationships, presented with a state of mind characterised as ‘unresolved’ (George et al., 1996). Their narratives had distinct qualities such as frequent lapses in reasoning, missing links and confusing time-lines of events. These qualities were understood as implying that the parents had not yet processed and recovered from their experiences of past attachment trauma (George et al., 1996). Importantly, it was also thought that these parents had a problematic preoccupation with their childhood attachment losses and traumas that interfered with how they experienced their relationship with their own child (George et al., 1996).

Investigating this further, research considered how the experience of being with a young baby triggered parents’ ‘unresolved’ memories from their childhood. It was thought that the intrusion of past traumas into the parent’s mind impacted on the way parents were able to interact with their infants. This was thought to result in their exhibiting behaviour that was frightening for their infant (Main & Hesse, 1990). This then moved the focus of the research onto the role played by parental behaviour. By looking at parental behaviour during interaction between mothers and infants classified as having a disorganised attachment in the SST, it was suggested that there were three main types of parental behaviour which were



significant. These were frightened, frightening or withdrawing behaviour (Main & Hesse, 1990). A coding scheme to capture these behaviours was developed (Main & Hesse, 1990) and studies using this coding scheme claimed there was a link between parents who had an ‘unresolved’ state of mind, showed these kinds of behaviour and had children who developed a disorganised attachment to them (Main & Hesse, 1990; Schuengel, Bakermans-Kranenburg & van Ijzendoorn, 1999).

Developing this idea in more detail, more specifically, it was posited that parents who had unresolved attachment traumas are more likely to provoke fear in their infant because they were unable to respond adequately to their infant’s communications (Lyons-Ruth, Bronfman & Parsons, 1999). It was argued that because these parents are so caught up in their own trauma and needs, frequent breakdowns in communication occurred wherein the parent repeatedly missed or misinterpreted their infant’s cues (Lyons-Ruth et al., 1999). These breakdowns in communication were termed ‘disruptive affective communication errors’ and were seen as deeply traumatic and frightening for the child (Lyons-Ruth et al., 1999). To capture a more detailed picture of these ‘disrupted’ communications, Lyons-Ruth et al. (1999) developed another coding scheme which elaborated on Main & Hesse’s (1990) categories, the Atypical Maternal Behaviour Instrument for Assessment and Classification (AMBIANCE) (Lyons-Ruth et al., 1999). The AMBIANCE included in its categories ‘frightening/disorientated’ and ‘withdrawn’ behaviour as well as ‘disrupted affective communication errors’, ‘role/boundary confusion’ and ‘negative/intrusive behaviours’.

As a result of coding for these disrupted parental behaviours using the AMBIANCE scales, a further development was made in the research. This was that there were two very different types of behavioural profiles of mothers with disorganised infants. These profiles were labelled ‘hostile/self-referential’ and ‘helpless/fearful’ (Lyons-Ruth, 2003). Firstly, it was found that mothers who displayed more frightening, role-confusion and negative-

intrusive behaviours fit a hostile/self-referential profile (Lyons-Ruth, 2003). In this profile, the mother sought attention from her infant as though she needed comfort and thereby ignored and overrode the infant's attachment signals. She also took her own initiative and attributed feeling states to the infant which could have little to do with the infant's actual experience. At the same time, the mother also showed hostile, avoidant and resistant behaviours that were rejecting of the infant (Lyons-Ruth, 2003).

In contrast, mothers who fit into the helpless/fearful profile were found to show more fearful and withdrawing AMBIANCE behaviours and have infants with a disorganised-secure attachment (Lyons-Ruth, 2003). These mothers were said to appear loving and timid with their infant, often submitting to their infant's attempts to make contact with them. However, these mothers often failed to take the initiative in greeting or approaching their infant and regularly hesitated, moved away, or deflected the infant's requests for proximity before giving in (Lyons-Ruth, 2003). Significantly, these mothers also were said to show higher rates of withdrawing behaviour, combining their responses with an underlying anxiety or tension, wherein they often disengaged and seem preoccupied with whatever is on their mind and so missed their infant's attachment cues and thus showed a high rate of disrupted affective communication errors (Lyons-Ruth et al., 1999). Importantly, the infant's experience of being with a mother who withdraws and who is emotionally inaccessible was said to be itself frightening. This is because it leads to the paradox of infants needing their mothers for their survival yet finding her state of mind and behaviour distressing as they cannot reach her in her thoughts and she cannot acknowledge her infant's needs and therefore tend to them (Lyons-Ruth, 2003).

Notably, research has argued that identifying this helpless/fearful profile of maternal behaviour is more difficult than recognizing a hostile/self-referential one (Dutra & Lyons-Ruth, 2005). This is because whereas hostile behaviours are relatively straightforward to

identify as maladaptive, intrusive and disagreeable, the helpless/fearful profile, on the other hand, requires very close and sensitive observation of the mother and infant for it to become apparent (Dutra & Lyons-Ruth, 2005). This is because mothers can appear caring and their helplessness can easily go unnoticed. However, a very significant finding from videotaped and AMBIANCE coded mother-baby interactions has shown that the subtle experiences of 'helpless' mothering are traumatic and frightening for babies, potentially as much as explicitly hostile and more obviously abusive parental behaviours (Dutra & Lyons-Ruth, 2005).

These advancements in the research have also been accompanied by a consideration of the mental health repercussions of these parental behaviours for infants later on. Significantly, it has been found that the incapacity of parents to behave and respond appropriately to their infant's communications has serious consequences for later psychopathology (Barach, 1991; Liotti, 1992; Dutra & Lyons-Ruth, 2005; Ogawa, Sroufe, Weinfield, Carlson & Egeland, 1997). It has been hypothesised that infants whose communications and emotional states repeatedly go unnoticed or else are picked up on but are misunderstood by their parent, have an increased likelihood of developing a tendency to dissociate in adulthood (Ogawa et al., 1997). Evidence for this has been found in a longitudinal study that investigated a sample of fifty-six mother-infant dyad at social risk (Dutra & Lyons-Ruth, 2005). Results showed that disorganised attachment, maternal lack of involvement with the infant at twelve months and, notably, disrupted maternal behaviours at eighteen months, contributed significantly to the prediction of dissociative symptoms at nineteen years of age (Dutra & Lyons-Ruth, 2005). Furthermore, there is evidence to suggest that infants who are excessively exposed to parental behaviour that is frightening are at more risk of developing borderline or anti-social personality disorders in adolescence (Lyons-Ruth, Bureau, Holmes, Easterbrooks & Brooks, 2013).

Given the serious mental health risks, prevention is clearly of great clinical importance. Psychoanalytic parent-infant psychotherapy (PIIP) is one form of treatment that addresses disturbance between parent and baby. The treatment aims to foster a more sensitive and attuned relationship between parent and infant, thereby improving infant attachment security and setting the infant on the path towards healthy development, reducing the risk of subsequent mental health difficulties (Barlow, Bennett, Midgley, Larkin & Wei, 2015). In an effort to achieve this, the literature on PIIP describes how the treatment enhances parents' understanding of their relationship to their infant using various clinical techniques within a psychoanalytic framework.

In terms of parents who have an unresolved attachment trauma in the backgrounds, PIIP has been shown to be a treatment that increases parental insight into how the past has been unhelpfully interfering in their present relationship to their infant to the detriment of their forging a close and secure relationship to their infant (Fraiberg, Adelson & Shapiro, 1975). The treatment is thought to facilitate this by providing a safe therapeutic environment where the meaning of the parent's interactions with their infant can be explored and their underpinning emotions, memories and unconscious phantasies based on their experiences from their own childhoods can be understood (Baradon & Joyce, 2016). Parental unresolved attachment trauma is thus brought to light in the treatment by exploring the preoccupied and dissociated states of mind when parents feel overwhelmed while in the presence of a young baby. The therapist's role is to feed this back meaningfully to the parent, creating an awareness and preventing this from continuing to occur (Baradon, 2010; Fraiberg et al., 1975). In addition to this, clinicians have written about how by using their relationship to the parent, they are able to talk about difficult emotions that would have otherwise remained detached from the parent's conscious emotional life (Lyons-Ruth, Dutra, Schuder, & Bianchi, 2006). This is important as past communication patterns with attachment figures tend to be

subtle and implicit. Therefore, they can be difficult to identify and articulate until they surface in the therapeutic relationship and are explored openly in the treatment (Lyons-Ruth et al., 2006).

In specific reference to disorganised attachment, the literature on the topic states that a parent who has experienced trauma and a difficult attachment in their childhood experiences a particular kind of conflict that needs to be addressed in PPIP- the fear both of the giving the child a similar experience to their own, yet also fearing what it would mean to respond to the infant's attachment cues (Lyons-Ruth & Spielman, 2004). In this scenario, within the treatment it is important that the therapist helps the parent differentiate the infant's attachment needs from their own feelings so as to prevent unnecessary placing onto the infant the parent's own difficulties (Lyons-Ruth & Spielman, 2004).

However, although these techniques and descriptions of PPIP are informative, the specific question of how parental behaviour that is linked to the development of disorganised attachment in infants might be addressed in treatment can only be inferred from these descriptions. This is because there is little written on how the disrupted behaviours that cause the infant distress are addressed directly in treatment. For this reason, this study hopes to reveal how these problematic behaviours manifest themselves and can be addressed in treatment, and thus add to the literature on clinical technique in psychoanalytic parent-infant psychotherapy.

In this endeavour, this study aims to understand the treatment process and to explore the patterns of interaction between mother, baby and therapist within two sessions from a single PPIP case. Firstly, this study tries to find out what kinds of behaviours as listed on the AMBIANCE rating scales behaviours can be observed and to find out what seems to be the trigger or preceding event before these disrupted behaviours occur in the two sessions. The therapist's responses and clinical techniques employed to address the disrupted behaviours

are also explored. The second aim of this study is to consider if there is any noticeable change in the amount of maternal disrupted behaviour shown towards the infant by comparing two sessions from different time points in the treatment. This hopes to provide some initial answers to the question of how disrupted maternal behaviours associated with disorganised attachment in infants can be addressed effectively in PPIP.

## **Method**

### **Context**

This study is part of wider research ongoing at the Anna Freud National Centre for Children and Families (AFC). It has been undertaken in the context of the Parent Infant Project, a clinical service that offers a range of psychotherapeutic interventions for parents and their babies and which also conducts research in the area of parent-infant psychotherapy.

### **Study Design**

This is a qualitative study that uses video footage recorded as part of the research undertaken by the Parent Infant Project. It focuses on one parent-infant psychotherapy case study and uses video recordings of two fifty-minute sessions. The baby is three months old in the first session and is ten months old in the final session. The mother and baby were in treatment at the AFC over the course of several months and were seen by a senior clinician from the Parent Infant Project. At the start of treatment, the mother and baby were finding it difficult to bond with the baby often being distressed and mother not knowing why. Mother had her own childhood attachment difficulties and had experienced a traumatic birth with her baby.

The two videos used in this study are from different time-points in the therapy. The first video is a session from the middle section of the therapy. It was chosen as it illustrates the treatment while in full flow and when the relationship between patient and therapist is fully established. The second video used is the final session of the treatment. By using these two recorded sessions, a comparison between them is possible.

The two sessions were explored in two distinct ways. Firstly, the AMBIANCE coding instrument (Lyons-Ruth et al., 1999) was applied to both sessions. The AMBIANCE is an observational measure developed to assess the quality of parental behaviour during interactions with their infants, usually toddler-aged. It has been routinely applied to quantitative research that has looked at the interactions taking place in the context of the SST. It aims to capture atypical parental behaviours that are associated with disorganized attachment in infancy. It involves looking for maternal behaviours on five dimensions: 1) affective communication errors, 2) role/boundary confusion, 3) frightened/disoriented behaviours, 4) negative/intrusive behaviour, and 5) withdrawal. If used for its original purpose, the behaviours on each of the five dimensions are coded and the parent is given overall score of the level of disruption. A number of the particular behaviours listed on the AMBIANCE have extra significance as they have been found to occur three times more often than other behaviours in parents of infants who have disorganised attachment in the SST. For use in a laboratory setting, specialist training is required to recognise the behaviours outlined in the coding scheme.

The AMBIANCE instrument was used in this study as it is considered the most detailed tool for recognising parental disrupted behaviours, allowing researchers to detect even the subtlest of disrupted behaviours. However, this study did not use the AMBIANCE, as it was originally intended, to measure for the level of disrupted behaviour in the mother. Additionally, the primary researcher in this study was not formally AMBIANCE trained.

Rather, to meet the aims of this study, the coding scheme was used as a guide to capture the kinds of disrupted behaviour that the mother was showing in the sessions. To do this, all maternal interactions with the baby observed in the session were coded in accordance with the categories outlined in the AMBIANCE. Each instance of disrupted behaviour was coded and sometimes a behaviour was coded more than once, if the behaviour fit in to more than one category. The different categories of disrupted maternal behaviour were only considered in relation to the mother's behaviour towards her infant or behaviour that impacted on the baby's experience. The coding scheme was not applied to behaviour that was directed towards and impacted solely upon the therapist.

Secondly, using an explorative approach, both sessions were coded thematically to understand the events that preceded maternal disrupted behaviour as well as what happened afterwards in the therapist's interventions in response to those maternal behaviours. In terms of the preceding events, this was achieved by examining what were the most common types of situations that appeared before sections of maternal disrupted behaviour, and describing the nature of these events. For instance, whether it may have been the baby's distress or the therapist's intervention that occurred just before the mother exhibited disrupted behaviour and whether there was a certain type of situation that seemed to precede a significant amount of maternal disrupted behaviour.

The therapist's responses to the mother's disrupted behaviour were also coded using a thematic method. The codes reflected clinical terminology which drew upon the literature on different therapeutic techniques in PPIP. With some refinement, these clinical terms were grouped under main headings according to what appeared to be the main aim of the technique employed. For instance, all techniques that seemed to be in service of helping to soothe the baby and being sensitive to the mother and baby's feelings, whether in moments of distress or to be able to bring to light an emotional aspect of their experience, were grouped under the



heading of ‘emotionally regulating techniques’. The therapist’s interventions were put into further broader descriptive categories including ‘exploratory’, ‘emotionally regulating’, ‘promoting interaction’ or ‘expressing the experience’ techniques.

Finally, the findings from the middle session were then considered in comparison to those from the final session.

## **Material**

This particular parent-infant case was selected for this study by the Parent Infant Project as it was thought to demonstrate a successful treatment. The video recordings were released by the project to doctoral students. The mother in treatment gave consent at the beginning of treatment to have her sessions video-recorded and used in further research. To ensure confidentiality, videos were not removed from the AFC and were watched and coded on the premises. Any identifying features were changed in the write up of this study.

## **Procedure**

Portions of the recorded sessions were watched and coded in conjunction with a senior researcher from the project. This researcher was trained in AMBIANCE coding and watched the entire middle session alongside the main researcher. Notes between the researchers were compared and consensus was reached through discussion. In this way, the AMBIANCE-trained researcher ensured that behaviours that were being observed fit into the categories outlined by the coding scheme. Importantly, there was little discrepancy in the type of AMBIANCE behaviour that was observed in the session and, thus, the coding was verified.

The coding for the therapist’s responses was also carried out in conjunction with a second person. This allowed for the initial coding to be checked and for a second opinion to

be given. This was carried out by looking at five discrete sections of the video from the middle session. These sections were of various lengths and were chosen as they were moments where the mother showed a high number of disrupted behaviours and with the therapist showing a wide range of responses. These sections were coded separately by the two researchers and then the findings were compared. Where there was disparity in the coding, agreement and consensus was reached through discussion.

## **Results**

To describe the events around maternal disrupted behaviours, three aspects of the pattern interaction between mother, baby and therapist were observed in the middle session. A comparison between the findings from the middle session and the final session was possible.

### **1. The frequency and type of maternal disrupted behaviour in the middle session:**

In the middle session, the mother showed many instances of disrupted behaviour. These behaviours were observed to occur throughout the session, but appeared to cluster around certain interactions and were particularly prevalent in the first half of the session. There were nine particular moments<sup>1</sup> where the mother exhibited a high frequency of disrupted behaviour. Within these nine moments the mother showed from five up to eighteen disrupted behaviours within a time frame that lasted from a few seconds up to several minutes long. Throughout the rest of the session, outside of these nine moments, disrupted behaviours were observed but less intensely concentrated around one interaction. These were spread out over a longer time frame sometimes lasting longer than several minutes.

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<sup>1</sup> See Appendix 1

In the nine moments where there were some particularly intense interactions between the mother and baby and many disrupted behaviours were shown, predominantly fearful/disorientated behaviour, a high level of affective communication errors as well as withdrawing behaviour were most commonly observed.

The most frequent type of disrupted behaviour was frightened/disorientated behaviour. This study found that over the course of the middle session the mother exhibited in total eighty-nine behaviours that fit into the category of frightened/disorientated. In the particular nine moments, the mother showed forty-five instances of disrupted behaviour.

The different types of the frightened behaviour included those where the mother spoke in a tense, high-pitched 'squeaky voice', seen most noticeably on entry to the room. At this time, but also throughout the session, her tone was frightened or 'haunted' and rose in intonation, signifying her heightened anxiety. She was also observed to regularly handle her baby in a timid and helpless manner, as though she was unsure and worried about close proximity. Part of this was how the mother was also seen to approach the baby in a roundabout way, sometimes approaching the baby to touch and caress her, only to quickly move or to back away so that there was significant distance between them. Alongside this, the mother was also observed to startle at the baby's behaviour and to attempt to engage her baby through speaking very fast and making movements, such as taking off her baby's cardigan, that when combined with mother's confused or frightened expression gave the appearance of mother appearing very anxious and uncertain how to proceed. Another aspect of the behaviour was how the mother regularly smiled fearfully, laughed nervously, sat frozen in positions which indicated tension, raised her hand to mouth in anxiety; and on one notable occasion wandered around the room looking confused while her baby was distressed. This last behaviour also indicated the mother's disorientated presentation.

Affective communication errors were the next most frequent type of behaviours observed. There were thirty-nine instances throughout the session in total and within the nine moments, nineteen affective communication errors were observed. The observed behaviours included how this mother appeared to try to hold her baby affectionately but simultaneously withdrew, providing physical contact which offered little comfort. This was most noticeable when the baby was distressed and the mother did not respond, or when she did, how she responded with stimulation in a tone incongruent with her calming message. This was apparent in the way that the mother did not always respond to the baby's vocalisations. In these moments, the mother appeared to invite contact with the baby verbally, but then distanced herself. This seemed to indicate inauthentic affect directed towards the baby, particularly visible when the mother laughed while her baby was distressed.

Withdrawing behaviours were also observed with forty different behaviours observed over the course of the session. Sixteen within the particular nine moments were observed. Similar to the frightened behaviours observed, the mother was seen to hold her baby cautiously, turning the baby away from her body in a way that seemed awkward; she kept her arms stiff and on one occasion put the baby down before any sign from the baby that this was what was desired. This seemed to cause an abrupt end to the interaction and with engagement with the baby kept at a distance, revealed a strong sense of the mother's hesitance around interaction. Compounding the sense of hesitation, the mother regularly averted her gaze, actively recoiled or pulled back from infant. She also stroked the baby with fingertips rather than her whole palm. In moments where she seemed particularly withdrawn, the mother was seen to interact silently with her baby.

Negative/intrusive behaviours were also observed though far less frequently. In the middle session, ten instances were observed over all with seven occurring in the nine moments. These behaviours were observed when the mother loomed into her baby's vision

and on the two occasions when she wiped her baby's nose in what seemed to be an intrusive manner.

Role/Boundary Confusion behaviours were least commonly observed. There were six instances overall with one occurring during the nine moments. The behaviours observed included when the mother sought reassurance from the baby, attempting to soothe the baby although it was already calm.

Given that the results show that the mother exhibited a high level of frightened/disorientated, affective communication errors and withdrawal, it would appear that the mother in this session fit into a helpless/frightened behavioural profile rather than a hostile/intrusive one.

Two brief examples of the of interaction captured are described below:

1. Mother enters the room and announces their arrival to her baby. Mother's voice is high pitched and anxious and she holds her baby stiffly. Mother places baby in a sitting position on the floor and sits down next to her. Baby sharply looks away to the side and mother laughs nervously, exclaiming 'oh'. The baby makes soft vocalisations. Mother looks nervous. The therapist addresses how the baby likes to take her time before she is ready to look at mother and therapist. Baby again looks sharply to the side. Mother says, 'oh dear!' and laughs nervously. She sighs and lightly strokes the baby's head.
2. After an interaction in which therapist has been engaging baby in play, baby becomes unsettled and starts making grunting unhappy sounds. Baby looks away. Mother says, 'oh no' and lifts the baby up tentatively to sit on her lap. Baby seems uncomfortable and moves around in the position she is being held in. Mother comments that it's like the baby 'wants to escape'. Therapist responds by

acknowledging Mother's comment. Mother quickly puts baby down on the floor again. Baby's cries escalate and she lets out a piercing shout. Mother says 'oh' and seems alarmed but makes no move to comfort baby. Therapist intervenes and suggests that mother engages with baby. Mother lightly touches the baby's tummy with her finger tips rather nervously and asks her hurried questions in a soft voice, such as 'what are you trying to say?' Baby's cries increase. Mother takes off baby's cardigan in a rushed and worried way and then stops touching baby. Baby cries and mother watches, asking if that felt better for the baby. Baby continues to cry. Mother says 'uh oh' and shows little expression. Therapist intervenes.

## **2. The events preceding maternal disrupted behaviour in the middle session:**

In trying to envisage in what context the mother's disruptive behaviour appeared, the nine significant moments where there was a high frequency of disrupted behaviours were explored to see what sort of situation preceded them. By focusing in particular on these nine moments it was felt that the preceding factors could be more reliably illustrated. This was because outside of these moments, the behaviours were far more dispersed behaviours and scattered across the session in such a way that it was difficult to determine what the preceding event or trigger. The nine moments were when the mother showed a higher degree of dysregulation and thus methodologically it was easier to predict what preceded them.

Overall, it was found that in the middle session, the mother's disrupted behaviour appeared to be preceded both by certain behaviours in the baby, such as when the baby became distressed, unsettled and cried, or else showed withdrawing behaviour, such as averting her gaze and ending the interaction suddenly. The therapist's interventions were also

found to be a significant preceding event. The entry to the room at the start of the session also seemed to provoke anxiety in the mother.

During six out of the nine significant moments in the session where the mother showed a high level of disrupted behaviours, the baby's behaviour was characterised by her becoming either distressed or agitated, and she communicated this through vocal cues, crying and by making agitated body movements. This seemed to cause in the mother a tendency to show frightened behaviours. For instance, the mother would appear startled by the baby's behaviour and show an expression that was difficult to read, laughing nervously and smiling although appearing frightened at the same time. During these moments, a number of affective communication errors were made with the mother failing to respond or else laughing quickly and anxiously in response to the baby's distress. The mother also appeared to withdraw in these moments; although holding the baby affectionately, she regularly averted her gaze and turned the infant to face away from her own body. In addition, when the baby's distress increased, her mother tried to comfort her while at the same appearing confused and uncertain what to do and showing little emotion in her voice. She appeared to 'freeze' and made very restrained physical contact, holding her body at a distance from the baby in a posture that did not seem to provide comfort and stroking the baby's belly with her finger tips in rather a rushed and 'hard' way.

Additionally, in two of the nine moments, the baby's withdrawing behaviour was observed moments before the mother displayed disrupted behaviour. In particular, the baby averting her gaze, remaining expressionless and not engaging with the therapist's invitations to play appeared alongside a number of mother's disrupted behaviour. For instance, during a playful interaction, the therapist moved a colourful toy rhythmically in front of the baby's face. After watching the toy for a few moments, the baby reached for the toy and the therapist placed it in her hand. The baby made soft sounds and her mother responded briefly to her.

The therapist spoke to the baby soothingly and baby let go of the toy. The therapist moved the toy in little circles while the baby watched. The baby reached for it but again let go quickly. The mother laughed nervously in response to this and handled her baby timidly. The therapist moved the toy again in front of the baby who stared at it and reached out towards it and then made upset sounds. The mother expressed disappointment and her expression appeared frightened. Shortly afterwards, the mother handled her baby in a very stiff way as though her baby were inanimate.

Additionally, the therapist's interventions and responses to the baby's distress and withdrawing behaviour appeared to be a preceding factor for the mother showing disrupted behaviour as well. Out of the nine moments, on two occasions the therapist actively intervened in the miscommunication that seemed to be unfolding between the mother and baby and this seemed to trigger in the mother further fearful, disorientation, role confusion and intrusive maternal behaviour.

Overall it was observed that a pattern of interaction between mother and baby emerged; disrupted behaviours in the mother seemed to be preceded by certain behaviours in the baby. This in turn furthered the baby's distress and the cycle of inconsonant interaction continued. The therapist's responding to this cycle seemed to, at times, precipitate further maternal disrupted behaviour.

### **3. The therapist's responses to the mother's disrupted behaviour in the middle session:**

With an awareness of the types of disrupted behaviour that the mother exhibited as well as the preceding events that appeared before this behaviour, the third question of this study relates to what techniques the therapist used in addressing the disrupted behaviours once they had been exhibited.



Notably, in the middle session, the therapist responded to all nine moments where there was a high frequency of disrupted maternal behaviour. Many different clinical techniques were used and sometimes more than one was used during a single interaction. Many of the techniques overlapped and the therapist's responses could be coded and understood as serving various purposes. All of the techniques were listed during the initial coding of the therapist's responses and then these were grouped into the following four categories. These were-

Emotionally regulating techniques- these encapsulate techniques that seemed to be aimed to emotionally regulate the mother and baby. These techniques were observed in eight out of the nine moments and alongside techniques that helped to express the mother's and baby's experience, they were the most frequently observed. This category included techniques such as mirroring the emotional states of the baby and mother, marking the emotions of mother and baby and engaging the baby through rhythmic tone of voice and/or touch. These techniques were often made in response to heightened emotion in the baby as well as disorientation in the mother. They served to calm baby when distressed and to feedback to both mother and baby the feelings of the other.

Representing the experience- these techniques were also observed in eight out of the nine moments. They included techniques where the therapist expressed the mother and baby's state of mind and experience. This included the use of interpretation and need to tolerate the mothers mixed feelings about her baby. This could be seen in the way that the therapist spoke to the baby directly, explaining the baby's past and current experiences, putting the baby's emotions into a context for her. As mother was always in earshot of the interaction, this also seemed to serve to soothe mother and consolidate her own experience.

Promoting interaction techniques- these were observed in four out of the eight moments. They involved how the therapist modelled the interaction for the mother, promoted

the mother and baby to engage with one another, how the therapist reflected back the interaction, made and prompted interactive repairs between the mother and baby and played. These techniques could be observed in moments when interaction between mother and baby was mistimed and the therapist actively intervened to help mother and baby regain their understanding of one another.

Exploratory techniques- these techniques were observed in three out of the nine moments. They involved clarification, reassurance, advice, thinking about the baby's development and thinking about the mother's intergenerational structure. These techniques seemed to prompt the mother in her thinking. They supported mother to think about her baby in a wider context, how baby has changed over time, the baby's place in the family, mother's relationship to her own mother and grandmother. As these techniques could be more directive, they appeared to be mostly directed towards the mother during moments when the baby was not distressed and conversation was possible.

#### **4. A comparison between the middle and last session:**

In terms of the type and frequency of the disrupted behaviour observed in the last session, the mother displayed eight disrupted behaviours in total. Compared to the eighty-nine individual disrupted behaviours that the mother exhibited in the middle session, this reflects a dramatic reduction between the middle and the last session. The eight behaviours in the last session included two affective communication errors, two instances of fearful behaviour, two instances of intrusive behaviour, one instance of disorientation and one of withdrawal. In comparison to the middle session, the mother showed no significant moments<sup>2</sup> of disrupted behaviour as these eight behaviours were spread across the first part of the session and not grouped together to suggest that a problematic interaction was taking place.

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<sup>2</sup> See Appendix 2

The low frequency of the behaviour suggests that the interaction between mother and baby was within ordinary levels of disrupted communication. Additionally, due to the infrequency and because the mother showed a broad range of disrupted behaviour and there was not a prevalence of a certain type of behaviour, it could not be said that the mother fit into the helpless/fearful behavioural profile as she did in the middle session.

In considering the preceding events of these disrupted behaviours in the last session, because the disrupted behaviours were so few and there were no particular moments of disrupted interaction it is difficult to say that there were any particularly prevalent preceding situations. However, there were some notable events within the session that seemed significant. On one occasion, disrupted behaviour followed the mother describing to the therapist her baby's progressing development. Another instance of disrupted behaviour was followed by the baby falling over and later on in the session by the mother discussing difficulties in her relationship to her own mother. These could be argued as being preceding events that triggered maternal disrupted behaviour but, it is important to note that there was not enough disruption for the interaction to be considered problematic.

Notably, just as in the middle session, the therapist responded to all the instances of mother's disrupted behaviour. In this session, the therapist mostly used exploratory techniques. This may be because the baby seemed more content and less distressed in the session and therefore there was less demand for techniques to emotionally regulate, to promote interaction or to express the experience. Moreover, being as it was the final stages of treatment, the mother may have been processing and working through her personal issues with the support of the therapist, piecing together her own traumatic background and relationship to her mother and its impact on how she mothers her own baby.

Overall, unlike the middle session where it was observed that there was a cycle of maternal disrupted behaviour, distress in the baby and the therapist's input, in the final

session there were so few disrupted behaviours that no pattern of interaction between mother, baby and therapist could be detected.

## **Discussion**

This study has implications for further research and clinical practice. Firstly, in terms of clinical practice, this study shows that by looking at minute aspects of the interaction between mother and baby a very thorough understanding of disrupted communication can be achieved. In this particular case, it was observed that the baby's distress and withdrawal were intensely dysregulating for the mother and coincided with her showing frightened/disorientated, affective communication errors and withdrawing behaviours. This in turn exacerbated the baby's distressing behaviour so that a perpetuating cycle of disrupted communication characterised their interaction. Understanding the 'transmission loop' between the mother and baby shed light on how through the therapy the mother was helped to understand the difference between her infant's attachment cues and her own emotional difficulties which prevented her from responding meaningfully to them. This is very important because it is a central aim of PPIP (Lyons-Ruth & Spielman, 2004) and thus it is notable that this study was able to observe this pattern of interaction in such detail.

Moreover, it is notable that the mother's disrupted behaviours were discernible in the sessions as, in the case of the middle session, those that were exhibited were particular categories of disrupted behaviours associated with a 'helpless/fearful' behavioural profile and these are considered to be very difficult to detect clinically. This is because these mothers have been described as timid, 'sweet' in manner and temperament, even to be loving towards their infants and their disrupted behaviour is thus inconspicuous. However, they are also preoccupied and troubled, can appear frightened, withdrawn and often miss their baby's communicative cues (Lyons-Ruth et al., 1999). Therefore, the evidence from videotaped and

coded mother-baby interactions which reveal that the experiences of helpless/frightened mothering are traumatic and frightening for babies, as much as those experiences which are abusive (Dutra & Lyons-Ruth, 2005), highlights the importance that this study shows that these behaviours can be observable in a treatment context.

In this sense, in terms of research method, this study has another implication. It suggests that the AMBIANCE coding instrument (Lyons-Ruth et al., 1999) is a useful tool to detect subtle disrupted behaviours in a treatment setting. At present, the AMBIANCE scales have been used predominantly in laboratory settings and in quantitative research that have shown the connection between maternal disrupted behaviour with infant attachment status (Lyons-Ruth et al., 1999; Madigan, Moran & Pederson, 2006), trauma history (Lyons-Ruth et al., 1999), classification on the AAI (Goldberg, Benoit, Blokland & Madigan, 2003) and to measure outcomes of play-based treatment (Chasoit, Madigan, Lecce, Shea & Goldberg, 2001). However, only once has it been applied to clinical material from a PPIP case (Baradon & Bronfman, 2010). This study proposes that it could be a useful tool to help both clinicians recognise disrupted behaviour as well as researchers who are working in a treatment context. It also seems applicable to parental behaviour towards very young infants, not just towards toddlers, as it was initially designed to do. The AMBIANCE scales may also be a good measure of treatment outcome in PPIP as it can be used to reflect the frequency of disrupted behaviour and whether or not it reduces from the start to end of treatment. Moreover, the detailed descriptions of disrupted behaviours in the AMBIANCE shows very clearly what needs to be noticed and addressed clinically and therefore enhances the therapist's formulation and practice (Baradon & Bronfman, 2010).

This is related to another clinical implication of this study, the refinement of clinical technique. This study potentially offers a more nuanced way of understanding how therapists can address these disrupted behaviours within PPIP. In this study, the therapist was an

experienced clinician and given that they consistently intervened in moments of disrupted behaviour, it seems likely that they were very aware of the disturbance being played out between mother and infant. The therapist engaged very actively and used a range of different therapeutic techniques and interventions directed at both mother and baby. In general, the therapist's role in the sessions appeared to be to manage the baby's emotional world, down-regulating the baby's distress using emotionally regulating techniques. At the same time, they also played a part in understanding the mother's anxieties about responding to her baby's cues and used exploratory techniques and expressed the experiences and states of mind of the mother and baby aloud to achieve this. By modelling the interaction for the mother, it was possible for the therapist to help the mother recognise and meet her baby's communications and needs. Significantly, the dramatic reduction in maternal disrupted behaviours between the two sessions in this case suggests that the therapist's techniques were effective in treating the disrupted communication and could be considered an encouraging example of what may be achieved in treatment.

A question that remains in this study is to what extent it was important that the therapist was able to address the disrupted communication between mother and baby. It is potentially equally significant that the mother was helped to process and work through some of her own attachment traumas as well as helped to come to terms with the birth trauma she experienced. In the two video-recorded sessions used in this study, it was observed that the mother frequently referred to her difficult relationship to her own mother and this seemed to fit well with the common psychoanalytic understanding of mother-baby disturbance, which focuses on how the parent's past unresolved attachment difficulties interfere with the parent's ability to understand and respond to their baby's communications in the present (Fraiberg et al., 1975). Additionally, it relates to the understanding of how the parent who has experienced trauma and loss in their childhood attachments experiences a particular kind of conflict with

their baby about what it means to form an attachment to them (Lyons-Ruth & Spielman, 2004). Within the sessions, it was observed that mother was anxious about being able to provide her baby with what she needed as though her familial background might somehow interfere with her nurturing ability unintentionally. On one occasion in the middle session, the therapist encourages the mother's suggestion that she was frightened of interacting with her baby as if she might bring some harm to her baby because of her own limitations. Thus, the theme of transmission of intergenerational attachment trauma appeared alongside the mother displaying disrupted behaviour towards her baby and perhaps indicates another aspect of the treatment that requires investigation.

Additionally, there are further areas for future research which would be able to reveal the patterns of interaction within PPIP in more detail. For instance, given the above, the themes within the therapy and how the mother was able to process and work through her own childhood attachment trauma allowing for a closer bond with her baby could be a topic for further study. In regards to the limitations of this study, as it covers two sessions from a treatment, it would be interesting if all sessions from the treatment were to be considered and to guarantee validity, if several treatments were to be compared. Additionally, as this case was chosen by the AFC Parent Infant Project as it reflected an example of a good outcome, it is important to consider that in more extreme cases of disrupted behaviour the results would be harder to judge. Interestingly, on one occasion in the middle session, the mother corrected her behaviour when she misread her baby's cue. This possibly reflects that the mother in this case had the burgeoning capacity to recognise her behaviours and to judge if she was responding appropriately to her infant. In more maladapted relationships between mother and baby, such positive results may not be present. Furthermore, this study ended up looking specifically at those disrupted behaviours linked to a helpless/frightened behavioural profile

and the findings from this study may not be transferrable to treatment of mothers who show more of a hostile/self-referential profile.

Finally, given the spiral of interaction between mother and baby in this case, although this study looked for preceding events to the mother's disrupted behaviour, it seems likely that they were as much a trigger for baby's distressed behaviours and it is difficult to say which one was the primary factor. To fulfil the aims of this study it was necessary to demarcate some boundaries of the interaction, and though they may seem arbitrary in the natural flow of interaction, through this method it was possible to highlight how the mother reacted to her baby's communications and attachment cues with trepidation. Further studies may want to look more closely at the 'transmission loop' to gain a more detailed understanding of triggers and causes for mother and baby's disrupted communication and lastly, further research may also want to look in more detail at which specific therapeutic interventions are effective in treating certain types of maternal disrupted behaviour.

## **Conclusion**

It has been established in the research that the subtle experience of being with a parent who repeatedly misses or misinterprets attachment cues and communications can be traumatic for a baby. With limited understanding of whether there is a real threat to their well-being, babies are left with the impression that there is not a reliable or safe adult to turn to and they are at risk of developing a disorganised attachment. Moreover, the experience of having a limited response to their distress over an extended period of time is terrifying and can lead to potential mental health difficulties in later life. Given this, the findings of this study are hopeful. The marked change in the amount of disrupted behaviours exhibited between two sessions is remarkable. Although not definitive, the findings of this study suggest that there is a decrease in disrupted behaviour which may be worth exploring further



in quantitative research as it has been said that inductive research can provide useful hypotheses for quantitative research (Willig, 2013). This study therefore argues that it is important these disrupted maternal behaviours are studied further and in particular that the ways in which PPIP addresses them is further researched.

## Appendix

### 1. Results from the middle session

	<b>Main instances of maternal disrupted behaviour in the middle session</b>	<b>Preceding Event</b>	<b>Therapist Response</b>
<b>1.</b>	<ul style="list-style-type: none"> <li>• 8 x frightened/disorientated</li> <li>• 3 x withdrawal</li> </ul>	<ul style="list-style-type: none"> <li>• Entry into the room</li> </ul>	<ul style="list-style-type: none"> <li>• Emotionally regulating</li> <li>• Representing the experience</li> </ul>
<b>2.</b>	<ul style="list-style-type: none"> <li>• 6 x frightened/disorientated</li> <li>• 1 x boundary/role confusion</li> <li>• 4 x negative/intrusive</li> <li>• 3 x withdrawal</li> </ul>	<ul style="list-style-type: none"> <li>• Baby withdraws, avoids gaze</li> </ul>	<ul style="list-style-type: none"> <li>• Emotionally regulating</li> <li>• Representing the experience</li> <li>• Exploratory</li> </ul>
<b>3.</b>	<ul style="list-style-type: none"> <li>• 4 x affective communication errors</li> <li>• 2 x negative/intrusive</li> <li>• 5 x frightened/disorientated</li> <li>• 4 x withdrawal</li> </ul>	<ul style="list-style-type: none"> <li>• Baby agitated, vocalises</li> </ul>	<ul style="list-style-type: none"> <li>• Emotionally regulating</li> <li>• Representing the experience</li> </ul>
<b>4.</b>	<ul style="list-style-type: none"> <li>• 6 x affective communication errors</li> <li>• 9 x frightened/disorientated</li> <li>• 3 x withdrawal</li> </ul>	<ul style="list-style-type: none"> <li>• Baby distress, cries</li> </ul>	<ul style="list-style-type: none"> <li>• Emotionally regulating</li> <li>• Representing the experience</li> <li>• Exploratory</li> </ul>

			<ul style="list-style-type: none"> <li>Promoting interaction</li> </ul>
5.	<ul style="list-style-type: none"> <li>3 x affective communication errors</li> <li>4 x frightened/disorientated</li> </ul>	<ul style="list-style-type: none"> <li>Baby withdraws</li> </ul>	<ul style="list-style-type: none"> <li>Exploratory</li> </ul>
6.	<ul style="list-style-type: none"> <li>7 x affective communication errors</li> <li>1 x negative/intrusive</li> <li>8 x frightened/disorientated</li> <li>4 x withdrawal</li> </ul>	<ul style="list-style-type: none"> <li>Baby distressed</li> <li>Therapist prompts interaction</li> </ul>	<ul style="list-style-type: none"> <li>Emotionally regulating</li> <li>Representing the experience</li> <li>Promoting interaction</li> </ul>
7.	<ul style="list-style-type: none"> <li>5 x affective communication errors</li> <li>2 x frightened/disorientated</li> <li>1 x withdrawal</li> </ul>	<ul style="list-style-type: none"> <li>Baby distressed</li> </ul>	<ul style="list-style-type: none"> <li>Emotionally regulating</li> <li>Representing the experience</li> </ul>
8.	<ul style="list-style-type: none"> <li>1 x affective communication errors</li> <li>4 x frightened/disorientated</li> </ul>	<ul style="list-style-type: none"> <li>Baby distressed, cries</li> </ul>	<ul style="list-style-type: none"> <li>Emotionally regulating</li> <li>Representing the experience</li> <li>Promoting interaction</li> </ul>
9.	<ul style="list-style-type: none"> <li>7 x frightened/disorientated</li> <li>3 x withdrawal</li> </ul>	<ul style="list-style-type: none"> <li>Baby distressed, cried</li> </ul>	<ul style="list-style-type: none"> <li>Emotionally regulating</li> <li>Representing the</li> </ul>

			experience <ul style="list-style-type: none"><li>• Promoting interaction</li></ul>
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## 2. Results from the last session<sup>3</sup>

	<b>Instances of maternal disrupted behaviour in the last session</b>	<b>Preceding Event</b>	<b>Therapist Response</b>
	<ul style="list-style-type: none"> <li>• 2 x negative/intrusive</li> <li>• 1 x affective communication error</li> <li>• 1 x frightened/disorientated</li> <li>• 1 x withdrawal</li> </ul>	<ul style="list-style-type: none"> <li>• Mother describes baby's progressing development to therapist</li> </ul>	<ul style="list-style-type: none"> <li>• Exploratory</li> <li>• Emotionally regulating</li> </ul>
	<ul style="list-style-type: none"> <li>• 1 x affective communication error</li> <li>• 1 x frightened/disorientated</li> </ul>	<ul style="list-style-type: none"> <li>• Baby falls over</li> </ul>	<ul style="list-style-type: none"> <li>• Exploratory</li> <li>• Emotionally regulating</li> </ul>
	<ul style="list-style-type: none"> <li>• 1 x frightened/disorientated</li> </ul>	<ul style="list-style-type: none"> <li>• Mother discusses relationship to her own mother</li> </ul>	<ul style="list-style-type: none"> <li>• Exploratory</li> </ul>

<sup>3</sup> Although eight maternal disrupted behaviours were observed and are noted in the table above, these did not signify 'main instances' as they did in the middle session. This is because the behaviours were infrequent and spread over the course of the session rather than group together in such a way that would indicate that a disrupted interaction was taking place.

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### Part 3: Reflective Commentary

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Student number: 1027205

## **Introduction**

In October 2016, as part of the Doctorate in Child & Adolescent Psychoanalytic Psychotherapy, I embarked on a research project at the Anna Freud National Centre for Children and Families (AFC) in the context of the Parent Infant Project (PIP)- a clinical service that offers a range of psychotherapeutic interventions for parents and their babies and which also conducts research in the area of parent-infant psychotherapy. I have always had a particular interest in early mother-baby disturbances and their treatment and, also, given that I am training in a Child and Adolescent Mental Health Service (CAMHS), I believe that early intervention is very important. Thus, I was interested in pursuing research that would contribute towards understanding how these disturbances might be addressed clinically and potentially adding to the evidence as to the effectiveness of parent-infant psychotherapy.

### **The process of the research:**

#### **Initial stages**

At the start, as a small research group made up of clinical trainees/budding researchers and led by a main supervisor, we considered broadly the idea of process research and how we might begin to describe behaviours and processes that occur within parent-infant psychotherapy. We were fortunate to have video footage of parent-infant psychotherapy treatment sessions released to us by the PIP which offered us large amounts of very rich data with which we could begin to explore the therapy process. We understood that our research would be looking at a single treatment case study and that it was hoped our studies would add to wider research undertaken by the PIP. It was also hoped that our individual projects within our group would look at different aspects of the treatment and would relate to one another in a way that would provide support for the different studies and also offer a multi-dimensional perspective on the case.

To begin with, we became familiar with the particular case study and watched the recorded treatment sessions several times over a number of weeks. As a group, we discussed our initial impressions of the case. My own was that this was a treatment of a sensitive mother who was experiencing much anxiety about what it would mean for her to look after her baby. It appeared to me that the mother's insecurity and concern that her own failings and childhood difficulties would somehow disturb and upset her baby caused her to be extremely confused and fearful of how to care for the baby, especially when it was distressed. Correspondingly, the baby appeared unsettled and to become emotionally dysregulated quite quickly, especially in the beginning of the treatment, and could also be quite withdrawn with its mother, as well as with the therapist. Thus, the videos allowed us a very intimate window into this mother and baby's lives, which was fascinating.

Initially, we did not have much information available to us about the case and our responses to the videos were based mainly on clinical experience and intuition. As such, it felt as though discussions focused on our clinical formulations based on the skills that as trainee child therapists we were developing in our clinical practice. It was important therefore that we were encouraged in supervision not to be too guided by our clinical interpretations of the treatment and to foster our skills as researchers. However, although this was an initial issue that needed to be addressed, it was also important that our clinical skills could inform our understanding of the videos that we were watching; I felt that the sensitivity to the treatment was a result of our clinical skills and that it helped guide the research project take shape. This early stage involved a shift in the thinking and an attempt to look at the material through a 'research lens', basing our ideas on what was observable rather than clinical intuition.

Another new experience was to be able to watch clinical work. As trainee child therapists, we have various supervision of our clinical work, however, we are not ourselves

recorded nor is there usually any opportunity to actually watch clinical work being undertaken. This project thus offered a unique experience and a wonderful learning opportunity. It is perhaps also for this reason that watching the videos invoked a tendency to want to understand the case in a more clinical rather than in a research-based sense. It invoked feelings of wanting to try make sense of the treatment from the perspective of a child therapist, and this needed to be discussed in group supervision. Watching therapy take place, rather than reading a transcript and a case study, brought to life the clinical work in a very real sense. I think this was particularly when watching the video and looking at the process from a distance could be quite painful, particularly during distressing moments when the baby was distraught.

Initially, there were also some practical considerations that needed to be addressed. It took some time to sort out frustrating IT issues before as a group we were organised and could watch all the sessions from the treatment. This still remained somewhat haphazard given that not all sessions from the treatment were available to us. We also began by watching the sessions out of order initially, which was confusing. Additionally, in some videos the mother and baby were unfortunately out of camera shot making it sometimes difficult to get a full picture of the interaction. There were other practical considerations such as that the video footage could not be removed from the AFC; for those of us that travelled long distances to CAMHS clinics during the week it meant that our time with the footage was quite pressured. These practical issues compounded a lot of the more general anxiety in the group about how to formulate a research question. In retrospect, I have wondered whether the anxiety around trying to organise the practical side of the research was to do with the tension of being both a child therapist working in a demanding and busy CAMHS environment and a researcher with some burgeoning though undeveloped skills, and possibly symbolic of the wider tension between clinical work and research method.

Moreover, it felt quite overwhelming that the video recordings provided us with such a range of possible research avenues. The video data allowed us to examine in great detail the ways in which the participants in the therapy interacted; how they talked to one another, their facial expressions, gaze, body posture etc. and it was difficult to know where the starting point of the study should be, and initially, how as a group we would organise who would research which aspect of the treatment. Given some of the constraints on the projects, our research began to drift apart and eventually it felt as though we were pursuing very individual projects.

For my part, I became especially curious about the therapist's interventions in the treatment. I was very focused on the idea of what the therapist was doing and what it was that made this therapy a success. In retrospect, I think this was probably a reaction to being able to watch video recorded footage of therapy for the first time and the novelty of it causing me to feel eager to capitalise on this opportunity and learn about clinical technique in more detail. However, following supervision with the senior clinician from the treatment, I was encouraged to think about the therapist's input in relation to the mother's behaviour. I had formed the opinion, based on my own reading for the literature review and through discussion with this supervisor, that the mother in the video was ambivalent about being a mother; although it was clear that she was kind and loving towards her baby, at the same time she appeared anxious and frightened and seemed to lack confidence. This was in stark contrast to the therapist who was very active in the sessions, helping the mother and exploring the difficulties with her. It was put to me in supervision that given these initial observations it seemed likely that this particular mother would fit into certain types of behavioural profiles associated in the research with mothers who were hindered in their capacity to relate meaningfully to their babies as a result of their own traumatic background. It was also pointed out to me that this mother was not overtly hostile to her baby but rather



seemed timid and anxious and perhaps looking at the combination of her subtle behaviours and the therapist's responses would be interesting. This added another dimension to the research and seemed more detailed than merely looking at the therapist's techniques in the treatment, which I now think would have come across as a list and probably not very informative without the context of the maternal behaviour to which it was responding. Thus, my first research questions began to form along the lines of the mother's way of being and communicating to her baby and the therapist's responses to the mother.

### **Middle stages**

Having formed an idea of the area of study I would like to pursue, I began to think about how I would go about the research methodologically. In particular, I thought about how I might capture the mother's behaviour in terms of coding. I had read about the AMBIANCE scales in a previous literature review and I wondered about applying this to the session. However, as the AMBIANCE coding system had not before been applied to video footage of a treatment session I was not sure whether this method would be appropriate. As the AMBIANCE coding scheme was originally developed for use in a laboratory setting to observe interaction between mother and her toddler and had not been applied to a video-recorded therapy session with a three-month-old baby, at this point the idea of applying AMBIANCE coding to the session was experimental. Furthermore, at this stage, it felt rather confusing to work out how to incorporate the mother's behaviours, the therapist's responses. I also then considered the therapist's reactions to moments where the mother showed behaviours as listed on the AMBIANCE scales. I had to work out some aims to the study that would offer a picture of the whole process of therapy and the interaction between all the participants. Alongside this there were further methodological aspects that needed to be clarified. For instance, would I be looking at the whole treatment, or just one session? As

such, at this stage of the study, both the aims and how I would go about the research practically had to become a lot more defined.

Having watched all the available video footage from the treatment, I tried to answer the question of which videos to look at, how many and whether it would involve a comparison between videos or an exploration of change over time. I began to discuss the design of the study in supervision. There were also practical considerations; given that I would be looking at the detail and subtlety of the mother's behaviour and the therapist's responses, which would likely include responses that were directed to the baby, it was felt that I would need to find a session where all three participants were in the camera frame. It was decided that I would begin by looking at a middle session where it was certain that I would be able to observe all three participants clearly to see what would be possible. This was important due to the doubts whether I would be able to find many instances of disrupted behaviours given their subtle nature.

As I began coding for AMBIANCE behaviours in the mother in a middle session, I realised that I had much more clinical experience than research experience which initially presented some difficulties. Being more inclined to think in an analytic way, informed by psychoanalytic theory, coding according to the behaviours as listed in the five categories in the AMBIANCE scales was a very different way of looking at clinical material. Initially, it felt removed and slightly limiting. At times, it seemed that my clinical intuition and tendency to try to read between the lines and attempts to understand the unconscious processes were getting in the way of looking at a transcript and coding according to the manual. This was a change in gear and required some supervision. Helpfully, I was able to code for AMBIANCE behaviours alongside an experienced researcher and this meant that I could verify that what I was seeing were indeed disrupted behaviours. It is important to note that at this stage it became clear that it would be possible to code the sessions for maternal disrupted behaviours,

and, indeed, that the mother was showing a very high number of these behaviours in the session.

However, as time went on and the coding become easier and a more refined process, I again found that the sensitive understanding of mother and baby behaviour, which had been fostered in my clinical training, actually aided my awareness of the subtler behaviours that I was trying to detect. Additionally, I felt aware that I could employ skills that had been learnt during my pre-clinical training in which I had undertaken a baby observation. The skills of close observation and attunement with the mother and baby were essential to this study and thus I feel that the clinical skills and research, despite in the beginning having an uneasy relationship, became complementary.

In the next stage of the study, I began to look at how the therapist in the session addressed the mother when she showed AMBIANCE behaviours. Having read a significant amount of literature on the techniques of parent-infant psychotherapy, I started by coding for a multitude of different types of clinical techniques as has been listed in the literature on psychoanalytic parent-infant psychotherapy. I quickly realised that I was going to have to demarcate moments of the interaction in the session so that I could make a formulation of the interaction. For instance, that when the mother showed many AMBIANCE behaviours in one specific moment that the therapist responded in turn. This seemed difficult as the natural flow in the interaction seemed to have no clear moments which indicated a beginning or end to the interaction. Additionally, the mother showed many AMBIANCE behaviours throughout the sessions and the therapist was also very active. Thus, separating out what the mother was doing and whether this was what the therapist was responding to was difficult. Again, I found that this did not suit my previous way of understanding interaction clinically and initially I found that the ‘moments’ of interaction that I sectioned off were rather arbitrary.

Moreover, it became further complicated when I began to think about the events before the mother showed AMBIANCE behaviours. I included this in the study as I thought that by thematically understanding what types of events seemed to precede the mother showing disrupted behaviours I would be able to say more about the complete interaction. I began to look for themes in the type of ‘event’ that happened just before the mother exhibited AMBIANCE behaviours.

In the end, I decided to look at fewer but more pronounced moments where the mother showed a high frequency of disrupted behaviours. There seemed to be moments of interaction between the mother, baby and therapist where disrupted behaviours were clustered. In this way, I was able to explore the pattern of interaction between the participants in the therapy and I felt I could comment more meaningfully.

Additionally, following advice from supervision it was felt that it would be interesting if I could say something about the therapy process and whether there would be change over time in the amount of disrupted behaviour that the mother exhibited. Therefore, I decided to look at the final session and compare this to the middle sessions. In doing this, I was buoyed by the discovery that there was a change between the middle and last session. Intuitively, it was felt that this is what I would be able to conclude. However, I had not anticipated the reduction in the amount of disrupted behaviour that the mother showed would be quite as dramatic. It was a surprise that in the final session there were no significant moments of maternal disrupted communication and that the baby seemed far more settled, with the therapist required to make far fewer interventions.

## **Final Stages**

I was offered the opportunity to present my preliminary findings at a psychotherapy research conference a year later. Being able to present my findings succinctly in a

presentation format was very helpful in being able to define exactly what it was that I had been looking for and what I had found. It was clear to me however, that at this point although I had a good general idea what my findings were, they required more attention and refinement. Part of this included having them verified by an independent reliability checker.

Additionally, it highlighted to me that I needed to refine how I was coding for the therapist's interventions. This was because I had been coding all the interventions and responses according to clinical techniques as listed in the literature on parent-infant psychotherapy. The list of techniques felt too long and not adequately descriptive of what their purposes were. I therefore decided to thematically group the techniques into what was felt to be their therapeutic aim. Once this had been done, I was able to check the results with another person and it felt that a tighter description of the therapist's intervention was made possible.

The conference was also useful as well in that the feedback and questions following my presentation suggested further areas that I needed to look at. For instance, I realised that more needed to be explained about the nature of these maternal disrupted behaviours, why they were so important and the risks associated with them. Additionally, more description was needed around the case, who had been the researcher, whether there were indicators that this would have been a successful case from the beginning and to make clear that the therapist was not addressing disrupted behaviour directly but that it was responded to in the natural course of the therapeutic interaction. Overall, this helped shape the research project and to make the aims more defined.

### **Final thoughts on the impact of this research on my clinical practice**

Overall, I found this research to be extremely useful in my development and practice as a trainee child therapist. In particular, this project has drawn my attention to the subtlety of

clinical technique. For instance, whereas on first watching the video footage, the therapist's attempts to address the mother and baby's disturbance seemed effortless, with further observation and familiarity with the footage it became clear the work the therapist was doing was highly complex and multi-layered. It was impressive and an important realisation in terms of my own developing clinical skills. I was aware and could appreciate that the therapist had to juggle both the infant's needs and experiences with the mother's anxieties and insecurities, while at the same time exploring and listening to her sometimes speaking about her past and her worries for her baby's future.

Additionally, I found that using the AMBIANCE coding instrument was a very useful way of honing my skills of observation. In particular, while in the final stages of the write up of the study I was working one day a week in a Mother-Baby Unit (MBU). I had worked in an MBU previously, but I felt that having had the experience of watching a treatment of parent-infant psychotherapy unfold as well as being very familiar with the types of maternal disrupted behaviour, informed how I understood this second experience. Being familiar with the AMBIANCE coding and the behaviours listed in the categories in it made me especially aware of the mother and baby's interactions. It was quite an eye-opening experience as at the MBU where there were some very unwell mothers with psychiatric diagnoses, presenting with states of psychosis and mania. I was faced with the fact that these mothers probably could not be measurable on the AMBIANCE scales given their difficulties would be off the charts in the levels of disrupted communication. These mother's behaviours were so completely disrupted towards the infant often to the extent that the baby was no longer being looked after by them at the unit, but rather by staff. It made me wonder about how it is considered traumatic and frightening for babies to be in the presence of a caregiver who cannot meet their attachment cues and needs and the concerning prognosis for these infants.

I had one particularly poignant moment while working at the MBU involving a mother and her new-born. A senior clinician in the team had spent time over a period of several weeks encouraging this mother to interact and be sensitive towards her baby. I had observed as well that several members of the team often tried to promote the mother's ordinary interaction and care of the baby. I too had spent a lot of time talking to this mother and in moments where she was lucid she was able to describe to me her traumatic and sad history which was marked by numerous attachment losses. She had an episode of peri-natal psychosis shortly after her baby was born and she clearly could not meet, let alone acknowledge, her infant's attachment needs. This baby was looked after by multiple carers in the unit and this was having an observable impact with the baby becoming more withdrawn. The baby was taken into foster-care a few weeks after arriving at the unit. I felt a profound sadness and the need and importance for early intervention hit home. I felt aware that babies just like this one would be likely to be referred to CAMHS a few years later on in life. It seemed vital to me that further research be undertaken in this field so as to be able enhance the treatment of these difficulties as well as promoting them in the National Health Service. This experience thus cemented for me the importance of this type of research.