PARENT-INFANT PSYCHOTHERAPY WITH A CHILD SHOWING EARLY SIGNS OF AUTISM: Is improvement in the nature of internal parental representations a key factor in therapeutic change?

An in-depth qualitative study of a single case

By

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Abstract

It has been claimed that parent-infant psychotherapy improves the parent-infant relationship (Barlow et al, 2015). However, little research has been done to explore how the internal parental representations of the main caregiver is connected to improvement in a child's early signs of autism. Such symptoms can be considered in a relational context, since disturbances in the parent child relationship are known to be risk factors for infant social and emotional disorders. As early research confirms that the primary carer plays a significant role in regulating the infant's mental states, this study will draw on concepts of intergenerational transmission and investigate a possible link between the nature of the parents' internal representations and the symptoms of their child. This study will look at a single case where a child's early signs of autism have improved after a twenty session treatment of parent infant psychotherapy and concurrently explore the changes in the internal representations of her main caregivers. Based on a qualitative narrative analysis of three sets of data; from parents' interviews, process recorded notes of clinical sessions and parent infant video material, the hypothesis will be tested that improvement in internal representations is a key factor in the modification of symptoms in the child.

Keywords: parent-infant psychotherapy, early signs of autism, autism, parent-infant relationship, intergenerational transmission, internal parental representations, autistic symptoms, ghosts in the nursery, angels in the nursery, family relationships.

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CHAPTER ONE

Introduction

Autism is one of the most challenging childhood conditions, with what can be a devastating impact on family relationships. For some families, a diagnosis of autism feels like a death sentence. The long journey towards a diagnosis means that by the time the family comes for treatment the child is often beyond the age of two years, which is the optimal age for intervention, and autistic behaviours are already entrenched. However, research shows that there is hope for families to see a measure of improvement in their child's symptoms and in their family relationships if intervention is early enough (Acquarone, 2007; Schuler, 2005).

This research tells the story of a family in which there is a child who is showing early signs of autistic behaviours; and explores the impact of the child's autistic-like symptoms on family relationships. Many of the behaviours improved as a result of twenty sessions of parent-infant psychotherapy. The change in the child's symptoms appeared to be aligned with changes in other family members; especially her mother, who is her main caregiver. The nature of this alignment is the main focus of my investigations; which is to explore whether

there is a connection between the change in the child's symptoms and change in her parents' internal representations.

The rationale for focusing on both the change in representations and in symptoms stems from a concept that is central to the practice of parent-infant psychotherapy, that unresolved trauma in the parent can manifest itself as symptoms in the child (Barrows, 2003; Heimann, 1942; Hopkins, 1992; Lebovici, 1988; Manzano et al., 1999; Russo, 2014). Therefore, to improve the symptoms in parent and child a dyadic therapeutic approach, such as parent-infant psychotherapy, is required.

1.1 What is Parent-Infant Psychotherapy?

> Parent-infant psychotherapy (PIP) is a dyadic intervention that works with parent and infant together, with the aim of improving the parent-infant relationship and promoting infant attachment and optimal infant development. PIP aims to achieve this by targeting the mother's view of her infant, which may be affected by her own experiences, and linking them to her current relationship to her child, in order to improve the parent-infant relationship directly.
>
> Cochrane Review, 2015; Abstract

The practice of parent-infant psychotherapy normally assumes the presence of the child, parent(s) and therapist(s) in the setting. The main focus is the parent-infant relationship; the client is not the parent or the child, but the relationship between them. However, it is sometimes necessary to shift the focus to the primary caregiver in individual psychotherapy or to the couple relationship or the family unit as required.

The aim of parent-infant psychotherapy is 'to understand and facilitate normal communication and the development of emotions and relationships'

(Acquarone, 2004: pg.20). To achieve this most effectively with regard to autism the signs must be detected within the first two years of life. Neurodevelopment and psychoanalytic studies support the view that intervention at this early stage, while the brain is still plastic and malleable, can arrest a pathological process such as autism and the child can be reclaimed into the world of human feeling and communication (Alvarez, 1999).

The idea above that unresolved trauma in the parent can manifest as symptoms in the child, assumes that the parent was also affected by the way he or she was parented. Based on this assumption it seems logical to suggest that an understanding of the parents' relationship with their main caregivers would provide insight into the parenting of their child and possibly the nature of the child's particular symptoms. This intergenerational connection between child, parent and grandparent would further suggest that change in one would influence, or be influenced by change in another part of the constellation.

1.2 The Research Questions

Two questions can be drawn from the title of the research; the first seeks to understand what leads to change in a child's symptoms. This question is approached through an exploratory, in-depth qualitative study of a case of:

1. Parent-infant psychotherapy with a child showing early signs of autism?

The second question seeks to go deeper to examine whether a change in the child's symptoms is connected to a change parental representations, by asking;

2. Is improvement in the nature of internal parental representations a key factor in therapeutic change?

The second question focuses primarily on the nature of the mother's relationship with her internal mother, with the hope of gaining a perspective on how, or if, an improvement in parental representations has a bearing on the child's symptoms. The exploration took place over fourteen months, during which time the family received twenty sessions of parent infant psychotherapy, which incorporated systemic and individual psychotherapy.

My goal is not to write an expert paper on autism; which is a more specialist task; however, in chapter five I will speak about the child's autistic-like symptoms and behaviours in accordance with the DC:0-5 diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood. It will then be possible to view the child's symptoms within the context of the autistic spectrum.

1.3 Personal Motivation for Research

I have been preoccupied with the subject of personal change since early childhood, and have sought to be an agent of change throughout my career. Christian values and beliefs instilled by my parents and grandparents have undoubtedly contributed to my interest in the question of what leads to long-term internal change.

My early education at the Rosa Bassett Grammar School, followed the radical philosophy of the 'Dalton Plan' (Pankhurst, 2007), encouraging independence, dependability, hard work according to one's capacity and a strong sense of

social responsibility. Committed to ongoing personal change, mainly through spiritual pursuits; I undertook a first degree in theology, which fuelled my interest in social change through charitable social engagement. My preoccupation with change has influenced my career choice as a psychoanalytic parent-infant psychotherapist, which was the culmination of over 30 years of work with children, young people and families. During this time, I worked alongside my husband to set up projects that provided a secure base for isolated, troubled young people, where they could be supported to change from harmful to healthier patterns of relating. After 13 years in this field of work we became long-term professional foster carers, providing permanence for siblings, with the goal of keeping them together and supporting them to break harmful intergenerational patterns of behaviour. The challenging demands of fostering led me to train as a child and adolescent psychotherapist.

As a psychotherapist, I worked with young offenders, school refusers, families, individuals, couples and fostering and adopting families. However, my interventions always felt too late and change was slow. It was my experience of fostering Adam (not his real name), a new-born baby, straight from the hospital that convinced me of the importance of very early intervention in the infant-caregiver relationship and led me to further specialise as a parent-infant psychoanalytic psychotherapist.

Adam, was just three days old when we first met him. His mother was unable to bond with him, and left him at the hospital in the care of the nurses, who named him, met his needs for feeding, bathing and holding, and duly fell in love with him.

He was a beautiful baby and my husband and I also fell in love with him at first sight. He activated fond memories of the birth of our four children. Little did we know how different Adam's start to life was from that of our children, because he had been exposed to drugs and alcohol abuse within the womb. We had received no warning of what was to come.

At first he responded positively to the love and very attentive care of the family. However, within two weeks of taking Adam home he started to shake violently. I recalled how my mother used to swaddle my baby brother securely in a shawl when he felt unsettled, and I instinctively did the same for Adam. Taking care not to alarm the children, my husband sat quietly out of sight, folding Adam firmly and securely to his chest until the shaking subsided. This happened frequently over the next few weeks and was the effect of his mother's drug use during pregnancy.

After undergoing the traumatic experience of withdrawal Adam settled happily into our family. When he was six months old we experienced another trauma; we were informed that he would be moved to another carer because the agency urgently needed our specialist skills to take on three siblings. I was devastated to lose Adam and wondered how he would feel to be uprooted from us, his main attachment figures. Nevertheless, I facilitated his bonding with the new carer and waved him off, sobbing uncontrollably as the car pulled out of sight.

In the days that followed, I received several calls from the new carer. Adam was distressed and unable to sleep. I expect, like me, he was also grieving. The trauma of losing Adam remained with me for many years, manifesting in recurring dreams in which I had forgotten to feed or bathe a six-month-old baby

that was left in my care. The baby in my dream always seemed content but he had stopped growing and was small for his age. I would awake with feelings of anxiety and guilt that I had forgotten to care for him.

At the age of four years Adam was diagnosed with autism. I suspected that his early traumas, in and out of the womb, contributed to this diagnosis. Thankfully, his symptoms were mild and with his carer's attuned care and the benefits of a good education he has enjoyed his eighteen years of life thus far. I often wonder to what extent the trajectory of Adam's life was changed by his first six months with our family.

Even as I write about Adam's trauma I am reminded of another baby who was left behind. I was a child of the Windrush generation. My intrepid parents migrated to the United Kingdom at the tender age of 21 to build a better life for their children. I was under two years old and my late sister just a year older, when left in the care of loving maternal and paternal grandparents. My mother wept bitterly between visits to see us. Six years later we joined our parents and two siblings (and a baby on the way) in our new house in London.

I often wonder how this separation affected me and whether my unconscious motivation for this field of work is a way of nurturing that one-year-old baby within me that was left behind. And what of my parents; was their migration bid for change an attempt to 'transcend the legacies of slavery' (Fletchman Smith, 2011) and break oppressive intergenerational patterns that held them back? Indeed, I have inherited their intrepid faith and values and a belief that deep change is possible despite external symptoms.

1.4 Experience

Since qualifying as a psychoanalytic parent infant psychotherapist I have participated in numerous therapeutic treatments of families with children displaying autistic behaviours. The focus of these treatments has been on early intervention in the first two years of life, when the brain is still malleable and unhelpful patterns of behaviour can be modified before they become entrenched. Some children came with a diagnosis of autism, while others displayed early signs of autism, such as withdrawal from family, lack of eye contact, lack of speech, isolated repetitive play, no capacity to symbolise and a lack of enjoyment of relationships.

The referring professionals would sometimes locate the problem in the child, such as crying non-stop, eating and sleeping disorders, separation anxiety, etc., or within the parent, such as anxiety and depression, a feeling of being persecuted by the child or difficulty bonding with the child, etc. The most effective treatment, however, would usually entail working with the parent and child together as well as the child within the parent, who was still struggling to resolve childhood issues. The focus would be on the parent-child relationship, rather than on the individual adult or child.

Individual play based work with the child would normally result in significant changes in symptoms; however, for the change to last it was necessary for the family to also change to support the child's new and healthier ways of relating. Usually, the parents changed in their perception of the child and also in their perception of their own parents before there was a lasting shift in the child's symptoms, that could be sustained within the family system.

After starting my research, I was appointed to the role of Clinical Lead at a parent infant partnership (PIP), where professionals from all services working with infants from pregnancy to age five, collaborate to provide the infant with the best possible start in life. The focus of the PIP team is on early intervention in the first 1001 days of life: pregnancy to age two years.

The PIP is a collaboration between a local authority, a voluntary sector counselling organization and a national, umbrella organization to a network of PIPs that provide specialist psychotherapeutic services to babies and their relationships. It brings together key services including health visiting, midwifery, perinatal services, children's centers, early years and the voluntary sector, and parent-infant psychotherapy into an integrated service model.

The PIP team works with the most complex families in the borough, mainly through home visits. The sensitive nature of the work requires the exercise of caution in the use of psychodynamic tools so that vulnerable clients do not feel overly persecuted by psychoanalytic interpretations.

The practice of parent-infant psychotherapy differs from individual psychotherapy in that it draws on developmental psychology, attachment theory and observational skills, while gently modelling to the caregiver how to relate to the infant. This triadic and/or systemic way of working is a specialist skill required for working with the parent-infant relationship. Currently, there are not enough therapists that are trained to work in this way and for this reason two key aims for this research include: to provide a resource for trainee parent-infant psychotherapists and to identify replicable findings that can be generalized or transferred to other similar cases.

1.5 National Context

There is a growing evidence base regarding the effectiveness of early intervention from pregnancy to age two years. Politicians from across the political spectrum have come together to promote early intervention in the first two years of life through the 1001 Critical Days all party manifesto (Leadsom, 2013). The national organization, Parent Infant Partnership UK (PIP UK), is instrumental in the delivery of the government agenda. They achieve this by setting up and supporting specialised parent infant relationship teams across the UK with the aim of making psychotherapeutic support available to all families who are struggling to form a secure relationship with their baby. To achieve this goal, a workforce of professionals is needed, who are trained to work with the parent-infant relationship. It is my hope that this research will be a resource for trainees and professionals and will add to the growing evidence base (Leach, 2017) that early intervention in the first 1001 days is crucial for best outcomes for families.

1.6 Structure of the thesis

Chapter one gives a general context for the research, including the setting and my motivation for doing this research. In chapter two I take a brief look at the aetiology of autism and the approach of parent-infant psychotherapy as an agent of change. The assumptions and conceptual framework are also outlined in this chapter. In chapter three, the Literature Review examines the normal development in family relationships and the role of the primary caregiver in regulating the infant. The second half of the review looks at the impact of

autism on family relationships and concludes with theories of change. Chapter four outlines the method and design of the study and presents the use of the single case study approach as the best means of undertaking this research. In chapter five I introduce the family, and give a flavour of how I worked with them in the sessions, using excerpts from the sessions. Chapters six, seven and eight deal respectively with the change in symptoms, internal representations and relationships. Each chapter follows the child over the months of the intervention in order to show the progressive change in each aspect. Chapter nine describes the anxieties of the family as they approached the end of the intervention and how their anxieties were addressed. A brief account is given of the progress of the family six and twelve months after the end of the intervention. In chapter ten I discuss the qualitative and quantitative findings of the research: presenting a summary of quantitative measures that was applied at the end of the intervention. The limitations and contribution to practice are also presented, with suggestions for future research and a brief conclusion.

CHAPTER TWO

Is change possible where there are early signs of autism?

Before exploring whether an improvement in the nature of internal parental representations is a key factor in therapeutic change, we must first consider whether change in early signs of autism is possible at all.

Previous research suggests that not only is change possible through parent infant psychotherapy via many ports of entry (Stern-Bruschweiler & Stern, 1989; Dugmore, 2013) but it takes place at an extraordinary speed (Barrows, 2003). Eight common elements have been identified for successful treatment of autistic symptoms (Acquarone, 2007); six by Phillips and Schuler's (2005) review of 60 cases to see what works, and a further two common elements were identified by Massie's review of 31 cases (Edelson & Rimland, 2003).

The first element states that there should be a clear theory of how the child's mind is functioning and once the child's symptoms are resolved, the theory of mind should continue to guide the family. Also, the parents are required to display a strong sense of autonomy, efficacy, mission and sacrifice on behalf of the child. Successful treatments also require continuous engagement with the child, involving a team effort from everyone in the child's network, including parents, siblings, the extended family and key people in other settings, such as

school, nursery and play groups. There should be a drive to normalize the child and treat him or her like other children: encouraging the family to integrate the child into the community. It is also important to build on positive elements in the child's characteristics and to begin early: between the ages of six months and four years due to the plasticity of the brain within that period. Finally, the child should show some signs of normal intelligence prior to treatment.

2.1 Is There a Link Between Autistic Symptoms and the Primary Caregiver?

Historically, Kanner forged an unhelpful link between autistic symptoms in the child and a cold maternal response (Kanner, 1943; Bettelheim, 1967). Linking the parents with the symptoms of the child caused anger and guilt in parents and a suspicion of psychoanalytic techniques. Since then, it seems that progressive research in the treatment of autism has been hindered partly due to Kanner's 'refrigerator mother' idea where defects in the maternal relationship was thought to be the cause of autism. However, many variants of autism are organic or genetic, and are therefore not caused by the parents' behaviour, although the symptoms might change the parents' responses to the child.

Recent research into the field of parent-infant psychotherapy has provided more helpful ways of articulating social and emotional disorders such as autism. For example, the Cochrane Review (Barlow et al, 2015), concluded that parent infant psychotherapy is effective in improving parental and infant mental health and the parent-infant relationship by 'targeting the mother's view of her infant, which may be affected by her own experiences, and linking them

to her current relationship to her child'. The insight gained due to a treatment of parent-infant psychotherapy increases the parent's capacity to understand the meaning of the child's symptoms. Rustin (2017) states;

> Meaning in young children's behaviour and in their parents' responses is there to be found... Understanding, naming and elaborating meaning is what will be of greatest help to parents whose desire for a relationship with their child is at risk under the impact of unacknowledged intense anxieties.
>
> Rustin, 2017. pp 148–160

On the basis of this understanding the parents are better equipped to regulate the child's emotions, thereby reducing anxiety. One could argue that Barlow's view is similar to Kanner's but somehow it avoids the pain of blame because both mother and child are at the mercy of unconscious forces beyond their control.

In making the connection between present and past to correct the mother's view of her child it is necessary to engage painful emotions when severing harmful ties to past relationships and forging new and healthy bonds between parent and child as guided by the therapist. The process can feel threatening as parents and child learn new ways of relating together. However, a strong therapeutic relationship can protect the work.

2.2 Aetiology of Autism

Autism is described as 'a lifelong neurodevelopmental condition' and an impairment in the capacity to relate to others (DC:0-5; APA, 1994; WHO, 1987; NICE 2011). Wing and Gould (1979) identified three features of behaviours

typical of autism, i.e.: severe social impairment, severe communication difficulties, both verbal and non-verbal and the absence of imagination, including pretend play, with the substitution of repetitive behaviour.

The aetiology and nature of Autistic Spectrum Disorders (ASD) cannot be explained by a single theoretical approach. Research reveals neurological, cognitive and behavioural components that can be more fully understood using a pluralist approach, due to the wide range of social cognition problems in autism. Psychotherapy, both individual and parent-infant, has been useful in understanding the emotional and interpersonal aspects (Sploladore, 2013): assessing what is unique in the child's personality, including the emotional aspects, and bringing the parent child relationship under scrutiny to gain a multifactorial understanding of the aetiology (Sploladore, 2013).

The DC:0-5 diagnostic manual outlines common features of autism, such as the onset in early childhood; a delay or abnormality in functions due to biological maturation of the central nervous system; and genetic influence, i.e. normal variations in multiple genes affected by different environmental conditions and other environmental conditions such as rearing; toxins and prematurity. DC:0-5 states a belief that autism is treatable but not often curable and recommends early and intensive intervention.

The past 50 years has seen a rapid, and thus far, unexplained expansion in the application of the label of autism to childhood developmental conditions. Timimi, Gardner and McCabe (2011), dismiss the diagnostic category of autism as a myth and advocate a removal of what they term an invalid and stigmatizing label that does violence to children, discrediting the DSM definitions and NICE

guidelines as influenced by the pharmaceutical companies that fund and control them, and who, they believe, are the ones benefiting from the diagnosis.

Hobson (1993) and Trevarthen et al (1996) view autism as a disorder of intersubjectivity; a lack of a sense of other persons; while Tustin (2008) distinguishes ‘organic’ (damage to the brain) from ‘psychogenic’ (damage to the psyche) autism. Psychogenic autism is said to result from blockages and distortions in the beginnings of perception and their associated emotions. One therefore needs to understand the nature of the psychic damage in order to be of help to autistic children (Sploladore, 2013).

Reid (1999) identified a sub group of children that developed autism after a trauma in the first two years of life; autistic post traumatic developmental disorder (APTDD). Their repetitive behaviour resembled the repetitive re-experiencing of trauma seen in Post-Traumatic Stress Disorder (PTSD). Alvarez (1992), Piontelli (1987) and Liley (1972) warn ‘against simplistic, linear etiological theories of autism’; stating that neither the ‘organicist’, in the cognitivist camp who advocate biochemical and neurological causation requiring drug and behavioral treatments, nor the ‘psychodynamicist’, who blames the environment and recommends therapeutic psychotherapy have the full picture. Nowadays both groups recognize multiple causation of autism and a need to bring together expertise in a concerted approach (Bailey et al, 1996).

2.3 Aims and Research Questions

My aim in this research is to gain new insight into the question of how parent-infant psychotherapy enables change in the symptoms of a child showing early

signs of autism. I will seek to explore beyond the appearance of change, to enquire into the process of how change happens, by addressing a secondary question: For a child that shows an improvement in autistic symptoms as a result of a treatment of parent infant psychotherapy, does this correlate with an improvement in her caregivers' internal representations? To achieve these aims I will study the single case of a family with a child displaying early signs of autism over a course of 20 sessions of parent-infant psychotherapy.

2.4 Assumptions

An underlying assumption of the research question is that there is a link between the nature of the parents' internal representations and the symptoms of the child. Massie's (2007) research revealed how the appearance of symptoms, such as a lack of eye contact, isolated repetitive play, lack of social and verbal communication, etc., can activate unresolved aspects within the parents. The bewildered parents and family members seek to accommodate the symptoms by making adaptations in their responses to the child's behaviour; meanwhile, the child withdraws further and further from their reach, bringing about a shift in the family dynamic and the pattern of family relationships. Should this shift go uncorrected, the new pattern of relating becomes embedded in the family and possibly gets passed on to the next generation. This intergenerational transmission, or 'ghosts in the nursery' (Fraiberg, 1975) caused by trauma within the family, is a focus of this research. The challenge, however, is to find a way of measuring the parents' experience of their internal parents. The following theoretical concepts are useful in this task.

2.5 CONCEPTUAL FRAMEWORK

2.5.1 The Motherhood Constellation

The pregnant woman is said to give birth to three generations; the infant, herself as mother and her own mother as grandmother' (Merbaum, 1999). Engaging with the new mother's psychic world means engaging with all three generations, in both their positive and negative aspects (Abraham, 1913; Ferenzi, 1913; Jones, 1913, Rappaport, 1958; La Barre et al, 1960). Stern (1995), elaborates on the grandmother's psychic role in the mother's internal world: stating that the new mother undergoes a developmental shift characterized by a new intrapsychic organization (the motherhood constellation) of infant, mother and maternal grandmother (Merbaum, 1999).

2.5.2 The Grandmaternal Transference

Dugmore's development of Stern's (1995) concept of the 'motherhood constellation' in her paper, 'the grandmaternal transference in parent-infant/child psychotherapy' (2013), fits nicely into the theme of my research. She argues that the new mother must identify with her own mother and remain in touch with herself as a child in order to parent her child sensitively. Three key aspects of the grandmother's role are highlighted: the psychological containment of mother and child, allowing separation between mother and child and fulfilling the paternal function of negotiating a safe distance between mother and child, thus allowing the emergence of the oedipal constellation.

According to Dugmore, *'the importation of the role of grandmother into the parent-child clinical setting, via the transference, would seem likely, if not inevitable'*, even though she is physically absent. The therapist must be careful to address both a negative and too positive grandmaternal transference as they may devalue or derail the work. For the therapy to succeed, all three generations of mother, grandmother and child must be engaged with.

2.5.3 Intergenerational Adjustment of Family Relationships

This research considers the intrapsychic organization, explained above, when the parents are open to change, having undergone the process of making room for a new baby. They are also in touch with the raw and primitive emotions of infancy as their own baby needs are activated and they are inclined to respond to the needs of their infant in the same way that they were parented. Unresolved aspects of their own childhood are then played out in the relationship with the new baby.

While working with parents that bring a child for the treatment of early signs of autism, I have noticed a pattern over time; progress within the parents would usually herald a noticeable improvement in the symptoms of the child. Furthermore, the parents' view of their own parents would shift significantly over the course of the therapy. At the start of therapy some parents present an idealised view of their own parents, unable to acknowledge any negative or harmful patterns in the way they were parented. Others present a denigrated view of their parents, unable to see any good aspects of their upbringing. As a

result of therapy parents are helped to acknowledge the good and bad aspects of how they were parented and this in turn enables them to identify the harmful and helpful patterns that could impact the parenting of their child.

It therefore seems that the parental internal representations play a significant part in the way they see their child, i.e. through the eyes of their internal parents. If helped to see the child in his or her own right, the child is freed from unhelpful projections from the parents' past, in order to develop as a unique individual.

2.5.4 Internal Representations

Stern (1977) described internal representations as dynamic interpersonal moments that tumble out of memory when thinking about another person. Such moments begin at the start of the earliest attachment relationship and become well established by the age of two-and-a-half or so. Representations are easily modified during this time, which is why change in the child is so rapid if interventions are made within this window.

Change in the parents' representations takes time, however, because of the stability of the adult attachment status (Juffer, et. al.1997). While there's a change of maternal sensitivity in response to short-term treatment, change in internal representations take much longer. For this reason, the treatment took place over a period of fourteen months with a further twelve months' follow-up to enable new internal representations to become established.

CHAPTER THREE

Literature Review

In a review of the literature pertaining to my research question various theories will be presented of how change is achieved through parent infant psychotherapy and especially with regard to autism. My main findings will be considered within the context of these key theories. The review will address how normal development can be derailed in the first year of life and how the practice of psychoanalytic parent infant psychotherapy works to get development back on track. I will also explore how trauma is transmitted from the parent's past and how such transmitted trauma affects the way that the parent views and responds to their child.

3.1 Normal development of family relationships in the first year of life

One cannot separate the treatment of the child from the parents in the first two years of life because normal development starts with a merged parent-infant dyad. According to Winnicott (1987) 'A baby cannot exist alone, but is essentially part of a relationship'. Another paediatrician, Brazelton (1991), said that he could only help infants to optimal development if parents were involved.

However, apart from what the parents bring, he recognises in his study of the new-born, the powerful interaction between the 'motor, affective, automatic and cognitive systems and how they fuel one another as the infant strives to achieve each developmental task.' Infants are interactive organisms from the start; not only sensitive to their environment but active in shaping that environment.

3.2 The infant's connection with primary caregiver

The powerful, innately motivated capacities of the child (Trevarthen, Aitken, Papoudi & Robarts, 1988) are evident even before birth as the foetus responds to the mother's internal and external environment with all of his senses (Murray & Andrews, 2000). From birth, the child's personality is shaped in the context of relationships with caregivers and with the environment (Johnson, Dziurawiec, Ellis and Morton, 1991). It is crucial that the new-born baby forms an attachment (Bowlby, 1969) and attunes (Stern, 1985) with and is attuned to by caregivers because failure to bond means failure to thrive and this could even end in death (Spitz, 1952). The baby connects, communicates and expresses personality through gazing, pre speech, movement, etc. and caregivers must read and respond to his signs, and by enlarging his communication facilitate his development (Sander, 1983, 2000; Greenspan & Weider, 2006). So powerful is the connection with the caregiver that the infant becomes distressed when contact is broken (Murray and Trevarthen, 1985; Tronick, Als, Adamson, Wise and Brazelton, 1978). In this closely attuned interaction early dyadic competencies develop (Stern, 1985; Brazelton, 2000; Sander, 1983, 2000; Stern 2000); which form the foundation for more complex triadic ways of relating

that require joint attention where the child follows the gaze of another towards a third object (Trevarthen & Hubley, 1978; Winnicott, 1941). In an empirical study Striano and Rochat (1999) demonstrated that early dyadic competencies are carried over to strengthen later triadic competencies: forming a foundation for even the more complex proto-imperative (e.g., pointing or reaching) and proto-declarative behaviours where gestures are used to share the experience of an object with another (Bakeman & Adamson, 1982; Bates, Benigni, Bretherton, Camaioni & Voltera, 1979; Scaife & Bruner, 1975; cited in Alvarez & Lee, 2004) in an intentional way (Bretherton, 1991). Thus, the way is prepared for the development of language and enculturation (Carpenter, Nagell & Tomasello, 1998; Hobson, 1993, 2002 cited in Alvarez & Lee 2004), providing a context in which the child develops his personality. The quality of relationship and attunement with primary caregivers has a strong influence on the nature of the baby's developing personality.

According to Brazelton, (1991) it is important to enlist the strong positive forces that are inherent on each side of the parent-infant relationship for optimal development. The parents bring their expectations and the child brings 'reflexes, sensory capacities and states of consciousness. If the infant bonds well in the first year of life he can explore further afield, continue to enjoy relationships and develop his personality through life.

3.3 The Impact of autism on family relationships

As in normal development, the onset of signs of autism also involves a response from both sides of the parent-infant relationship. Massie's retrospective study in the 1970's of 20 home videos revealed that the onset of signs was

perceivable. From three to six months, the babies that later developed autism lost their smiles for their mothers, avoided eye contact, and did not mould to their mothers but struggled away from her. They showed no excitement when reunited with her and lacked playfulness. Their passivity seemed to turn to depression by six months and by one year the babies became impassive as symptoms set in (Massie, 2007). The families became increasingly desperate and disorganized in their helplessness as the baby slipped away, despite efforts to compensate for his or her failure to engage.

Their baby's repeated lack of response caused parents to unconsciously inhibit the cycles of communication by rushing the engagement due to the pain of rejection from the child: to adjust their behaviour according to the child's deficits and eventually to cease to expect a response (Beebe, 1982; in Acquarone, 2007). Play became frantic and intrusive in the desperation to engage the child, thereby losing the sense of timeliness, rhythm (Stern, 1977) and enjoyment.

Autism is said to reduce the personhood of the child; whose suffering is often underestimated, as is the stress and tragic limitations on normal family life (Alvarez and Reid 1999: pg.xii). The autistic child is said to lack the ability to judge the mental states of others (Hobson, 1993). His inner world is said to lack the rich three-dimensional space where experiences and phantasies are stored for the purpose of interacting with others (Alvarez and Reid 1999).

In some instances, the autistic parent-child relationship manifests as a painful state of fusion, which blocks the normal processes of psychological development, rendering the child too psychologically weak to cope with the awareness of bodily separateness (Tustin, 1992). This mutual state of fusion

suggests that in such cases, autism is not just a problem for the child but is a family problem, in which the child is kept in a place of dependency and treated as a young baby. His baby needs around food, toilet training, sleep, etc. control the family and parents feel too guilty not to succumb to his demands. If parents can be helped with the painful process of separating from the child, they can gain sufficient distance to observe him or her in a new light, which can free the child to grow independently.

3.4 What leads to change in parent-infant psychotherapy?

According to Dugmore (2013) no published research contradicts the claim that parent-infant psychotherapy leads to change but what is not clear is whether change is due to prevention (Fonagy, 1998; Pozzi, 2003) or early intervention (Barrows, 1997; England, 1997). Indeed, both come into play in that some early signs of autism can be modified in the first year of life due to the plasticity of the brain. But after symptoms become entrenched at the age of two and a half or so, an intervention is required to manage them. Research indicates that if signs are caught early, parents can be helped to respond to their infant's social deficits; the baby's development can be stabilized and symptoms prevented from crystallizing in the second and third years of life (Acquarone, 2007).

3.5 Neuroscience

The neuroplasticity of the brain in the early years is also key in the treatment of autism through parent-infant psychotherapy (Acquaone, 2004; Baradon et al.,

2005; Pozzi, 2003). On this is based the belief that any child can learn and improve in their development. The work with the autistic child is driven by this idea that the brain is malleable and can change itself, to an extent, in response to stimulation (Diodge, 2007). Writers such as Gehrhardt (2004) and Stroh (2008) have made these concepts accessible to parents and clinicians.

3.6 Theories of Change

There are very few highly effective treatments for children with autism, however, those that achieve a degree of success seem to portray many of the characteristics highlighted in the theories below.

For change to occur it is not enough to work with the child's symptoms alone. Paul Barrows (2003) describes three main areas that can be addressed in seeking to bring about change in parent-infant work: the parents' mental state, the infant's mental state and the relationship between parent and infant. Research has shown that it is not enough to focus on just one area. If the focus is on changing the parents, the baby cannot wait (Fonagy, 1993; Thomson-Salo et al., 1999) and there is no guarantee there would be an impact on the baby (Juffer, Van Ijzendoorn, & Bakermans-Kranenburg, 1997). Direct work with the baby (Thomson-Salo et al., 1999; Norman, 2001) does not guarantee change in the parent's mental state, and such change does not guarantee change in the baby or the parent-infant relationship (Barrows, 2003). Barrows quotes Hopkins (1992) who recommends that the symptoms in the infant can be best treated by treating the parent-infant relationship.

The theme of this research is closer to the representational model of parent-infant psychotherapy practiced in Europe (Cramer & Palacio Espasa, 1993 &

2004; Cramer & Stern, 1988, in Pozzi-Monzo & Tydeman, 2005), which focuses on the mother's internal representations and how these affect the mother-infant relationship. This approach is similar to the work of Selma Fraiberg, particularly her method of working long term with very disturbed children and her insight into the impact of intergenerational transmission. Key to this study is her seminal paper, 'Ghosts in the Nursery' (Fraiberg, 1975) which states that parents bring to the task of parenting, their own experience of having been parented: their resolved and unresolved conflicts, which become activated when they parent their own children (Manzano et al., 1999). Like 'Ghosts in the Nursery' and unconscious 'wild things' (Fraiberg, 1975; Raphael-Leff, 1989), these conflicts invade the parent-infant relationship and negatively impact feeding, toilet training, discipline, etc., by influencing the way parents interpret their child's behaviour. As parents gain insight within the therapeutic relationship they are able to free the child from their unconscious projections.

Lebovici reasons in a similar vein that due to childhood trauma, the parents may relate to a Fantasmatic child (Lebovici, 1988), which is the unconscious construction built up in the parents' minds, as a result of the parents' conflicts with their own parents. The parents may also relate to an imaginary child, covered with the parents' expectations, which the child might not live up to. In such ways values that have been stated or hidden can be transmitted from generation to generation. It is this close connection between parents and child that lies at the heart of intergenerational adjustment and provides a key to understanding how the symptoms of the child can be modified by the parents' growing awareness and understanding of their inner parents and the intergenerational dynamics that exists in the family (Acquarone, 2004).

Paula Heimann (1942) speaks of such symptoms as ‘foreign bodies’ which are the parents’ narcissistic projections (ghosts): unassimilated parts of the ego: projections for which the newborn baby is a prime target. To end the transgenerational cycle of transmission the object must be assimilated before it becomes established in the infant’s psyche. Projections that have been withdrawn can emerge in the parents’ relationship which is why parent-infant work usually unveils difficulties in the relationship. For this reason, it is important to work with the family unit even though this is a more complex way of working and change can be slow.

The foreign body can also be projected onto the therapist, who is then able to link it with the parents’ childhood experiences, thus disconnecting the past from the present (Hopkins, 1992; Britton, 1989) and withdrawing unhelpful projections from the child.

Britton explains how the therapist is able to support change in the parent-infant relationship by taking a third position from which to observe object relations. This cultivates a capacity for reflective self-functioning in the parents. Fonagy (1993) sees the capacity in the parent of ‘reflective self-function’ to be a key ingredient that contributes to change in the child (Barrows, 2003).

A useful idea for this research is seen in Teresa Russo’s (2014) paper on twins, which presents an interesting perspective on the transformation of symptoms in the child. She suggests that traumatic experiences can solidify into physical symptoms, as in the case of Jane, a depressed mother and Helen, her two-year-old daughter who presented with symptoms of constipation, sleeping difficulties, clinginess and separation anxiety. Russo demonstrates how tough,

sticky symptoms can become fluid as the child is helped by the clinician to play out her difficult experience. The mother is also helped to become unstuck because in many cases that come to treatment the parents' capacity to play and enjoy the child has been eroded by the trauma of coping with his presenting symptoms. By observing the clinician, the parents learn to play again.

Manzano (1999) presents another perspective on this process of transforming symptoms in a paper on narcissism in parenthood where he states that the first object of the child's libidinal drives is the mother (Freud, 1909). The child is said to be the mother's love object, and a representation of herself. Parents see and love themselves in their child (Freud, 1914): putting their own ego ideal on the child. The child identifies with this, making it his own ideal, which he will in turn project onto his own children. This is the root of intergenerational transmission. Whatever is projected onto and into the child includes a self-representation; hence narcissistic. The shadow of the parents has fallen onto the child resulting in a relationship between self and self.

The parents' past trauma can also determine how they relate to their children, and can give rise to symptoms such as sleep disorders. For instance, the loss of a significant person from the past might manifest in the parent waking the baby frequently to check if he's alive.

Main (1988) explains that parents are less likely to repeat the mistakes of the previous generation if they can acknowledge those mistakes in their own parents. This process of helping parents to see their own parents clearly can feel quite threatening, requiring sensitivity and patience from the therapist. However, a strong therapeutic alliance can create a safe space for the parents

to verbalise their true feelings, thereby removing their projections from the child and reconnecting them to the past where they belong.

And finally, according to Cramer and Stern (1988), change can come through containment; when the family knows that they are listened to, the therapist is experienced as a benign parent.

The above concepts portray some of the characteristics necessary for the effective treatment of autistic symptoms and influence the work with the child. Many parents do not know how to play so a wide range of activities are introduced to parent and child within the sessions, such as sorting, stacking, placing objects, matching and engaging in new activities that will activate all areas of the brain. When parents see the capacities of their child as s/he responds to the therapist they feel emboldened to do the same with the child. In this way the child and the parents change in the way they relate together.

I will also mention Norman (2001) and Thomson-Salo (2002), due to the primacy that they give to the infant: directly addressing the baby in the session, with the aim of activating and containing his anxieties in the here-and-now of the infant-mother relationship. Though Norman was strongly criticized for using verbal interpretations to a non-verbal infant (Flink, 2001), Salomonsson (2007) identifies with his approach of speaking directly on behalf of the infant. Giving the baby a voice in the presence of the parents, can enable them to understand issues from their baby's point of view. However, this must be done in a sensitive and inclusive way so as not to overwhelm the parent with primitive feelings of envy and exclusion. The use of 'motherese' (a rhythmic, high

pitched way of speaking that is more engaging for infants) on such occasions can embrace and contain the child and the parent together.

Speaking directly to the baby is also demonstrated in Robin Wilson's paper (2014): talking with infants; this speaks of the hope that the clinician can bring to the baby as he is helped to understand the world through different eyes. The available outsider, in the person of the parent-infant therapist can be available to the infant in a way that the parents cannot be, owing to their own distress. Wilson demonstrates through two case studies that the infant understands far more than the parents imagine and is able to make use of the outsider to help her to be seen by her mother.

The above literature review supports the idea that change is possible through parent-infant psychotherapy. The following chapter outlines a method of enquiry used to explore the different aspects of the research questions.

CHAPTER FOUR

Methodology

In the previous chapters we saw how a diagnosis of autism can have a serious detrimental impact on family relationships, and how parent-infant psychotherapy can be useful in modifying symptoms in the child due to its regulatory effect on the parent-infant relationship. Based on the theoretical concepts of 'the motherhood constellation' (Stern, **1995)** and 'the grandmaternal transference (Dugmore, 2013) we also explored a possible link between the child's symptoms and his or her internal parental representations (Massie, 2007), and wondered whether a change in the child's symptoms might correlate with an improvement in the caregivers' internal representations? In reviewing the literature, we saw that improvement in early symptoms of autism is indeed possible and several theories of change were presented. Guided by these theories, this chapter will propose a methodology that will enable us to explore the above problem by addressing two questions.

1. The first question is exploratory in nature, which is an in-depth qualitative study of a single case of parent-infant psychotherapy with a child showing early signs of autism.

The aim of this in-depth exploration is to later develop analytic generalizability.

The second question also explores the assumed link between the nature of the parents' internal representations and the symptoms of the child, by asking;

2. Is an improvement in the nature of internal parental representations a key factor in therapeutic change?

These two aspects of the research problem require different approaches, and a methodology that is able to address both aspects. However, before identifying a methodology I will clarify the philosophical underpinnings of my study; this will help in identifying the best methodology for this study.

4.1 Epistemological Position and Approach

An epistemological framework is the philosophy of knowledge that underlies any form of research; the framework influences how the researcher perceives and interprets the clinical material. Various frameworks are available, so it is important to assign a framework deliberately to one's research rather than to inherit one by default (Van de Ven, 2007). According to Giannoni (2003),

> In any epistemological framework, reliability, and quality of inferences and constructs require an explicit description of how the empirical material was collected and all the operations performed in relation with the empirical material.
>
> Giannoni (2003), 48:643-658

Research methodologies usually sub-divide into quantitative and qualitative approaches. The choice of one method over the other is dependent on the question of ontology: how one views reality, and epistemology: the theory of knowledge that informs the research (Tul, 2010). One's ontological and epistemological positions inform the choice of research questions and

methodological approach used. Together, these elements: ontology, epistemology, methodological strategy and specific methods used to manage data, comprise the researcher's research paradigm.

Quantitative research usually adopts a positivist paradigm, also called the scientific paradigm, which utilizes a fixed quantitative design that is focused on describing, predicting, verifying and identifying how causes relate to outcomes. Methods and instruments used include questionnaires, tests and statistical analysis within controlled settings. Qualitative research usually adopts an interpretivist paradigm and utilizes a flexible design to explore, discover, interpret and understand phenomena. The interpretivist position considers subjective meanings and non-quantifiable data as knowledge. The methods and instruments used include interviews, observations, focus group discussions and non-numerical analysis (Tul, 2010).

My research questions incorporate both qualitative and quantitative data and therefore does not fit neatly into either positivist or interpretivist frameworks. I have therefore chosen 'critical realism' as a philosophical position because it situates itself as an alternative paradigm to the positivist and interpretative positions. It does not reject interpretivism or positivism but combines explanation and interpretation: adopting a reflexive philosophical stance based on ontological realism, epistemic relativism, judgmental rationality and cautious ethical naturalism (Archer, Et Al, 2016). Ontological realism asserts that much of reality exists and operates independently of our awareness and knowledge and does not always answer to empirical surveying and hermeneutical examination. A toolbox of appropriate resources is required that is sensitive to the nature of things in the social world. Knowledge about reality is usually

context dependent, requiring a thick, robust account of phenomena. Epistemic relativism accepts our limitations and fallibility, despite our commitment to truth. Judgmental rationality holds that it is possible to make claims about reality that are relatively justified, while still being historical, contingent and changing (Archer, Et Al, 2016). Cautious ethical naturalism asserts that "facts and values are not insulated from one another…facts are "value-laden" (thick descriptions) and values are "fact-laden" (possess a factual element).

Several leading psychoanalysts have adopted a similar philosophical position such as Giannoni (2003), who proposed an epistemological perspective for psychoanalytic research that allows for both quantitative and qualitative data: integrating the hermeneutical approach with modern empirical research. He calls this the 'scientific-hermeneutic' approach and suggests that this adjective expresses the complexity of human nature which is both body and mind together. Bowlby similarly claimed that 'under the label of psychoanalysis, it is obvious that two complementary disciplines are struggling to coexist and expand': the scientific natural one and the historic (Bowlby 1988, p. 71). These views are supported by Hinshelwood (2013) who sees psychoanalysis as a science of the unconscious, bringing together 'causal-description' and 'hermeneutic-understanding'. Freud also holds to a similar position: considering his subjective psychoanalytic case studies to be valid research data, and viewing psychoanalysis as a 'para-science' that is as rigorous as natural science: addressing the subjectivity of meaning (Hinshelwood, 2013). Critical realism is a useful methodological stance to adopt when undertaking single case study research due to its reflexive approach.

4.2 Reflexivity

Due to the subjective nature of psychoanalytic qualitative research, which involves active engagement with the data, reflexivity is crucial to ensure transparent interpretation. Finlay and Gough (2003) state that subjectivity in research is unavoidable, but using reflexivity… subjectivity can be transformed from problem to opportunity, allowing researchers to 'come clean' about what has impinged on the research process … thereby increasing its integrity and trustworthiness'. The researcher is required to demonstrate that data has not been contaminated during the process of interpretation by showing evidence of careful reflection on the professional and personal investments s/he may have on the research outcomes. Maso (2003) states that;

> Researchers bring with them their own emotions, intuitions, experiences, meanings, values, commitments, presuppositions, prejudices and personal agendas, their position as researchers and their spontaneous or unconscious reactions to subjects and events in the field.
>
> Maso, I (2003) in Finlay, L & Gough, B (2003) pg. 40

Researchers no longer question the need for reflexivity, the question is, how to 'do' it (Maso, 2003). It is important that reflexivity is practiced at every level of the research process, from formulating the question through to the data analysis. The researcher must know what motivated the question, what beliefs are behind it and what conceptual framework it expresses, and must be eager to know the answer.

Reflexivity is integral to psychoanalytic psychotherapy and is used as introspection in the use of transference and countertransference (Finlay & Gough, 2003). This involves thinking about the feelings and unanticipated

thoughts that arise within the session and using such thoughts and feelings as a source of insight into the client's situation. Reflexivity can also be used as intersubjective reflection (Finlay & Gough, 2003), which involves using one's subjective feelings along with theory to probe the participant's account or to make interpretations.

Researching close to one's clinical practice, as in this study, requires an even greater level of transparency and reflexivity. In one sense, the nature of psychoanalytic practice already assumes this. Froggett & Briggs (2012), states; '…if psychoanalytic forms of attention and interpretation are brought to bear on the research object, a subtle intertwining of near and distant perspectives becomes possible'. Therefore, distance and objectivity is required to produce good research. In this study I have endeavored to adopt a reflexive psychoanalytic stance throughout the research process, not only in the collection and analysis of data but also in the selection of tools and measures. The main goal here was to be as unobtrusive as possible so as not to interfere with the flow and integrity of therapy. The use of video provided multiple levels of reflection in the transcribing, revisiting, coding and the selection of vignettes: allowing me to achieve 'nearness and distance' by "mentally stepping back to survey the whole in a mind's eye" (Froggett & Briggs, 2012). In writing the case study I analyzed as I went along in order to reflect my thoughts and feelings at every stage in response to the client's material.

4.3 Research Methods

In order to address the two aspects of the research questions a combination of approaches was used: firstly, a qualitative single case study, to which was

applied the narrative psychology method to bring order to the copious amount of data and enable me to access internal representations. Secondly, the application of quantitative measures, which allowed me to measure the child's symptoms and the quality of the parent-infant relationship at the start and end of the intervention. In this section I will explain the work that each of the methods used contributed to the study.

4.3.1 The Single Case Study

As stated above, using a single case study approach facilitated an in-depth exploration of one case, with the aim of developing analytic generalizability. As a research instrument, the narrative case study is said to be good for the in-depth study of social and clinical problems, to understand stages or phases in processes and to investigate a phenomenon within its environmental context (Gilgun, 1994; Spence,1993). The case study method is described as "the only possible way of obtaining the granite blocks of data on which to build a science of human nature" (Murray, 1955, p. 15). Selma Fraiberg (1975), used a case study to lay a foundation for the practice of parent-infant psychotherapy.

Some scholars are resistant to the use of the single case study as a means of scientific enquiry (Gerring, 2004); however, I am guided by experts in this approach who feel that in such a project as mine, the case study approach is most appropriate (Yin, 2014; McLoed, 2002). My study is conducted in a real life setting, within the context of my clinical practice; where the favoured way of learning is to discuss cases on a weekly basis; this provides 'Context-dependent knowledge and experience' (Flyvbjerg, 2006). My aim is that the outcomes of my study will have relevance for my ongoing clinical work and that

the lessons learned will inform the clinical practice of my team when approaching similar cases.

I am nevertheless aware that this approach is considered by some to be unscientific (Gerring, 2004). In his 2006 paper, Flyvbjerg addresses the following ‘Five Misunderstandings About Case-Study Research’;

(a) Theoretical knowledge is more valuable than practical knowledge;

(b) One cannot generalize from a single case, therefore, the single-case study cannot contribute to scientific development;

(c) The case study is most useful for generating hypotheses, whereas other methods are more suitable for hypothesis testing and theory building

(d) The case study contains a bias toward verification and

(e) It is often difficult to summarize specific case studies.

Flyvbjerg concluded that even though the case study is a “detailed examination of a single example, nevertheless it can provide reliable information about the broader class.”

The case study method is said to be ideal for an in depth exploration of complex issues such as changes in internal states and symptoms. Rolls (2005) makes a case for the use of case studies to ‘bring psychology to life’, enabling the scientist to ‘investigate avenues of the mind and behaviour that are not ordinarily available’. He believes that the case study allows the researcher to examine an individual in much greater depth than experimental methods of investigation (Rolls, 2005, pg. 2) and lends itself to qualitative research.

A criticism of case studies is that they are subjective; however, the use of reflexivity, as mentioned in the section above, allows the story of the individual to be heard, as well as the voice of the author. This age old method is the tool of historians and the basis of historical and spiritual writings, such as the parables of Jesus; which conveys contextual knowledge from generation to generation, using stories about everyday life.

Allison and Kelikow (1999) emphasize the importance of choosing a significant and special case. If such a case can be placed in the right theoretical framework, this boosts the contribution of the case study and also guides the data collection. According to Flyvbjerg (2006);

> 'Common to all experts, … is that they operate on the basis of intimate knowledge of several thousand concrete cases in their areas of expertise.' … 'It is only because of experience with cases that one can at all move from being a beginner to being an expert.' … 'The highest levels in the learning process, that is, virtuosity and true expertise, are reached only via a person's own experiences as practitioner of the relevant skills'. Therefore, 'If researchers wish to develop their own skills to a high level, then concrete, context-dependent experience is just as central for them as to professionals learning any other specific skills.'
>
> Flyvbjerg, 2006, pp 219-245

In a review of my research proposal Dr Jochem Willemsen (2017) addressed the much over-used criticism that findings from a case study are not generalizable: by making a distinction between statistical generalization, which draws on large numbers, and analytic generalization (Yin, 2014), which 'consists of a carefully posed theoretical statement, theory, or theoretical proposition', as seen in this study.

4.3.2 The Narrative Psychology Approach

I applied the principles of narrative psychology to the case material, to bring order to the copious data and to explore its meaning. This is an interpretative methodology that attempts to understand phenomena through the meanings that people assign to them (Orlikowski and Baroudi, 1991). It accepts that the researcher cannot be detached from his/her own presuppositions and beliefs. This methodology is useful for looking at change processes over time, for understanding people's meanings and developing new theories, drawing on natural rather than artificial data (Dudovskiy, 2018). It allows the researcher to present the unfolding story of the case and make sense of the data and the total experience of the actors, and also to make sense of the researcher's experience and role in the research (Holliday 2007: 122).

Byatt (2000:21), states that "Narrative lies at the heart of being human and pervades our everyday lives". It is more than a sequence of events; the events are made into a story by the narrator. Nor is it just a way of seeing the world but is a construction of the world; a change in narrative is evidence of a change in the way the narrator views and constructs the world (Murray, 2003).

According to Murray (1999) and Sarbin (1986), we are born into a storied world and we live our lives through the creation and exchange of narratives (an organized interpretation of a sequence of events). A narrative has three basic components; a beginning, a middle and an end. Its primary function is to bring order to disorder. The narrator tries to organize the disorganized and to give it meaning. This can be compared to the goals of psychotherapy, which can be seen as a process of re-storying as the subject gains increasing insight into the

meaning of his or her own story. The script is rewritten many times during the process of growth and healing that results from the therapeutic intervention.

Gergen & Gergen (1986), identifies three structures that organize many narratives; the progressive, which is movement towards a goal; the regressive, which is negative movement away from the goal and the stable, where there is little change. This is a useful analytic tool when applied in a flexible manner (not in a schematic way); especially within the context of the therapeutic intervention, where the narrator is helped to consider other versions of the narrative. Change is conveyed in the subtle shifts in the narrative as the narrator gains insight. For instance, a tragic story can be re-interpreted, and regression can be overcome, or a redefinition of goals can mark a 'turning point', where the narrator begins to see the world in a different way. Unlike other forms of qualitative analysis, the story is not broken down into themes. The researcher is not passive but brings assumptions, beliefs and different theoretical frameworks to help make sense of the story. Like tossing a stone into a pond, an appropriate theory will spread its ripples throughout the narrative account, revealing features that had been neglected by another theory (Hollway & Jefferson, 2000). The analyst 'plays' with the account in the light of the theoretical assumptions, which can be woven throughout the telling and interpretation of the story.

4.4 Generation of Data

The data for this study was generated from several sources, in the process of my 'work as usual'. Quantitative and qualitative data is routinely collected from every family that receives a service.

The data used for this research was encapsulated in:

- The referral form, which includes a risk factor analysis.
- The Ages and Stages Questionnaire - Social and Emotional (ASQ:SE)
- Hospital Anxiety and Depression Scale (HADS) score sheets
- Parent Infant Relationship-Global Assessment Scale (PIR-GAS)
- The Levels of Affective Functioning (LOAF) - Relationship Specific Disorders of Infancy scale
- Keys to Interactive Parenting Scale (KIPS) score sheets
- Parent Evaluation Feedback taken at the end of treatment and at the six-month follow up interview
- Transcribed video recordings of parent infant sessions
- Process-reports written after each clinical session

4.4.1 Tools and Measures

The research question is complex and multifaceted, requiring the combination of several research tools to fully explore. I have used tools to measure the quality of family relationships that are attested to be reliable, and non-intrusive, and are already embedded within my clinical practice.

1. *Risk Factor Analysis* – This is part of the referral form that is completed by the referrer and parent(s) together when they request a service; It profiles the negative issues in the parents' lives that are known to have a harmful effect on the caregiving relationship. It is later updated by the

therapist as the work progresses. A high level of risk is associated with severely compromised development in all areas.

2. *The Ages and Stages Questionnaire – Social Emotional (ASQ: SE2)* – focuses on social and emotional development and can be used from age two months. It produces a score that can be compared to a benchmark cut-off score for each age. As referrals are taken on the basis of high risk, this measure can be used to demonstrate whether the infant has attained, or remained on, the normal pathway of social and emotional development.

3. *The Hospital Anxiety and Depression Scale (HADS)* - This carries 7 questions each for anxiety and depression, to enable early identification of both difficulties. A decrease in scores is an improvement in functioning, and implies more space in the caregiver's mind for the baby.

4. *The Parent Infant Relationship Global Assessment Scale (PIR-GAS)* - is used to describe the strengths of a relationship as well as the severity of a disorder. Relationship difficulties are assessed based on the intensity, frequency, and duration of maladaptive interactions.

5. *Levels of Adaptive Functioning (LOAF)* - The DC:0-5 Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood manual introduced this measure to take the place of PIRGAS to ascertain whether there was a relationship specific disorder of infancy in early childhood. The LOAF measure also assesses the Dimensions of Caregiving, including the caregiving environment as well as the child's contributions to the caregiving

relationship. There are four levels of adaptive functioning, with level one being well-adapted and good enough relationships and level four describing disordered and dangerous relationships.

6. *The Keys to Interactive Parenting Scale (KIPS).* - This is video based and evaluates 12 different aspects of parenting behavior from analyzing about 15 minutes of interaction. This is only used if being filmed is acceptable to the parent. KIPS can be used from 2 months; it concentrates on actual parenting behavior and does not specifically look for psychological problems in the parent or compromised social and emotional development in the child. The scores on the 12 scales are recorded to provide a quick profile for tracking progress during treatment as well as pinpointing existing strengths and areas for improvement. An increase in mean score predicts higher quality parenting and better child social behavior as a toddler.

7. *A final parent-completed evaluation.* - This has space for free text so that a record can be kept of the parents' stories, but also asks questions that can be scored. PIP teams generally ask the same questions (with a change of tense) after about six sessions in the treatment phase.

4.5 Internal Representations

The most challenging part of the methodology was finding a way to access internal representations. There were four stages to this process as follows;

1. *Source of Data* – The qualitative data generated from transcribed video recordings and the processed notes of the sessions that were not video

recorded were the main source of information from which to infer internal representations.

2. *Organizing the Data* – Using the NVivo data analysis software the data was organized chronologically according to categories as follows:

    a. Child age 12 to 16 months – this phase included assessment

    b. Child age 17 to 20 months

    c. Child age 21 to 26 months

    d. Follow up - Child age 30 and 36 months

Within these categories the data was coded according to themes as follows;

    a. Child's symptoms

    b. Mother's response to child

    c. Father's involvement

    d. Internal representations (conscious and unconscious information about internal object relations, dreams, free association, symbolization (tattoos), interpretations in therapy sessions

    e. Transference and countertransference feelings

    f. Observed changes in family relationships

3. *Applying narrative psychology* – Using narrative psychology guidelines, the material was further organized into a story with a beginning, middle and ending, as narrated by the parents. I then noted the progressions, regressions and stable periods and compared the changes within each

category. The theoretical framework outlined in section 2.5 guided this process, i.e. ‘ghosts in the nursery’, ‘the motherhood constellation’ and ‘the grandmaternal transference’.

4.5.1 Inferring Internal Representations

The narrative psychology methodology is quite useful here as it allowed me to notice the subtle changes in the narrator’s story: how it was interpreted and re-interpreted and the memories provoked, thus conveying the nature of internal object relations. Mother was an eloquent narrator and provided a rich narrative from which to infer her internal representations.

I was able to link the changes in the child’s development to the changes in mother’s perception of her internal mother chronologically due to the thematic arrangement of the data. This was distinguished from the changes in the child’s relationship with her actual grandmother.

Mother’s free associations during the therapeutic sessions provided another way to get in touch with unconscious material, such as memories about an elderly imaginary mother figure. Also, mother’s concrete acting out of her inner struggles and the narrative around them, using tattoos about her mother, symbolized the struggles in her internal world. These gave insight into her relationship with her internal mother.

Throughout the intervention, the countertransference feelings invoked by the therapeutic material gave an indication of the quality of the grand maternal transference, which could then be explored in the session. I was also able to

meet and converse with the maternal grandmother on two occasions, and to observe the quality of the real mother-daughter relationship.

I utilised the main tools of psychoanalytic parent-infant psychotherapy: observation of the parent-infant relationship, noticing the quality of the transference and countertransference material, and interpretation of the clinical material based on the theories outlined in the literature review. The mother's words, including body language, were video recorded, and used verbatim to corroborate my interpretations. Excerpts from the transcribed video recorded sessions form a substantial part of my report. The transference and countertransference feelings engendered during the session provided a means of experiencing the client's usual pattern of relating to significant others. The therapist is usually cast into the role of 'mother' or significant other and made to feel what it is like to be in those roles. This is felt to be a useful way of gauging the intensity of the relationship with the client's internal parents. I have sought to preserve much of the rich observational material produced during the routine practice of psychoanalytic parent-infant psychotherapy.

4.6 Selection of Family

Step 1: Selection of Participant Family

The criteria for inclusion in the study was that;

- the screening tools revealed early signs of autistic behaviours, such as lack of eye contact, repetitive play, lack of social interaction (speech and play) and other signs of autism as stated in the DC:0-5 manual.

- The child achieved a score of 100+ on the Ages and Stages Social Emotional screening tool at the first screening.
- The child was under two years of age at the start of treatment.
- The family had maintained regular attendance for treatment and had completed at least 20 sessions of parent-infant psychotherapy.
- All relevant routine measures had been applied throughout treatment.

Step 2: Invitation to Participate in the Research

The first family to achieve the above criteria in the pilot year of the project was contacted six months after completion of the intervention to arrange a routine follow-up review. After the review I informed mother, who was the main caregiver, about the research and she agreed to participate.

Step 3: Obtaining Informed Consent

To ensure that mother understood the purpose of the research, including the benefits risks and burdens of participation and had access to all the information needed to make a free choice, an information sheet (Appendix 1) was given to her to keep, thus ensuring that she was able to retain the information long enough to make an effective decision. She was then required to complete the participant consent form (Appendix 2). I explained to mother that she could withdraw consent at any time.

Step 4: What if the family refused consent?

Should the family have refused consent, data already collected with consent would have been retained for educational purposes in line with the organisation's data protection policies, but no further data would have been

collected nor any other research procedures carried out in relation to the family. I would then have approached the next family that fulfilled the criteria for involvement, according to the date that treatment started.

Step 5: Withdrawing Consent

The participant family was informed about their right to withdraw from the study at any time. Their data would be removed from the study and deleted.

Step 6: Exclusion

The criteria for exclusion from this research was; that the family failed to complete the treatment; the infant was above the age of two years at the point of referral to the service; the parent presented with signs of psychosis or that the infant did not show early signs of autism.

4.7 Risks, Burdens and Benefits

To the best of my knowledge, participation in this research did not give rise to added risks or burdens during the actual intervention, nor negatively impact the treatment received by the participant family as they were asked to participate after their treatment had been completed. Every effort was made to minimize risk related to the confidentiality of data by ensuring that no patient identifiers were entered onto written material and all such material was anonymised. The participant family could also have felt anxious about the confidentiality of video recordings of the sessions. This risk was minimised by drawing the participants' attention to the content of their signed video consent form which gave assurance that videos would be returned to the family or destroyed after the study, unless permission was given to use them for teaching purposes. The

family could also have felt anxious about the publication of findings. This anxiety was reduced by assuring the family that all published material would be available for them to scrutinize.

Regarding matters of confidentiality; there is strict adherence to the Caldicott Principles, which provides an ethical framework regarding the use of identifiable data. Written consent was obtained from the head of the organization hosting the research, regarding the use of data, and the undertaking of research within the boundaries of ethical practice: including the recording and storage of clinical data and the disposal of such at the end of treatment. This arrangement was monitored at monthly supervision with the Chief Executive Officer.

The risks to me as researcher were minimal; i.e. possibly being affected by the trauma of the client; however regular supervision was a protective factor.

The family felt that they had benefited from participation by making a contribution to the practice of parent-infant psychotherapy and also that the suffering of their family was not in vain. Hopefully the assurances of the participant information form will reassure them that every attempt had been made to thickly disguise the material and protect them from undue exposure.

4.8 Analysis of Data

The processed notes and transcribed video recordings used for this research underwent several levels of analysis before the study. The practice of parent-infant psychoanalytic psychotherapy assumes the continuous analysis of the therapeutic material, reflecting on transference and countertransference feelings and the rich observational material on which interpretations are based.

After each therapeutic session processed notes are written, the writing of which requires even further careful analysis and reflection on transference and countertransference feelings engendered by the material. The material is further analysed at peer and individual supervision.

Analysis also occurred throughout the research process in the coding of the data, using NVivo 10 data analysis software to organize the material chronologically according to themes. To these themes was applied the principles of narrative psychology to write the narrator's story; this required reflexivity and an analytical stance to ensure that the broader literary framework rippled throughout all phases, and made more explicit in the final discussion. My reflections and analytic perspectives were interwoven throughout.

The quantitative data tools were applied and the results analysed at the start of the intervention, which revealed the severity of the child's symptoms and informed the direction of the therapy. The results of this analysis also formed the basis for the interpretation of the end measures, the aim of which was to reveal the distance travelled as a result of the intervention.

In the final analysis and discussion chapter at the end of the thesis I revisit the research question to consider the work that each method contributed to the outcomes. The theories presented in the literature review were revisited and any new themes that arose as a result of my in depth exploration of the case discussed, including any new hypotheses that were generated. At that stage I discuss the internal and external validity and authenticity of my research: to what extent it is credible, trustworthy, generalizable and replicable.

The latter stage of analysis determined the usefulness of my findings to the therapeutic community and to the training of parent-infant psychotherapists and also revealed further gaps in knowledge that requires further research.

4.9 Ethical Approval

This study has been reviewed and approved by the University of Essex and by the East of England – Essex Research Ethics Committee to ensure that the rights, safety, dignity and well-being of everyone that takes part in this study are protected.

CHAPTER FIVE
The Family and their Relationships

5.1 The Family

Mandy was referred to the parent-infant partnership (PIP) service by the perinatal services. She was described on the referral form as a mother of three daughters in her early thirties; who was well known to the Mental Health Services, with a diagnosis of Emotionally Unstable Personality Disorder (EUPD). There was also a history of child sexual abuse; the perpetrator being her step-father. This was unresolved and still brought a lot of mixed emotions in Mandy in the form of anger, depression, anxiety and self-harm behaviours.

Despite all this, Mandy was said by referrer to be a loving mother of her three daughters, but sometimes all these emotions had an impact on her ability to relate to her family. At the time of referral, she was stable in her mental health; nevertheless, there was concern that the children witnessed all of Mandy's emotions. Along with the focus on the parent-infant relationship, the referrer requested that the PIP service should focus on giving the family a good understanding of Mandy's childhood history and also the right skills and tools in communicating and relating to one another.

One-year-old Lucy, the referred child, is the youngest of Mandy's three daughters. Mandy and her mother were both worried that Lucy was displaying signs of autism like her sister Imogen, who has a diagnosis of autism. She *'does things that's not right' they echoed*. *'When prevented from doing what she wants she throws herself on the floor – that's not normal. She's angry like a 2-year-old – she throws herself back in a tantrum as if you've smacked her*'. ... *'it's very hard to soothe her when she's angry; she has to be given her blanket, her dummy and be held by me all at the same time. … Most people who have met Lucy have noticed her aggressive, harmful behaviour.' and that she's slower than children her age'. 'She does not allow her sisters to touch Mandy'. 'She has developed habits, such as head-butting the sofa really hard, constantly and repetitively. She would lean forward and put her forehead on the floor for ages without moving...' 'She becomes hysterical with sudden noises, just like her sister Imogen.'*

Lucy's father was in his early twenties. It was his desire to have a baby and he was very involved with Lucy's care. At Lucy's birth, he wore a white T Shirt so he could get her imprint on his chest, but sadly the midwife cleaned her up before handing her to him. He is still disappointed. Like Mandy, he experienced a very challenging childhood and was carer for his autistic brother. Throughout the fifteen-month intervention I observed him to be a sensitive, caring father; determined to give Lucy a better life than he had as a child.

Lucy and her siblings have different fathers. Harriet, her eldest sibling was 10 years old and lived with her father during the week and with Mandy and the girls at weekends and during holidays. Harriet was said to be '*very clever and*

so good – she comes top in everything'. She is a very emotional and sensitive girl who '*feels things a lot deeper and is much more sensitive than most'.* In the mornings Harriet would sometimes go to her mother's room and collect Lucy so that her mother could get some more sleep. Mandy said that she was very emotional during her pregnancy with Harriet, which was probably why Harriet was emotional. With Imogen, the middle child, Mandy said she was cut off in her feelings during her pregnancy. She felt that this was partly why Imogen was emotionally *'cut off'* and was diagnosed with autism and developmental delay. She attends a special school. Mandy found it particularly challenging to cope with Imogen due to her symptoms, which sometimes invoked strong feelings of anger in Mandy. Imogen's father had regular contact with her, though he was not as reliable as the other two fathers.

5.1.1 Mandy's Family Background

Mandy said that she was subjected to trauma throughout her life and even when in the womb. She could only remember *'everything that was bad'* about her childhood*; 'there were no good moments'.*

Her father, a paranoid schizophrenic, used to beat her mother severely: on one occasion keeping her awake for two days while she was pregnant, threatening that if she fell asleep he would axe her to death. Just before Mandy's birth, her father locked her mother in their flat, but she escaped and made it to the hospital just in time. Mandy was so small when she was born that her mother used to buy dolls so that she could use the clothing for her. She does not know her father because he was not allowed to see her after she was born.

Mandy remembers that she lived with her mother on the top floor of the tallest tower block in London. She remembers feeling the building sway in the wind and not being allowed on the tiny balcony because it was so dangerous.

Her step father came to live with them when she was six and subjected her to sexual and emotional abuse until she moved out at the age of 20. She was the main carer for her half-brother from a young age because her mother worked day and night, while her step father wasted his earnings on drink and drugs.

5.1.2 First Meeting with the Family

PIP Session 1 – Lucy aged 12 Months (from processed notes)

At my first visit, ten-year-old Harriet opened the door, with one-year-old Lucy on her right hip and seven-year-old Imogen peeping out from behind her. She reminded me of a child mother; she said her mum was still in bed. Mandy came to the door shortly afterwards. She looked like a little girl in her fluffy pink dressing gown. She invited me in to the living room while Harriet organised herself and her siblings: collecting their objects to go to another room.

The living room was clean and tidy and brimmed with a large variety of brightly coloured toys, mostly for Lucy and a large pink knitted blanket covering most of the floor space, again for Lucy. Mandy sat beside me and called for her partner, Lucy's father, to make her some coffee. Father responded promptly and passed through the living room to go to the kitchen, returning shortly with coffee for her. *'Your daughter needs breakfast'*, Mandy informed him, and again he returned shortly afterwards with a bowl of porridge and Lucy's spoon. This felt like a familiar routine.

5.1.3 Observation of Interactions – Parents and Child

Father went to collect Lucy and sat her in the middle of the table by the window, telling her to *'stay'* while he turned away quickly to get the high chair. I felt his anxiety about being observed by a stranger and also felt anxious as I watched one-year-old Lucy in the middle of the table. Her father opened the high chair and sat her in it and then quickly turned away again to get the tray that goes in front of her. He started to feed Lucy with a spoon and she tried to hold the spoon to feed herself. He told her firmly that she could not have the spoon and she continued to cry and moan with every spoon-full. I felt sad that her innate pull towards fulfilling her developmental milestones was not recognised but I could also see that father was trying to set clear limits for Lucy.

When Lucy finished eating, Father left the spoon in front of her: I felt relieved that he recognised and responded to her cue. She pushed the spoon tentatively to the edge of the tray, looking at her mother in a quietly challenging way as she did so. Mandy looked sternly at her and said, *'don't you dare put that on my floor'.* Lucy's face crumpled and she started to cry and look at me as if for sympathy. Mandy put her face close to Lucy's and asked her why she was looking at me like that. I felt quite anxious and helpless and wondered about what feelings were evoked in Lucy, who kept her eyes averted as her mother spoke, and continued to look pitifully at me as if imploring my support. I said feebly, *'you're trying to find out about gravity – you're learning how things fall to the ground'*. Mandy's response was that she does not like her floor to be dirty as she hardly gets any chance to clean because Lucy is so clingy. Father

put Lucy on the floor and she tried to reach up with her arms to be picked up. He looked down at her and told her to use her legs because she should be walking by now. Lucy's face crumpled again and she started to cry. I said that it is quite normal for a one-year-old to be still crawling. He picked her up and held her up playfully towards the ceiling. Her tummy was on his open palm as she balanced in mid-air. I felt anxious.

Lucy evoked high levels of anxiety in me and a strong caregiving response as I observed her position in the middle of the table and perched on the high chair; looking unsupported and vulnerable. Both parents seemed not to recognize or encourage normal milestones in Lucy's development and Father voiced words of shame and disappointment that she was not yet walking.

Briggs (1997) describes the quality of the parents' containment of Lucy as 'Flat': They missed or blocked her communications due to their own preoccupations; Lucy become a 'receptacle' for their states of mind. She had developed 'floppy grips': characterised by her withdrawal from relatedness and emotional contact. This was especially observed in her eye grip, which was weak and avoidant. The 'fit' between mother and child was 'accommodating': Lucy was 'loosely held' by Mandy's arms and in her mind (Briggs, 1997). Nevertheless, it was obvious to me that father was devoted to Lucy and was readily available to attend to her needs. Mother seemed tired and irritable, because of her EUPD and having just woken up. She found it hard to tolerate when I drew the therapy back to Lucy; exuding such strong feelings that Lucy found it too painful to look at her. Lucy's helpless and vulnerable response was accompanied by strong defiance as she challenged them in order to achieve her milestones.

5.2 Mandy's Internal Representations

What did Mandy see when she looked at Lucy and what did Lucy see when she looked at Mandy that felt so painful that she averted her eyes? In the first meeting above, Mandy saw a demanding child who dirtied her floor and made her life more burdensome. She explained in subsequent sessions that '*Lucy is clingy and moany and sounds unhappy even when she does not look it'*. Mandy believed that this is because she was *'moany all through the pregnancy with Lucy and now Lucy is constantly moaning.'*

Mandy held a similar view regarding her other children. Harriet was said to be emotional because she sees her mum crying all the time. During her pregnancy with Harriet she was emotional and Harriet has turned out to be an emotional child. With Imogen she was cut off in her emotions during pregnancy and Imogen now has a diagnosis of autism. She '*does not understand emotions apart from happy and sad'.*

Mandy saw herself as an angry abused little girl. Her self-narrative was overshadowed by the anger about her abusive childhood, which had affected all her relationships. When her abuser's name is brought up '*there's a rush of feeling and it's as if 'I'm a little girl again – the anger is ridiculous right now'.* She tried not to transfer the anger to her children, especially when their behaviour was challenging like Imogen's due to her autism. When not fuelled by anger Mandy saw herself as unfeeling. *'I can't feel anything - I can't show love because I can't feel love – I have no emotions at the minute and I don't care anymore'*. She said she tries to do loving things like giving the children their cuddles because they are the most important thing to her; however, she

feels nothing. She speaks with other mothers at school and she is able to *'witness the flood of emotions'* when they speak about their children. She said, *'I can just taste it and know that's how it's supposed to be ... I have taken myself outside of my story but now it's too far and I've started to notice the lack of affection I show my family'.*

At supervision we wondered whether perhaps Mandy suffered from Alexithymia, which manifests in a substantial difficulty with knowing and expressing what one feels and why one feels that way. Mandy certainly exhibited many of the symptoms and characteristics linked with the condition, such as somatic behaviour, past history of eating disorders and drug and alcohol abuse, a history of childhood abuse and self-harm, outbursts of anger and a detachment that makes it difficult to forge meaningful relationships (Lumley et al, 2007). Adverse Childhood Experiences (ACEs), such as abuse, can contribute to the development of Alexithymia (Divinagracia, 2017). Not surprisingly, this condition can have a negative impact on the parent-child relationship due to the negation or lack of mirroring of the child's feelings, as witnessed in Mandy's interaction with Lucy at our first meeting.

Mandy also struggled to hold things in mind, even important memories about her children. *'I can't hold on to things properly – I don't have many long term memories'*. *'I don't remember half of Harriet's childhood with her dad – I have nothing to hold it – it's like I've lost the glue that holds everything in place'.* It seemed to me that Mandy found a way of coping by forgetting, because it was far too painful to remember.

Mandy viewed the world as an unsafe place for her and her children and lived in constant fear that they would be taken from her due to her mental health. These feelings came to a head when Lucy was about six months old; when Mandy could not leave the house due to a sudden onset of extreme anxiety, during which time she *"felt scared that something bad was gonna happen".* These feelings would come at least once a week and would last for about two days. She believed that these anxieties turned into physical symptoms, such as migraines and flu, even when she knew she was physically well. Her mother would come and help by supporting her to stand at the front door. She would shake violently and could not even venture into the garden. It took 5 months before she was able to go out. Her mother would get her half way down the road and she would turn around and run back to the house. During these times, every curtain in the house was shut. Mandy only started to open them bit by bit when the midwife voiced concern that Lucy needed natural daylight.

5.2.1 Mandy's Maternal Representations

Looking back on her early childhood, Mandy remembered her mother to have been '*caring, naïve, stubborn, supportive and dated'.* Caring because she would always find time for a hug or a story. When she had her eating disorder her mother would force her to eat so she could get better. Her mother was naïve because, *'if she saw I was upset I could easily convince her that I was fine.' 'When her abusive partner tried to stop her going out he easily convinced her that it was for her good'.* Her mother was Stubborn because, *'If she wanted something done a specific way she was inflexible. Her ornaments had to be in a certain place on the shelf and she would know if they had been moved even*

a millimeter'. Her mother was dated because '*she could not tolerate nakedness'*. She always had to cover up in the house.

Mandy also viewed her mother as hardworking and unavailable. She worked long hours and juggled three jobs, *'doing anything that would bring in the money'* because her partner wasted his earnings on drink and drugs. She was so busy working that she didn't get to raise Mandy's half-brother. *"She stopped when she heard him call me mum",* explained Mandy. Her brother was sick and her mother took a week off work to look after him but he would not allow her to do anything for him. *'She stopped her evening work when she realised that she had no connection with her son'*.

Again, looking back, Mandy described a mother who was abused, unsupported and exploited by her partners, who inflicted extreme physical and emotional violence on her. Nevertheless, she tried to be a good mother to Mandy and taught her to value the truth and to have good manners. Of her strict upbringing, Mandy said '*I was brought up adult like – speak when you're spoken to – manners'*. *'She didn't want me to grow up telling lies'.* Sadly, her abusive step-father exploited this respect for the truth to his own ends and destroyed the trust between mother and daughter.

He came to live with them when Mandy was five and spoiled her at first, because he *'always wanted a daughter'*. He would secretly buy big bags of sweets for her and tell her to hide them under her bed. It started off as an exciting game but when she turned six the game started to feel different when he touched her inappropriately when she was in the bath. She threatened to tell her mother but he said he would tell her. He twisted the story and told her

mother that Mandy said, *'if you don't buy me a big bag of sweets I will tell my mum that you touched me…'* Her mother believed him and was very angry with Mandy. "*I could not trust mum any more - She beat my arse". "He was always very good with mind games. I felt really alone then". "It was quite shocking that she didn't believe me really…looking back".*

Everything changed for Mandy after this. She said, *"Life became dark – mum not trusting me and not believing me didn't help. I had never said anything like this before and I had two other step dads before". "He got worse gradually until the point he actually raped me". "I would be touching him for favours to be able to go out with friends normally". "I don't know how it became normal – there was nothing I could do". "I stopped eating … I would hide the food … until mum found some food under the sofa … I was threatened with the drip". "I was never hungry".*

Without the trust of her mother Mandy had no comfort. She said, *'I was always upset – always in tears – but never in front of anyone – crying was weakness in my mum's eyes'. 'I would go into my room and cry or go in the bathroom, lock the door and cry'.* If physically hurt *'I would just get up and walk off – didn't go to anyone'.* She could not remember being 'held' by her mother. '*Mum would come and stroke my head when she gave me my medicine for tonsillitis – mum would sit beside me but not really hold me'. 'I only remember being held by him but not the way it should be'.*

Despite her suffering Mandy longed for her mother and protected her from the truth about the abuse, explaining to me; *'I saw how happy he made my mum - I didn't want to be away from mum'.*

She was about 27 when she finally told her mother what she went through growing up. When her mother asked her partner about the abuse he went quiet. She decided to leave him. When she was with Mandy later on she burst into tears and blamed herself. From this point they tried to rebuild the relationship that had been sabotaged by the abuser when Mandy was six years old and to retrieve the lost years.

5.3 Family Relationships at the Beginning

I contracted to visit Mandy on a weekly basis, initially to work with her and Lucy together in order to regulate the parent-infant relationship. I later felt that she also needed some individual sessions without Lucy present, to work with the trauma of her abusive past, and some systemic sessions with family members, especially father, to increase his confidence when playing with Lucy.

After the first painful PIP session, there was an unavoidable break and I met Mandy for an individual session two weeks later while Lucy stayed at her father's home. I suggested to Mandy that we work according to the framework of the Adult Attachment Interview (AAI) over a few weeks, to regulate the outflow of the traumatic material and to give her space to also remember the good things about her childhood. Mandy felt relieved to hear this. She explained that she had seen a psychiatrist and psychologist in the past and at each visit she was required to talk about her abuse. The time boundaries were rigid and she was left on each occasion with everything at the front of her head. It would take over two weeks to recover and a further two weeks to build herself up to face the next session, when the trauma would be repeated. Mandy used

the session to tell me the story of her childhood but without going too deeply into the traumatic material at this early stage.

Four days later I met with Mandy and Lucy for the second PIP session. This was a very hopeful intervention and it demonstrated to me that Mandy had the capacity to think about Lucy and to 'take in' and use my interpretations. I felt that apart from the 'ghosts' in her nursery: the harmful patterns of behaviour that I had witnessed at my first visit; there were also some angels: possibly the professionals such as the Health visitor, midwife and workers at the local school. The following is an example of how I worked with Mandy at the start.

5.3.1 Regulating the Parent-Infant Relationship

PIP Session 2 – Lucy aged 13 Months

Lucy sat on the sofa next to Mandy holding her pink knitted blanket; whinging and trying to get close to her mum. They sat side by side but Mandy did not reach out to hold Lucy. She complained that Lucy is *'too clingy'* and she *'can't stand it'.* Father entered and picked Lucy up. Lucy pointed to Mandy and leaned away from Father, pointing repeatedly and forcefully at Mandy. Father said playfully, '*no, you can't have mum'.* Lucy was insistent and Father returned her to the sofa to sit next to Mandy.

I talked to Lucy with motherese (high pitched sing-song voice) saying, *'you want your mummy – you want to be close to mummy'.* Mandy protested about not being able to do anything because of Lucy's clingy behaviour. I asked what she felt Lucy was saying to her. She responded, *'She wants to be close'.* I asked, *'What does that make you feel?'* She responded, *'Smothered'. 'What*

do you think Lucy feels?' I talked about Lucy giving cues and Mandy's response. If her cues are understood and her needs are met she can feel safe enough to be independent but if not she will continue to seek a response. It's healthy when she seeks a caregiving response. We need to worry if she stops giving cues. If she gives up reaching out and becomes self-sufficient, that would show that she knows her needs will not be met so there's no point trying. Mandy listened thoughtfully and with interest.

I asked Mandy whether she would sometimes play on the floor with Lucy. Mandy said, Lucy would *'play near me and wander away because she knows I'm accessible*'. I noticed how she incorporated my words into her response as if they originally came from her. I said, *'when Lucy feels that you are available it makes her feel safe enough to wander away and return to a safe base'.*

Mandy spread Lucy's special blanket across her chest and Lucy climbed up onto her lap to sit astride it. She put her head on Mandy's chest and seemed to relish the moment – content. Mandy allowed Lucy to nest and stroked her hair as we talked about responding to cues.

Later, Lucy wanted to get down. Mandy asked her, *'do you want to get down?'* and put her on the floor. Lucy stood and Mandy talked about her being nearly ready to walk. I said *'she stands very securely'*. Mandy got a bowl of chocolate stars from the table and Lucy sat on the floor to eat them as we spoke.

In this session Mandy's narrative and behaviour regarding Lucy changed dramatically, even after such a brief intervention. It seemed to me that Mandy needed permission to enjoy the relationship with Lucy and to go against an inner compulsion to push her away; because as a child, she said *'mum would*

sit beside me but not really hold me'. This was her internal model learned from her mother. Lucy's behaviour also changed dramatically after feeling the connection with her mother and she felt able to move away from Mandy to explore the room. This sudden change in behaviour indicated to me that the experience of being close to her mother was not new for Lucy, however it seemed inconsistent. Mandy's ready response to my encouragement to enjoy the relationship with Lucy also indicated to me that she had the capacity to respond to her cues and also to make good use of the intervention.

A week later at my next visit there was no reply when I knocked the door. I called Mandy's mobile and she came sleepily to the door and invited me in. Harriet and Lucy were both sick so Mandy had very little sleep. After the previous session, she was a bit tearful but she felt that she was coping because we were taking things slowly. We agreed to continue the following Monday.

PIP Session 3 – Lucy aged 13 Months

At the next session I observed that Mandy was not aware of Lucy's capacities. Some activities that Mandy said Lucy could not do she demonstrated that she could, such as holding a pen and imitating me when I wrote on the page.

In this session Mandy remembered some good memories amidst the bad memories about her abuser. She spoke of her half-brother who lived with her, her mother and her step-father. He was very close to her and she took him everywhere with her. She also remembered her relationship with her mother before the abuse. *'When it was just me and my mum I got all the attention – we were close – she would actually interact with me'.* Her closeness to her brother and her remembered experience of once having been close to her

mother served as an internal protective factor amidst the abuse. Amidst malevolent ‘ghosts’ (Fraiberg, 1975) from her oppressive past, were also protective angels (Lieberman, 2005).

5.4 Intergenerational Family Patterns and Fears

Systemic Session – Mother and Maternal Grandmother

Four days later Mandy invited her mother to attend the session while Lucy stayed with her father. It felt like Mandy was regulating the pace and course of the intervention by arranging who should be present.

After hearing about Mandy’s traumatic past I was surprised to see that there was an easy, friendly and relaxed feel to her relationship with her mother and Mandy seemed free to express herself in her presence. Her mother joined in the conversation naturally and together they were able to reminisce and fill in the gaps about the past. Mandy explained to her mother how I worked with everything in the family rather than just concentrate on the abuse. She felt hopeful that this time something would come of her treatment because she’s able to remember the good times that have been blocked out by the abuse. Her mother explained to me that she feels that Mandy has a blockage that prevents her from going really deep to deal with her past and perhaps this time she will allow herself to go deeper. I wondered what she felt the blockage was.

Fear of loss and breakdown

Mandy explained that she lives in constant fear that her children will be taken away if she opens up too much. When Imogen was two she had a breakdown and was nearly put in a ’women’s version of a mental hospital’. She does not

remember anything about her symptoms. Her mother explained that Mandy was in a constant day-dream state; always crying and self-harming – cutting herself between her legs and on her arms. Mandy showed me a tattoo, which said ‘mum’; it was decorated with beautiful flowers that covered her scars.

An intergenerational pattern of role reversal

Mandy continued and spoke passionately about her maternal responsibility for her children. She’s capable of looking after them and if social services dared to try and take them away there would be trouble. She does not even allow the children to take on adult responsibilities like she did as a child.

She remembered when Harriet heard her crying one night and came in to ask if she was OK. Harriet hugged her and Mandy felt guilty because it felt as if Harriet was taking the mother role. We explored what happened: after Harriet hugged Mandy and was assured that she was OK, she was able to return to bed because she felt satisfied that she had helped her mother.

Mandy said that her own mother did not show vulnerability during her childhood. Mandy would hear her cry in her room after being beaten but she would always deny that anything was wrong. I compared this with how Harriet was able to share her mother’s vulnerability and together they got through it.

Mandy continued, *‘I don’t see why my children should have to clean up after me – my floors are my chores’*. I wondered where her strong feelings about housework came from. She said her step-father would pass on his chores to her and if she did not do them properly, she would have to do them again so that her mother would not find out. He would even run his finger along the dado rails to make sure there was no dust.

I suggested that her way of protecting herself and her children from her childhood experiences was to set rigid rules about what they could and could not do. As we ended the session Mandy and her mother discussed how they had not made these links before about their behaviour.

Pattern of Being Let Down - Frequent cancellation of sessions

After the fruitful session with Mandy and her mother there was an eight-week gap during which time I made every effort to meet with Mandy but to no avail. I was determined not to give up on her because I felt that it was crucial to work with Lucy during this optimal time before her behaviours became entrenched.

The first missed session was due to a bank holiday but the following two weeks I knocked and waited, knowing that Mandy had agreed to the session, but there was no reply. She was helping out a friend and forgot about the session. We rescheduled, but she cancelled on the day due to being unwell. There was no reply to my follow-up text so I emailed to say that I was sorry not to have met her that morning and I was keen to know how she was doing. I said that after a long break it can feel really hard to get started again with therapy, especially when thinking about such difficult issues.

5.5 Stresses on the parent-infant relationship

Mandy gave a detailed response to my email. She said '*I'm so sorry for today'.* She was feeling *'stressed out'* due to difficulty with her tax credits and could not sleep at night due to worry. When she finally fell asleep in the early hours of the morning she would fail to wake up to take Imogen to school. We agreed to meet a few days later but she cancelled again due to the stress of trying to sort

out her tax credit. I acknowledged by email that things sounded really stressful and we would make up for the missed sessions when her finances are sorted.

That week Mandy's cousin passed away suddenly and the funeral coincided with her appointment. We rescheduled again for the following Monday, however, on the day Mandy cancelled because her bereaved aunt was staying with her. She offered an alternative time on the Friday of that same week and finally, after a two-month break, we were able to meet.

The stresses during the break seemed to have had a considerable effect on Lucy because Mandy was even more concerned about her challenging behaviour and the impact on the family. Apart from her self-harming behaviours Lucy was strongly rejecting her father, which was very painful for him to bear. He would come to see her after work and she would scream and not allow him to touch her or even to greet her. I suggested that it would be good to invite father to be part of the work with Lucy and Mandy agreed.

At that point a paediatrician, Dr R, joined the team as a trainee parent-infant psychotherapist. Mandy gave consent for Dr R to film the sessions because the focus was on Lucy's development rather than on her. She shook visibly for the first 15 minutes but relaxed as we proceeded.

5.6 Measures at the Beginning of Intervention

5.6.1 Risk Factor Analysis

At the point of referral, the risk factor analysis revealed 16 stresses on the parent-child relationship, three of which were in the high risk category; namely,

mother's mental illness, past drug and alcohol abuse and history of extreme sexual abuse.

Risk Factor Analysis

It helps the team in considering referrals if the checklist below is completed. Many known risk factors put a strain on the baby-parent relationship. An analysis of these allows intervention to be considered at a preventative level, before the infant's quality of attachment has been compromised. The presence of four to six moderate risk factors is significant although some combinations of a lesser number merit attention. However, there are certain serious conditions that, in some circumstances, call for interventions on their own. These have been shown in green below.

Biological Vulnerability in the Infant:	
Mother substance abused / on methadone during pregnancy	
Very low birth weight / extremely premature	
Failure to thrive / feeding difficulty / malnutrition	
Mother drank alcohol during pregnancy	
Congenital abnormalities / illness / serious developmental delay	
Very difficult temperament / extreme crying	✓
Very lethargic / non-responsive	
Resists holding / hypersensitive to touch	
Chronic maternal anxiety / stress during pregnancy	✓
Mother smoked during pregnancy	
Regulatory / sensory integration disorder	
Parental History and Current Functioning:	
Mental illness, including depression	✓
Serious medical condition / physical disability	
Own mother mentally ill / substance abused	
Alcohol and / or drug abuse (current or past)	✓
History of physical or sexual abuse, witnessing violence, neglect or loss	✓
Absent parent or stepparent in family (i.e. non-biologically related)	
Parents seem incoherent or confused	
Parent was in care (looked after) / adopted	
Learning disability / low educational achievement	
Criminal or young offender's record / been imprisoned	
Previous child has been in foster care or adopted	
Mother has experienced the death of a child	
Previous child has behaviour problems	✓
Presence of an acute family crisis	✓
Interactional or Parenting Variables:	
Lack of sensitivity to infant's cries or signals	✓
Lack of consistent caregiver for infant	
Physically punitive towards child	
Lack of vocalization to infant, few 'conversations'	✓
Lack of eye-to-eye contact	✓
Negative attributions made towards child, even if 'jokey'	✓

Lack of preparation during pregnancy	
Lacks knowledge of parenting and child development	✓
Infant has poor care (e.g. dirty and unkempt), physical neglect	
Does not anticipate or encourage child's development	✓
Quality of partner relationship; may be undermined or unsupported	
Infant a victim of maltreatment, emotional abuse or neglect	
Any violence reported in the family, especially if witnessed by a child	
Negative affect / verbal abuse openly shown towards child	
Socio-demographic Factors:	
Chronic unemployment	
Inadequate income / housing / hygiene	✓
Overcrowding in household	
Single teenage mother without family support	
Poor quality / more than 20 hours per week day-care	
Severe family dysfunction, current and in background	✓
Lack of support / isolation	
Recent life stress (e.g. bereavement, racism, job loss, immigration)	✓
Number of risk factors (Green)	3
Number of risk factors (Other)	13

Figure 5.6.1. Risk Factor Analysis at Start of Intervention

Other stresses included Lucy's difficult temperament and Mandy's chronic maternal anxiety. Having an autistic sibling in the home was also a source of considerable stress for the family as Imogen's symptoms exacerbated Mandy's EUPD and increased levels of anxiety and anger, giving rise to stress between family members, especially between Mandy and Lucy's father. Again, owing to Mandy's EUPD and Chronic Fatigue Syndrome, she lacked sensitivity to Lucy's cries and signals. Both parents had a strict upbringing and though not physically punitive to Lucy, they had unrealistic expectations regarding her behaviour. Lucy's inability to meet their expectations gave rise to negative attributions instead of encouraging her to achieve her milestones. They also lacked knowledge of parenting and child development and engaged in very few serve and return 'conversations' with Lucy (Harvard, 2011). Other stresses

included inadequate income and severe family dysfunction in both family backgrounds.

5.6.2 Ages & Stages – Social Emotional

This measure of social and emotional development begins at age two months and a score above the cut-off point indicates there is a problem. If the caregiving relationship is impacted by too many negative factors, then social and emotional development will suffer without intervention. Achieving or maintaining acceptable social and emotional development in a family situation of multiple risk is a positive outcome.

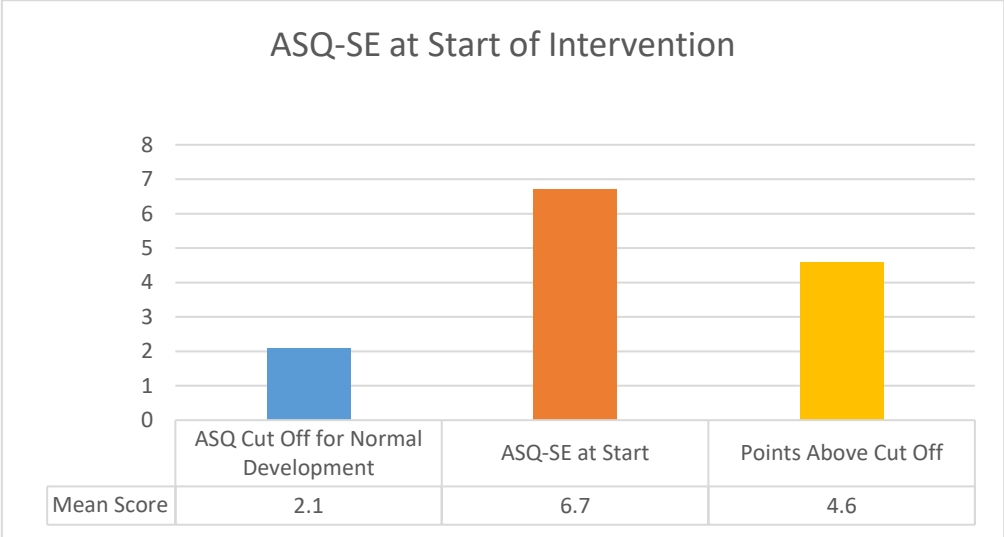

Figure 5.6.2. ASQ-SE2 score at Start of Intervention

The ASQ-SE questionnaire revealed an anxious child with no capacity to self-soothe or regulate her emotions: using repetitive, self-harming behaviour such as head banging and lengthy daily tantrums when frustrated. She showed no interest in people apart from her mother and her sisters, and would scream and reject even her father when he came to see her after work each day. She had trouble falling asleep but enjoyed a healthy 10 hours of sleep each day, waking

only once during the night. She enjoyed her food, but also enjoyed eating non-food items such as sponges and would alternate between constipation and diarrhoea. Eye contact was selective and Lucy exhibited extreme oppositional behaviour such as throwing a tantrum and ignoring her mother when asked to do anything. Lucy had few words to express her needs, such as, 'assat' (what's that?) so Mandy had to guess what she needed while she screamed with frustration, throwing objects and throwing herself backwards at the same time. At fifteen months she had just started to point to objects and look back at mother: a developing capacity for joint attention. There was no evidence of pretend play and no interest in singing or stories. The ASQ-SE cut-off score for normal development with no concerns is 50 (mean score 1.6) and 65 (mean score 2.1) where there are concerns that need to be monitored. A score above 65 requires referral to specialist services. Lucy returned a score of 210 (mean score 6.7), which was off the scale and reflected the severity of her symptoms.

5.6.3 Anxiety and Depression

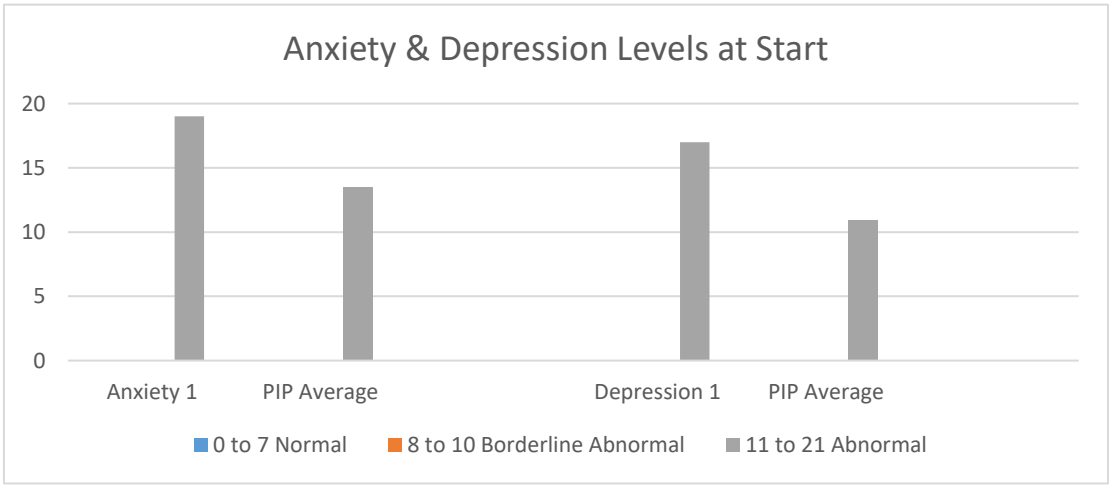

Figure 5.6.3. Mandy's Anxiety and Depression score at Start of Intervention

At referral Mandy showed signs of extreme anxiety and depression, with a HADS score of 19 for anxiety and 17 for depression.

A score of zero to seven is a non-case; eight to 10 is a borderline case and 11+ is a case. The maximum score possible is 21 for each category. Mandy's depression is likely to have had a significant impact on Lucy's symptoms because her mind was not available as a container for Lucy's anxieties.

5.6.4 Parent-Infant Relationship Global Assessment Scale (PIRGAS)

The Parent-Infant Relationship Global Assessment Scale (from DC:0-3) places the caregiving relationship into 9 categories, ranging from 'well adapted' (score 100-91) to 'documented maltreatment' (score 10 and under) and so an increase in score demonstrates an improvement.

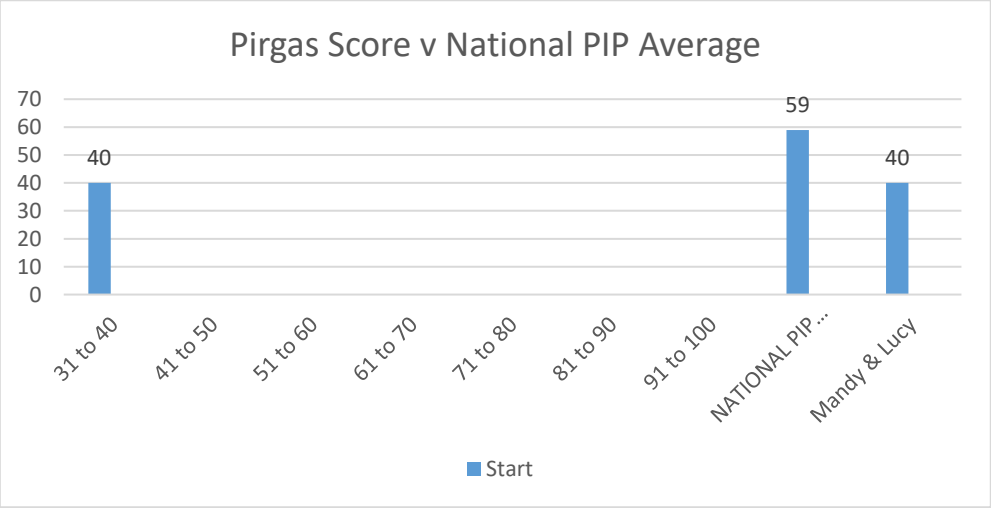

Figure 5.6.4 PIRGAS Score at Start of Intervention

The quality of the parent-infant relationship was assessed at the start of treatment and returned a score of 40/100: disordered.

5.6.5 Levels of Adaptive Functioning (LOAF)

The DC:0-5 contains a diagnostic algorithm to identify a relationship-specific disorder of infancy, shown with a particular caregiver and associated with symptomatic behavioural problems in the child. The criteria of the DC:0-5 confirmed that Lucy exhibited a persistent emotional and behavioral disturbance with her father and grandmother, which included oppositional behaviour, aggression, fearfulness, self-endangering behaviour and persistent crying. These behaviours affected Lucy's functioning and that of the family, causing distress, interfering with relationships and limiting Lucy's participation in developmentally-expected activities and routines.

LOAF - Relationship Specific Disorder of Infancy	Lucy	PIP AVGE
Was there a relationship disorder at start?	Yes	75%

Figure 5.6.5 Relationship Specific Disorder of Infancy Diagnosis at Start

5.6.5a LOAF: Caregiving Relationships

The scale below is a clinical evaluation of Lucy's caregiving relationships. This is a process of assessing emotional availability, where she is valued as an individual, the caregiver's sense of comfort and competence as a parent and the baby's own unique contribution to the relationship.

			PIP AVERAGE
Level of adaptive functioning - Caregiving relationships	Scale	At Start	Start
Well adapted to good enough relationships	1		
Strained to concerning relationships	2		25%
Compromised to disturbed relationships	3		50%
Disordered to dangerous relationships	4	4	25%

Figure 5.6.5a Levels of Adaptive Functioning – Caregiving Relationships at Start

There were concerns regarding 12 out of 14 categories of caregiving: mostly the psychological, social and emotional aspects, and five out of seven of the categories measuring Lucy's contribution to the relationship.

A level 4 was ascribed to the caregiving dimension, with level one being well-adapted and good enough relationships and level four describing disordered and dangerous relationships. Not only were adaptive qualities lacking, but the relationship pathology was severe and pervasive. Mandy's mental health issues limited her emotional availability so she was not able at that time to respond consistently to Lucy's need for comfort and engage her in age-appropriate exploration and learning. There were negative parental attributions to Lucy and significant developmentally inappropriate expectations that were not open to reflective challenge and compromised Lucy's development.

5.6.5b LOAF: Caregiving Environment

The scale below shows the level of functioning of the web of caregiving relationships surrounding the baby, regardless of whether or not the parents live together. The levels indicate harmoniousness, integration and coordination among the baby's different caregiving relationships.

			PIP AVERAGE
Level of adaptive functioning wider caregiving environment	Scale	Start	Start
Well adapted to good enough caregiving environments	1		
Strained to concerning caregiving environments	2		50%
Compromised to disturbed caregiving environments	3		25%
Disordered to dangerous caregiving environments	4	4	25%

Figure 5.6.5b Levels of Adaptive Functioning – Caregiving Environment at Start

A level 4 was likewise allocated to the caregiving environment; Mandy's mental health issues impinged on her capacity for problem solving, conflict resolution and caregiving communications. Though she went through the motions of emotional connection with Lucy, there were no feelings attached. She also struggled to self-regulate and to regulate the anxieties of Lucy and her siblings.

5.6.6 Keys to Interactive Parenting Scale (KIPS)

This evaluates 12 dimensions of caregiver-infant interaction from 10 to 15 minutes of video, and so is replicable; each category attracts a maximum possible score of 5. A score of 3 and above is 'good enough', giving a pro rata average of 36 that would imply the presence of some strengths. Changes in scores track the quality of parenting interaction; i.e. an increase in KIPS score shows an improvement in the caregiving relationship.

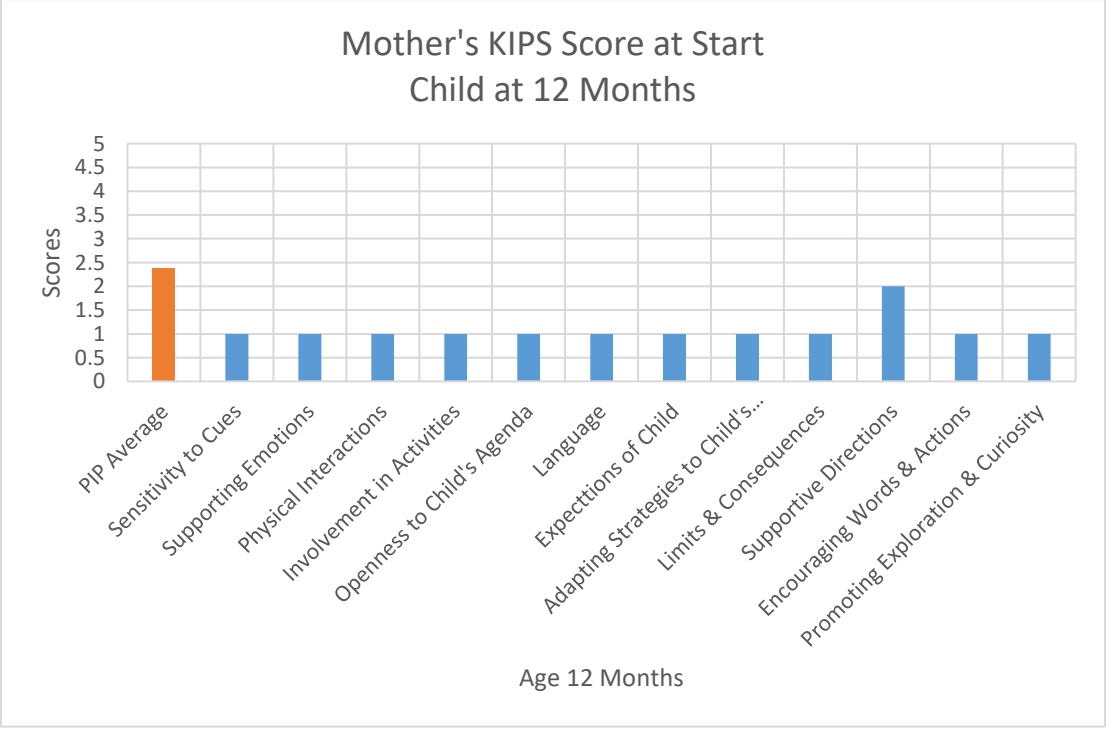

Figure 5.6.6 Keys to Interactive Parenting Scale at Start

Scale	Description
1 to 2.9	Low quality (indicating parenting concerns)
3 to 3.9	Moderate quality
4 to 5	High quality

This was the picture of the family at the end of the assessment phase. It was evident that both parents lacked the parenting skills necessary to support Lucy's development. We agreed to meet with Mandy and Lucy every Monday for parent-infant psychotherapy sessions. My colleague, Dr R, would focus on playing with Lucy during the session, while I would focus on the parent-infant relationship, giving Lucy a voice to help Mandy to 'see' her as an individual with her own mind, and making interpretations to give meaning to what was happening in the moment. Working closely together we were able to hold mother and child in mind and model new ways of interaction.

In the next chapter we will see signs of change in Lucy's symptoms, the parent-child relationship and the changing patterns of family relationships. However, it was difficult at first to test my hypothesis about change in the internal representations of mother because after the session with Mandy and her mother there was hardly any mention of the maternal grandmother. The mystery of the absent internal mother eluded me and I wondered whether I had totally misread all the cases that had led me to formulating my research question.

CHAPTER SIX

Process of Change in Symptoms

We were four months into the family intervention and more than half of the potential sessions had been cancelled by Mandy. This made it quite difficult to establish a strong alliance and to start the work of addressing Lucy's symptoms. Nevertheless, much had been achieved.

6.1 New Interest in Books and Play

We had introduced favourite children's books to Lucy and Mandy commented that her children had not shown any interest in reading. I explained that usually it is the parents that would introduce new experiences such as reading to the child. Only when the caregiver gives the child the gift of words filled out with fun and meaning, will they be able to give them back to the caregiver. This idea seemed to be new for Mandy. The following week Mandy announced;

PIP Session 5 – Lucy at Sixteen Months

M: *She's started liking to sit down read books now. She's the only child out of all three that actually wants to sit down with a book… My other two was never interested… ever… they didn't want to sit and read a book, whereas, she will.*

Y: *When did that start because I remember last time we talked you said that …*

M About four days ago

Y Right

M She brought me a book… um, and… we were… I sat there and I asked, 'do you want me to read it?' And, we started reading and she just sat there.

Y Did she enjoy it?

M She seemed to.

Y How about you, did you enjoy it?

M It was surreal, because although I've got three children, one being 10, it's the first time a child has wanted to do that with me. And it was new for me too.

Y Have you wanted to do it before?

M Stares at me and shakes head to say no.

I felt pleased that Mandy and Lucy were taking the learning from the sessions into their daily lives, but sad that Mandy and her children had not enjoyed the pleasures of reading together. In fact, Mandy seemed like a first time mother.

Lucy was seventeen months old, and was now able to tolerate our presence enough for us to start engaging with her directly. She would usually be sitting on the sofa on her special blanket when we arrived, hypnotised by the cartoons on the big TV screen, with her dummy in her mouth. She would completely ignore us for up to twenty minutes of the session and any attempt to reduce the volume of the TV or turn it off was met with screams and throwing her body back against the sofa. As she acted out, I would put words to her actions to give her a voice and meaning.

Her behaviour came across as very hostile, very adult and very deliberate; making me feel invisible. She projected very powerful feelings into the room and was in control of what could and could not be done. Her behaviour

reminded me of how I felt at the very start of the work with Mandy, when I would knock on the door week after week, knowing that she was home, yet she did not open the door. Despite her rejecting behaviour, I kept coming back and in the same way, Dr R and I continued to gently, but firmly, send Lucy the message that we would not be going away.

Dr R would position herself on the floor, just to the right of Lucy, talking to her through her baby doll and patiently enticing her to play. Lucy's attention would be captured eventually by reaching out for Dr R's glasses and she would gradually emerge from her hypnotised state. Only at this point when distracted by play, could the volume of the TV be gradually reduced and eventually turned off. Dr R would give full attention to the play; being totally available and offering her face for Lucy to put the glasses on and take it off; constantly speaking with Lucy and dramatizing, using different voice tones and expressions, asking; *'Where's Lucy mummy?... there she is.'* In this way, Mandy would be enticed to join the play and Lucy would be able to play from the safety of her blanket, until she felt safe enough to get down from the sofa.

A variety of objects and activities were utilised in play, such as popular children's books, Lucy's teddies, her baby doll, balls of different colours and textures, nursery and finger rhymes, puppets, stacking boxes and cups, and objects belonging to Dr R that Lucy found engaging, such as her glasses.

We were careful to follow the same routines at the start of each session so that there were no surprises. Lucy slowly started to trust us and became increasingly easier to engage as she developed an appetite and expectation for play. After about six sessions she showed signs of excitement on our

arrival; meeting us at the door with Mandy; eager to explore inside the bag of toys. She became more tolerant of our presence and was able to offer me her favourite objects, such as her blanket, teddy and dolly, for safe keeping during the session and as a sign of her growing acceptance and trust.

It was by no means an easy process to keep both Mandy and Lucy engaged and trusting; it required a very close working partnership between me and Dr R, who supported Lucy's play and encouraged Mandy to join in, while I focused on making interpretations about the parent-infant relationship. It also required a strong therapeutic alliance with Mandy and Lucy. We were always mindful of the frequent cancellations of sessions so we valued each moment of every session, filling the time with rich content as if it was the last session.

Over time, there were signs that Lucy was inviting Mandy to be her playmate outside of the sessions. The interest in us and in the contents of the toy bag became stronger than the hypnotic pull of the cartoons on the TV and it became easier to engage Lucy at the start of the session and to turn off the TV.

Despite the progress in Lucy's learning through play there was no perceivable progress with regard to her self-harming behaviours. She also displayed other symptoms when she became excited and did not know how to contain her feelings. I would introduce some psycho-education at those times because Mandy seemed to become more open and receptive to bring her fears about Lucy's symptoms.

PIP Session 6 – Lucy at Seventeen Months

M: She does this whole tensing thing. When she gets really excited she does this (tenses) she stands there and she does that…

Y: So she's trying to contain her feelings… they're feeling overwhelming and she's trying to contain them… so, they do that in many ways… they can spin, like she was doing there. They can run back and forth. They can tense their muscles…

M: Yeah she does that.

Y: It's all to do with regulating the emotions. If she can't regulate herself or make herself feel safe, she'll find different ways of doing it.

M: Hmmm, hmm. (Looks at Lucy as she moves about room and nods).

Y: She does it in lots of ways… she bangs her head, she…

M: She did that last night actually (fiddling with giraffe toy as she speaks) … she done it really hard… I was worried, to the point where… normally I would ignore her and she would hit her head a few times and she'd realize it hurt, and then she would just lay there and scream. When she gets to the point when she's laying there screaming then I can go to her… I can pick her up… I can comfort her… but am, all the time she's actually doing head butting, if you go to her to pick her up she would throw herself around. She doesn't want you to touch her at that time…

Y: So it sounds like you struggle with when to go and get her and when to leave her.

M: Most of the time I know just to leave her be… cos normally it's only sort of (claps hands together and nods head back and forth to show motion of head butting wall) like that on the wall; which is painful but it's not enough to actually hurt her… ammm … I would let her just carry on until she does the old throwing herself on the floor and then it's just lying there crying. I can go to her then.

Y She won't allow you to hold her… to make her feel safe?

S No, not if she's head butting...

I noticed the manifestation of behaviours such as spinning and tensing her body rigidly within the sessions, and these were gradually transformed through play. At these times Lucy's attention would be captured using finger rhymes and singing and dramatization using her dolly and favourite teddies.

I also noticed that Lucy's symptoms became worse when there was turbulence in the parental relationship, and on the above occasion Mandy and father had just broken up. At the start of the session Lucy appeared frozen and distant and at the end of the session, after having defrosted and engaged in play, she wailed pitifully when we said goodbye.

At this point Mandy still believed that Lucy should be left to cry when upset and that responding to her extreme tantrums and meltdowns would be spoiling her. It took several months for her to start to hear me when I advised her on how to contain and regulate Lucy's anxieties and how to help her to feel safe in the midst of overwhelming anxieties. I started to model in the sessions how to support Lucy with her emotions, especially when facing transitions.

To help Lucy to manage the end of sessions we introduced a 'Goodbye Song', and later on a 'Hello Song', which warned her about the transition and supported her emotions. The words of the song were simple and easy for her to understand as follows;

Goodbye Lucy, goodbye Lucy, goodbye Lucy

It's time to say goodbye

A few minutes before the end of the session I would start to sing this song softly, observing Lucy's response as she thought about the ending. As we put the toys in the bag we would sing goodbye to each toy to give Lucy time to adjust to the change. At first, she also needed to be held and comforted by Mandy but after a few sessions she was able to help us to put the toys away.

6.2 Loosening of Symptoms

Towards the end of her seventeenth month there was a dramatic shift in Lucy's symptoms that was immediately visible within the session. When observing the video, it seemed to me that the change in Lucy's behaviour was directly connected to the content of Mandy's narrative about an imaginary friend: an old lady with whom she played during the lonely years of her childhood, between the ages of three and twelve years (discussed further in Chapter Seven). Mandy's mood changed as she allowed us into her inner world: allowing herself to be vulnerable about the intimate details about her lonely childhood. While Mandy spoke about her inner objects Lucy played and interacted with me and Dr R, linking us together with Mandy in her play in a symbolic way, using her doll to express her emotions in response to her mother's vulnerability. This breakthrough in Lucy's play was sustained and the quality of her symbolism increased over time. Mandy allowed us into her internal world and we walked gently, accepting and respecting her internal objects, such as her imaginary friend. There was a strengthening of the trust and the bond between us and Mandy, between us and Lucy and between Mandy and Lucy.

After the breakthrough of the session where Mandy spoke of her imaginary friend I wished to consolidate the change so I scheduled several sessions in close succession. In the next session there was another breakthrough and a turning point in the intervention, when Mandy showed that she finally understood the importance of us working with Lucy urgently, before she turned two, while her brain was still malleable. She was able to explain this to father.

Another important breakthrough that affected Mandy's treatment of Lucy and Lucy's response to Mandy, was a shift in expectations about Lucy's behaviour. Both Mandy and Father had strict, rigid expectations about what is appropriate behaviour and what is an appropriate response. If Lucy had a meltdown or displayed self-harming behaviour they would leave her to manage her rage, seeing this as bad behaviour that should not be rewarded. However, Mandy's behaviour changed when she understood that Lucy needed her in those moments because she could not manage her rage alone.

PIP Session 9 - Lucy at Nineteen Months

Dr R: Has she stopped banging her head?

M: No

Y: No? In what circumstances does she do…?

M: Any

Dr R: With you?

M: Sometimes if she's over excited she'd do it… if she's upset.

Dr R: Yes, I'm going to play with you (to L)

M: It's mainly when she's am… it mainly when she's upset… that she does it… but, ah, no, she still does… it just ah, I deal with it better… Yeah, cos when she's angry, I stay calm.

Y Yeah?

M: I pick her up… I hold her right into me… she kicks about at first but I can pick her up now… am… and then I'd just stand there and I rock with her in the front room and I hold her close really tight… and… but not tight that it's hurting her but tight so that she knows that there's love there.

L/M: (Lucy gives Mandy book) Thank you (with exaggerated motherese).

M: And am… she just ends up crying… she just starts crying in my shoulder

Y: OK

M: But she calms.

Y: But the main thing is that she's being held… she's feeling safe… and if she can associate that feeling …

M: (sharing book with Lucy) Huh, six… six, 1,2,3,4,5,6 all gone. Eight, all gone… 10, wow. You are so clever (claps).

Y … so when she's feeling upset then she can associate that with being made safe by mummy.

M: Yeah

Y: Then she'll have less need to bang her head.

Dr R: (Lucy takes book to Dr R. Reading with Lucy) 4,5,6.

M: I'm hoping

6.3 The Importance of Father

Just before Lucy turned twenty months her father started to join us in the sessions and this was a catalyst for significant change in her symptoms and relationships. Father was anxious about his relationship with Lucy and her extreme symptoms of self-harm and was desperate for help. In the first family session Lucy sat with her back to her father while Mandy explained that Lucy had no good memories with him. However, in the midst of the negative narrative about Father Mandy inadvertently revealed that there actually was the foundation of a special relationship between Lucy and Father. For example, if Mandy put on Lucy's coat and shoes she would go to the buggy but if Father did so, Lucy would go to the door because Father believed that it was important for her to walk. Lucy enjoyed going walking with her father. In the next family session, I saw further evidence of a tender relationship with Father, where Lucy was able to include Father in her play by offering him the blocks to build.

I also noticed an increased toleration of others. A new therapist (whom we will call A) joined the PIP team at that time and assisted me in the second family session. Like Dr R, she had an engaging way with Lucy, and Father was

surprised to see how positively Lucy responded to someone she had not met before. In fact, she was now tolerant of other people, with the exception of Mandy's mother. She offered her toys to A, and invited her to play; seeing A as a benign, available object. I hoped that Mandy would also see A in this way because I had planned for A to provide some individual sessions of therapy where Mandy would be able to process her childhood trauma.

During the play session Lucy was slowly getting closer and closer to Father; who also allowed himself to enjoy playing, building blocks and singing with Lucy. The parents were helped to see the importance of recognizing and responding to Lucy's cues and to be available to her. When they lost their focus I pointed out to them how Lucy would turn her back to them and look to me or A, because they were not available.

In the context of play the parents were encouraged to give Lucy some words that she could use, such as 'again', when she wanted us to repeat her favourite song. Important skills were introduced, such as sorting colours and stacking boxes and bricks. When the game became too complex for Lucy we demonstrated how to simplify and vary in order to keep her attention.

Lucy seemed to enjoy playing with her father and would give a little dance of celebration when she gave him a toy. When he gave her a block to put away she held onto it and looked at him, smiling, before she reluctantly released it into the bag; as if savouring the connection between them.

Lucy also worked hard at connecting her parents through play; moving between them and inviting them to join in. Both parents became increasingly playful, allowing their inner child to be seen. Sometimes Lucy seemed far more

focused than her parents and their need to play would take over; making it difficult for them to allow Lucy to explore in her own way. As Lucy became comfortable to play with Father, he was encouraged to put words to her play and to make it more interesting.

At the end of the second session with father Lucy wailed as we packed the toys away but Mandy was able to calm her while we sang the goodbye song. Father continued the game of rolling the ball and she was able to continue her play with him as we departed. Father was keen to have some individual sessions with Lucy in order to be confident when with her alone.

I had slowly introduced Dr R and A into the sessions, knowing that I was due to travel for several weeks. To ensure the continuity of the work during my absence Mandy received five sessions of individual psychotherapy with A, while Lucy and Father worked with Dr R in the play room of the local children's centre. This work with Father contributed significantly to Lucy's development; strengthening the bond between them and empowering Father to embrace his role; especially that of helping Lucy and Mandy to separate.

Dr R reported that at the first father and child session, Father was tense and Lucy did not run to him when he arrived, but she acknowledged him with a warm smile when he knelt on the floor at her level. During play, Lucy moved from toy to toy but was able to keep the meaning of the game and would later return to the same toy or game and reproduce it. When playing with her favourite book she took the lead in turning the pages. At first Father was slow to make the animal sounds to stimulate her, so Dr R tried to help by talking about Lucy's attitudes and expressing her state of mind: pointing to the way

she reacted to the sounds of the animals: how she showed her curiosity, her capacity for joint attention, and how she signalled what she wanted to do.

Lucy worked hard to attract her Father's attention, but at first he seemed resistant. When he engaged with Lucy: throwing the ball to her; he behaved like a coach or trainer, training her to respond to the game in a *'proper'* way. However, when Dr R started singing, Father joined in and for the first time she saw him spontaneously smiling at Lucy and she returned his smile.

There was an amazing improvement in Lucy's concentration. She was more talkative than ever: vocalising about the objects and the situations she experienced and responding to her name when called. She also showed a capacity to wait, share and take turns when playing a game with Father and Dr R. Most striking, was her ability to express her feelings and emotions, to take initiative and to tolerate frustrations. A big surprise was seeing her tapping the floor inviting father or Dr R to come and play with her. She was pointing, babbling and provoking them to play in a very lively way.

Lucy also displayed confidence in her large motor skills by climbing in and out of the 'tree nest house' and hugging the large soft toys in a very sweet way. She smiled as she played hide and seek, while father joined in timidly. At all times Lucy was the leader in the activities.

At the end of the first session with Father Lucy jumped with excitement when she heard Mandy's voice as she returned from her individual therapy with A. Mandy helped Lucy down the stairs of the 'tree nest house' where she was playing and picked her up in her arms and kissed her; full of loving feelings.

Father arrived after Lucy to the next session and this time he greeted Dr R with a warm smile. Though Lucy did not go to hug or kiss him, she looked into his eyes and smiled at him when he greeted her.

Lucy chose a musical toy and walked around the room shaking it and dancing. Dr R chose one for herself and Father, and all three sang ‘the wheels on the bus’, changing the lyrics to use the names of family members. Father was relaxed, humorous and witty and Lucy was more ‘present’ in the session, interacting with father and leading the game. We later discovered that father and Mandy had decided to try again with their relationship, which had a direct impact on Lucy’s state of mind, expressed in her play.

After playing a while with the musical toys Lucy climbed up to the 'tree house' and Father went straight after her saying *'I'm gonna catch you!'* Lucy got very excited trying to hide; lying down on the floor and covering her face with a cushion. She trembled with excitement in anxious expectation to be caught. When Father finally caught her he hugged her and they both rolled on the floor, laughing hard. It was the first time that Dr R saw Lucy laughing with joy and having fun. She observed that Father was gently hugging Lucy, keeping his voice low so she would not be overly excited.

At the end of the session Mandy came to the room with A, and Father went to talk to them. Lucy smiled and walked towards her mother, but when she saw that she was busy talking to Father she went back to play with some soft toys scattered on the floor. Perhaps she was giving space for her parents to rebuild their relationship.

Dr R said, *'Lucy, it's time to say goodbye'* and started to sing the 'goodbye song'. Smiling and even dancing a little, Lucy went to find Mandy. She was quiet and co-operative while Mandy put on her jumpsuit and put her in her buggy; she waved goodbye as she left.

During the play sessions with Father and individual sessions with mother I did not see Mandy and Lucy, but followed their progress in supervision with A and Dr R. When I saw them again I noticed remarkable progress in Lucy's development, which was also obvious to Mandy.

PIP Session 14 – Lucy at Twenty-Two Months

M: *… I can see the change*

Dr R: *Can you?*

M: *Yeah, I see it in her wanting to talk*

Dr R: *Yeah?*

M: *Wanting to play too… is, is the most important part. She doesn't just want to sit there and she doesn't just want to hide all the time now, which is brilliant.*

L: *Focused on playing with stacking cups. Picks up two cups and brings to Dr R.*

Dr R: *Thank you. We were playing together and she was inviting me to play with her. She was pretending that she was serving tea for me.*

M: *Now, when she goes past other young kids, rather than sort of screaming if they literally walk towards her …*

Y: *That's a green one (stacking cups with Lucy)*

M: *Mummy has a green one*

Y: *And that's red … red.*

M: *… rather than just screaming if there are kids walking towards her... now she kinda smiles and waves at them and stuff… so I think she will be OK for going to nursery… I think…*

CHAPTER SEVEN
Change in Representations

The change in Lucy from session to session was very encouraging, but there was still a major concern about her reaction to her maternal grandmother. She was fine with Father's mother, even when they met after a long separation, but she would start to scream when Mandy's mother came near. This was very upsetting for grandmother and she responded by staying away because she was *'afraid of upsetting Lucy'*. I wondered to what extent Lucy was punishing grandmother on Mandy's behalf for the abandonments of childhood.

Mandy and her mother had worked hard on their relationship since Mandy disclosed about the abuse. Her mother moved in with her after leaving the abusing step-father, and they went on holiday together to start a new life. That was the only time that Mandy remembered being really happy and laughing. After the disclosure Mandy's mother was overwhelmed with guilt and blamed herself for what had happened. Mandy tried to protect her by only attributing goodness to her: describing her as a beautiful flower that blossomed all year 'round. She showed me a tattoo on her forearm, which she had had done as a symbolic representation of her mother. It was an image of delicate cherry blossoms, tattooed over her painful self-harm scars. Perhaps this was an apt picture of Mandy's relationship with an idealized, fragile mother and her inability to acknowledge the pain of the relationship. The scars of the abuse still

remained beneath the beautiful, but fragile cherry blossom petals and the underlying pain and trauma yet unresolved.

On the contrary, Lucy's representation of her grandmother was as someone to be feared. Mandy and Father could not understand why Lucy could tolerate being with me, Dr R and A but would scream if her grandmother or her maternal uncle entered the room. This remained a puzzle throughout the intervention and only improved towards the ending of the work.

7.1 Protecting a Fragile Mother

Mandy had no good memories of her childhood. She was denied the experience of normal play because her mother could not tolerate her getting dirty. Also, apart from her abuser, there were at least two other step fathers, and I wonder what experiences they brought to her.

Despite her painful childhood Mandy protected her mother and found it very hard to blame her in any way for failing to protect her during fourteen years of sexual abuse. Of course, she could place most of the rage at her step-father's door, but could not acknowledge that her mother was responsible for leaving her to bear the abuse alone.

Her relationship with her mother was held in limbo during the silent, lonely years from age six to twenty-seven, when she was finally heard by her mother and believed. The perceived internal 'good' mother before the abuse, the 'bad' mother during the abuse and the 'good' mother after disclosure could not be integrated for fear of contamination of the idealised mother that she had constructed in her mind.

Mandy's internal mother was a *'tough cookie'*, hard-working mother who had no time to nurture her and her brother: therefore, much of Mandy's baby needs were as yet unmet. She had no internal representation of an available mother that played or sang with her. For example, Mandy would enjoy colouring alongside her girls but this was more for her own satisfaction and a way of calming her own anxieties, rather than to support their play. She did not sing to Lucy; When encouraged to do so she responded; '*The only person that sings to her is her dad… females haven't sung to her'.* We became aware that a large part of our work with Mandy and Lucy would be to populate and bring colour to their barren internal landscape and create new representations of how a mother should be with her baby.

Both Mandy and Father were burdened with adult roles during childhood, so they expected an adult response from Lucy. Father's expressions of love for Lucy was through adult *'love songs'*. Mandy had told me at our very first session; '*I was brought up adult like – speak when you're* spoken *to – manners'*. So when I introduced the idea of working with Lucy through play, she looked quite distressed because the idea of play felt quite intolerable. She felt overwhelmed by the fear that she would end up failing Lucy. Furthermore, she did not enjoy play because she '*was never allowed to be a child'*, so play was *'a weird thing'.* When Lucy brought her a book to read after experiencing the pleasure of reading in the sessions, Mandy was surprised that they both actually enjoyed the experience.

Though Mandy was expressing her own struggles to be a play partner for Lucy, she was also painting a picture of her relationship with her own mother as a

child: her unavailable mother who needed to get things done and who worked three jobs to make ends meet, whose obsessive compulsive behaviour did not allow her just to *'be'* with Mandy and her brother to read or play with them.

The relationship with her mother was the only internal model that Mandy had to refer to when raising her children and though she had resolved not to allow them to suffer with adult responsibilities like she did as a child, it was impossible to protect them from the ghosts in her nursery: unconscious patterns of parenting inherited from the way her mother parented her (Fraiberg, 1975). Lucy seemed to be particularly sensitive to such painful, *'convex'* projections, that *'perverted meaning and conflicted with her states of mind'* (Briggs, 1997), and therefore she acted out when her grandmother was present.

What was activated in Lucy and grandmother when they met that could not be tolerated? Was it something that Mandy could not acknowledge herself and therefore by projecting the associated feelings onto Lucy, she was able to express the rage and hate that Mandy disowned? And how did Mandy manage her need for an available mother during her childhood when her own mother was so distracted with work and obsessive behaviours?

7.2 The Imaginary Mother

Mandy shared the poignant story with me and Dr R, of her imaginary friend called June: an old lady whom she invented to fill her inner void in her tender years from age three to age twelve. She had no other friend to play with, but June would come and play with her. Her account of her imaginary friend helped me to understand her deep need for a comforting, internal maternal presence.

PIP Session 8 – Lucy at Seventeen Months

Dr R: Do you remember yourself playing with your mummy?

M: Ahhh… no.

Dr R: No?

M: (quietly) no. Our play was more, ah, quiet… puzzles… things like that.

Dr R: Yeah?

M: Hmmm

Dr R: But, do you remember yourself playing alone?

M: Yeah, I used to play on my own a lot, yeah, with my, my teddies and my doll house and…

Dr R: A best friend? (Lucy is cuddling Squishie (teddy) and offering to Dr R)

M: I had an imaginary friend.

Dr R: Ah you have…

M: For a long time. I was the only child up until my brother came… and I was already…

Dr R: How old?

M: Eight years between us I think I was eight.

Dr R: Eight years? And what was the name? It was a male? … your imaginary friend.

M: Oh, it's a female… an old lady.

Dr R: An old lady?

M: Yeah … we used to play the piano together.

Dr R: Piano?

M: Yeah. We had an electric, sort of keyboard if you like… am, on a stand and things, … am and I used to play it and pretend I was playing to her.

L: Lucy takes dolly from cupboard and gives to Dr R, who already has Squishie. Dr R holds up dolly, talks for dolly to say hello to Lucy. Lucy takes doll. Dr R is enthralled and distracted by Mandy's conversation.

Y: Did you say an old lady?

M: Yeah

Dr R: Yeah, an ol… What's her name?

M: June

Dr R: June?

M: June

L: Brings baby to me.

Y: Thank you. Hello baby.

M: Me, I could have sworn I would see her. I could see her.

Y: (To Lucy) Is that your baby? Beautiful baby.

Dr R: How was she?

L: (Takes doll from me and brings to Dr R and vocalises) Ah ha

M: She was an old lady. She was always in her nightie…

Dr R: Really? (Takes doll from Lucy) Hello baby (to doll and kisses it).

M: … a really old fashioned nightie… and she had grey curly hair and… she was lovely… a really nice lady. She loved music, so I used to play music with her.

Dr R: Your last memory about her? Do you remember?

M: Am… yeah my mum got angry with… cos I didn't wanna do my work that I was given from my play school thing we were doing, cos I was playing music to her, and, am, …

L: (Lucy starts to laugh with mouth wide open as she walked the dolly across the floor. Cuddles dolly and looks at it).

M: … my mum shouted at me and said, am, she's not real so get on with it.

Dr R: Hmm

M: … and am, I never see her again.

L: Runs back to Dr R laughing with doll. Dr R takes doll.

Dr R: Hmm. And, am, how did you feel when your mum was…

M: Sad, sad… cos, am, as far as I was concerned she was real.

L: Walking around with baby… kissing and walking doll on floor and vocalising loudly.

Dr R: And she was.

M: But it made my mum angry for me to see her or play with her so…

L: (Kisses doll and bangs doll's feet on floor walking doll. Vocalises) Buh

M: … I ignored her.

Dr R: Dr R receives doll from Lucy absently while listening to Mandy. Lucy sits on floor looking at doll and waiting for Dr R to do something with doll. Dr R holds doll upright poised to walk. Lucy takes doll and walks her loudly on floor.

Y: So you said you ignored her, did she go away?

M: Eventually. She came for quite a while but, I just kept ignoring her and eventually she just… didn't come back.

L: Walks doll loudly on floor and looks at Dr R.

Y: How old were you?

M: About… about 12… by the time… I stopped seeing her. Hmmm.

Dr R: (Moves to sit facing Lucy and give her full attention) Hello.

Y: And do you remember when you started to be friends?

M: I was about three.

Dr R: Three?

L: Walking doll and vocalising.

M: I was really young.

L: Looks at doll and swivels around to face opposite direction – walks doll in front of her holding both arms.

M: My nanny's mum passed away… I've never met her… she was quite far away. My nanny's mum passed away and I remember having to go to a cousin's because my mum had to go to the funeral… am…

L: Continues to walk doll loudly on floor happily.

M: … it started not long after then

Y: Hmm

M: After that sort of experience.

Y: So your… so that was an old lady who passed away.

M: Er, yes, she was old, yeah.

Y: That's interesting… then your… your friend was also an old lady.

M: Yeah. I mean, I never met my great nan, am…

Dr R: You felt safe when she was with you.

M: Yeah, I just didn't feel alone.

As Mandy uncovered her early memories her voice was quieter than usual and I could sense the loneliness of the little girl inside her as she sought out the company of a mature, available adult with whom she could feel safe and understood. Somehow Mandy's ability to talk about her imaginary friend seemed to release a feeling of deep calmness within the session as she felt

the containment of the therapeutic presence. Lucy's play was free and full of laughter. She constantly linked the adults in the room by offering her precious objects to one and then the other. She led the play throughout the session: making herself vulnerable and lying on her blanket so Dr R could pull her along and then put her dolly on the blanket to be pulled along also. From time to time she would hug us spontaneously and go back and forth to Mandy for hugs and kisses. In fact, she played in a symbolic way with her dolly throughout the session, showing that she had the capacity to think about her baby's feelings by putting her to sleep and cuddling her.

It seemed to me that there were two babies in the room responding to the strong containment within the session; Lucy, who communicated her inner state through her doll, and Mandy, who comforted her vulnerable inner baby through Lucy's hugs and kisses.

With the departure of Mandy's imaginary mother when she was twelve, I wondered how the need for a containing internalised mother was met. She told me that she used drugs, alcohol and excessive partying in the past. Mandy's ability to talk about her childhood difficulties seemed to have had a freeing effect on her and on Lucy's play.

7.3 The Internal, Idealized Mother Meets the Real Mother in Individual Psychotherapy

When Lucy turned nineteen months there was evidence that Mandy's mother was keeping up with the new activities that were being introduced to her in the sessions, such as the stacking boxes. Mandy mentioned in passing; *'My mum*

bought those at her house and it's the first thing she (Lucy) goes to…' It seemed that grandmother was attempting to connect with Lucy at her level and becoming more flexible in her approach. Despite her effort to connect, Lucy still screamed and cried when she walked through the door.

PIP Session 14 – Lucy at Nineteen Months

M: *I mean ... my mum used to look after her for me on the weekends so I would get a little break… am… once a month the girls would go to their daddies, am, for the night… and then my mum would have Lucy for the night… I haven't been able to do that cos I won't put her at my mum's … because, she ends up upsetting my mum… if you like, because my mum is quite a softie… And my mum feels bad, like she's done something … and she doesn't come up anymore because she doesn't wanna upset Lucy.*

It was around this time that Mandy started individual psychotherapy with A, and had a protected space in which to use A's listening presence to explore her feelings about significant family members. Mandy's body language became more open and relaxed as the sessions progressed and she was able to share many difficult experiences about her childhood. She brought her journal to the second session and suggested that A could take it away and read it: demonstrating her willingness to open up still further and show her vulnerable parts. A declined from reading the journal outside the confidentiality of the session, which resulted in feelings of rejection in Mandy. She had not expected that A w*ould be* able to set firm limits and boundaries. After processing her angry feelings, Mandy felt more confident that A was tough enough to hold and contain her traumatic material, and was able to voice her rage about having been let down by her mother and other family members. She talked about her

children, through whom she expressed different aspects of herself, her abuser who was a persecutor and hated internal object, her aunt who was a betrayer, to whom she had disclosed about the abuse, but she left without a word, causing Mandy to lose all hope in adult protection, her partners whom she viewed as *'mixed blessings,* her brother for whom she felt exasperated maternal affection, and her mother, for whom she had an idealised love.

During these sessions Mandy described her mother in different ways: as *'my world', 'a tough cookie'*, '*quite a softie'* who '*felt bad about upsetting Lucy'*, and as '*absent*' and overly '*strict',* but was only able to express admiration and love for her. However, when she spoke of her relationship with her younger brother whom she had mothered, A asked her, "*So who was there to mother you?*" She responded: *"I had no one."* As the sessions progressed Mandy expressed, *"I do want to be a more loving mother because sometimes I can be so cold and harsh, like my mother."* Perhaps Lucy had also experienced this coldness when with her grandmother, and had no words, only tears to express her discomfort.

In supervision we recognised that grandmother had been the recipient of extreme abuse by Mandy's birth father, Mandy's step-father and possibly other partners. She needed to be the strongly defended '*tough cookie'* to survive. However, on the inside she was a *'softie'*, very weak and vulnerable. Both mother and daughter had been so objectified that they did not naturally attune to the feelings of others. It was hard for Lucy to feel safe and contained with such lack of attunement or containment.

During the therapy with A, Mandy acknowledged the rage inside her at a particularly vulnerable time when Father had broken off the relationship with her. She said she could not bring all her anger because *'it'll be a disaster for all of us'*, and could end in separation from her children, being locked up in an institution or even death, so she had to protect everyone from her awful feelings, like she protected her mother from the awful things about her childhood.

In individual therapy, Mandy also acknowledged the voice of the '*tough cookie'* mother, that kept telling her, *'don't be weak'.* Mandy recognized this in her attitude to her own children and made a conscious decision to allow them to express their feelings of distress and to comfort them so they would not keep their difficult feelings inside.

7.4 Signs of Breakthrough with Grandmother

After five intensive sessions with A I noticed a change in Mandy's narrative about Lucy's relationship with her grandmother. She reported; '*She's getting slightly better with my mum too., which is a really good thing'.* It still took about half an hour for Lucy to settle with her grandmother in the room, but now she was able to tolerate her presence. Grandmother would video call daily so Lucy could get used to seeing her. This showed quite a shift in grandmother's attitude to her grandchild and a willingness to attune to her needs instead of the strict and rigid boundaries that Mandy knew as a child.

There were still concerns about Lucy's relationship with her grandmother in the final session. Though she no longer screamed when grandmother entered the

room she was still afraid of her. Mandy said that the fear came *'out of nowhere… she was unwell one weekend* (while staying with grandmother) *and my mum brought her home… and ever since then she will not go near my mum'*. Mandy explained how her mother had given Lucy paracetamol, her comfort blankets and dummy but could not calm her so she brought her home. Father was very insightful when thinking about the issue with Lucy and grandmother, saying, '*maybe she feels like your mum let her down; and she brought her back here instead of looking after her'*. Both parents agreed that grandmother did not have the strength to stay with Lucy in her vulnerable time of sickness; she was far too fragile. As with Mandy, she now felt really bad for failing Lucy. However, when failed as a child, Mandy said that she *'never rejected'* her mother but '*wanted her more*. *Lucy is completely opposite … If she feels rejected by you… she rejects you'.*

Though the issue with grandmother and Lucy was not completely resolved by the end of our intervention, Mandy had a good understanding of the unconscious dynamics in play and the importance of an available mother to contain Lucy's anxieties. Grandmother continued to video call and to nurture the relationship with Lucy, and six months later at the follow up sessions, the story was different.

In fact, the story seemed to change on many fronts. As Mandy felt more equipped to pass on the containment she received in the sessions to Lucy, we saw a considerable improvement in her symptoms. In the next chapter we will see how these changes affected family relationships.

CHAPTER EIGHT

Change in Family Relationships

We saw in the previous chapters how difficult it was for Lucy to feel safe with Mandy's mother. Even more importantly for this thesis, we saw how Mandy's internalised mother manifested in the way she parented Lucy, using the rigid boundaries she experienced during her own childhood. However, as Mandy was able to acknowledge her mother's mistakes, she was able to avoid repeating them in her care for her children (Main, 1988). Meanwhile, Lucy's grandmother learned to approach her in a more sensitive and age appropriate way.

In this chapter we will observe the adjustments in family relationships. The initial change in the relationship between Mandy and Lucy was rapid; almost immediately there was a marked difference in Mandy's maternal sensitivity within the sessions. She did not push Lucy away with rejecting words as she did in the first session. There was also a gradual increase in displays of affection between mother and daughter, which eventually spilled over into the relationship with Lucy's siblings.

At seventeen months, Lucy was sometimes able to play with her siblings and allowed herself to be 'mothered' by them, but she was still very intolerant of

them going near to Mandy and would scream even if they sat near her. Mandy became more aware of intergenerational patterns of parentified behaviour, where the children became the caregivers. Though this behaviour did not totally stop there was a gradual decrease as Mandy took back the role of parenting Lucy from her siblings.

8.1 The Importance of the Parental Relationship

Lucy's behaviour towards her father still caused him much pain and seemed to me to be affected by the quality of the parental relationship, which was quite chaotic at times, with frequent break-ups and coming together again. Though Mandy did not deny Father access to his beloved Lucy it seemed to me that her merged relationship with Lucy excluded father and was a constant source of punishment for him, and I imagine for Lucy also. Mandy always made it clear that the children belonged to her and she had the power to share them with their fathers. I wondered if perhaps Mandy could retain a measure of control in the children's relationships with their fathers as long as they remained merged with her.

Mandy announced at our sixth session that she and father had broken up *'again'* and she was in the process of clearing out all of his possessions. She shared plans to redecorate the flat and hang new curtains to lighten up.

PIP Session 6 – Lucy at Seventeen Months after Split in Parents' Relationship

M: Yeah, yeah… and then I'm gonna get a new TV unit… a new TV unit… and then I'm gonna get some… am… bookshelves, if you like, to go in the alcoves… so I can put the DVD's on them… and then, am… that sorts out the storage… where I'm going to put all those.

Y: Yeah?

Dr R: Mouth (Lucy still eating and engaging with Dr R and doll)

M: …Am… yeah.

Y: 'cos often an external reorganisation… is… like… an internal reorganisation… so you are organizing the outside… but there must be some reorganization going on on the inside as well…

M: I feel sort of… I mean, I miss him like crazy… I loved him to bits. He was… he was … my world and…

Y: In the past you said that you loved him.

M: Yeah… I think I'm getting used to … to… how it is now… so now it's about me and my kids... and that's it.

Dr R: Ahhhh… (Dr R and Lucy playing closely, face to face… Dr R covering face – hide & seek - Lucy laughing)

M: I don't need a man; I don't want a man. I'm not gonna bring men into my kids' life… they don't need it… they need their mum. They've got a dad… so… they don't need another one. It's gonna be me and my kids from now on… just us (nods and looks at Lucy then looks vacantly ahead).

Despite the breakup Mandy and Father agreed to keep things the same for Lucy. In fact, Mandy was convinced that Lucy did not even notice the break-up. She would be going to stay with her dad at the weekends while Mandy decorated the flat.

It seemed to me that Mandy could not bring herself to acknowledge Lucy's pain when things did not go well between her and Father. Because she had been treated like an unfeeling object as a child, with no-one to acknowledge her pain, how could she see Lucy as a subject with real feelings. Perhaps Lucy vented her intolerable feelings on her father because, like an available mother, he was more able to receive, acknowledge and share her pain. I noted that there was no mention of Lucy getting angry when she stayed over at her father's home where she was not caught in the middle of her parent's projections.

From the above conversation, it seemed that Mandy's relationship with Lucy's father had taken on the same pattern as her relationship with the fathers of the other two children. When she allowed herself to 'feel' her heart would be broken and she would have to settle for an arrangement whereby she would have limited access to the loved object (fathers) through the child.

PIP Session 6 – Lucy at Seventeen Months

Y: *And so, it sounds as if you sort of have been negotiating parts of her…*

M: *Yeah*

Y: *… That you can share*

M: *Yeah… because I don't think it's fair for her to have to have one parent there for everything, you know, or you know, it's always only her dad or only her mum. She needs to see that we are still a united front where she's concerned… that we still have common interest of her quality of life… together… so I think it's good to have that.*

Dr R: *Now you have your dummy, and you have mummy (playing with Lucy's fingers) one little finger, two little fingers, three little fingers, four little fingers…*

Y: *And the other girls they have access to their dads as well.*

M: *Yeah, yes*

Y: *So you've worked out a way of being mum… being there for them… you always say, my Harriet, my Imogen (Mandy nods and smiles).*

M: *They are mine… but they do have a dad… (Dr R to Lucy -peep, peep, peep, peep, peep - repeatedly) and as long as their dads… try with them... and make them a priority sometimes, then that's fine…*

On the surface, this formula of shared parenting seemed to be working well for Mandy, nevertheless I could sense her underlying longing for more. Could she bear the expectation of being the priority in someone's life? Was she really satisfied with her children enjoying being their fathers' priority *'sometimes'*? Perhaps this arrangement also kept the loved object at a safe distance where they could not be destroyed by her anger.

8.2 Seeing Lucy as a Separate Person

Mandy described herself as being wrapped around her children; as if she and they would be destroyed if forced apart. As representations of herself she had placed her own ego ideal on them (Freud, 1909 &1914). She said of Lucy, *'she's really me in a little girl's body'.* So when Mandy became emotionally disconnected, Lucy clung to her, for fear of falling apart. Mandy knew that feeling throughout her childhood when she became cut off from her mother.

As Lucy became more tolerant of playing with me and Dr R, Mandy was able to see her as a separate person. At first she saw only aggression in Lucy's actions; which made sense in the light of Mandy's view that Lucy was an angry child version of herself. During the sessions, when we were hearing new words and celebrating new developments in Lucy, Mandy would be waiting for her to act out aggressively, but this hardly ever happened.

PIP Session 5 – Lucy at Sixteen Months

Dr R: (Takes glasses) … thank you. Where's Lucy? Where's Lucy? Oh I can't see her. Where's Lucy? Where's Lucy mummy? Lucy looks up and waves stethoscope in front of Dr R.

M: She's, she's… getting to that point now.

Y: Is she? What point is that?

Dr R: There she is, yeah.

M: Where she finds it funny to start hitting.

Y: OK

Dr R: I found you… I found you.

L: Looks at Dr R and vocalises - sounds like I found you.

Dr R: Yeees… You found me… you found me… you found me (nodding).

Y: I recognize those words… I recognise those words.

M: No see, that's, um, that's 'mine'. She's getting um… (Dr R laughs as Lucy takes glasses) she, she's getting to the point when she's… this is where she starts getting too grown up for her own good with her playing… sort of er, 'no that's mine… you ain't touching it'… and the attitude comes across. I mean, I can spot it coming already…

Y: aw right
M: cos obviously she's my child, I know her
Dr R: yeah.
M: I see the signs
Dr R: yeah
Y: mm mm.

The aggression that Mandy anticipated did not materialise in our sessions because Lucy's new interest in play made her less available to receive Mandy's projections.

8.3 Fear of Change and Separation

Mandy's relationship with her children was a way of having a relationship with herself because she saw them as part of herself and not as separate individuals. She described to me how she managed her feelings through her children: emotions were projected onto Harriet, her disassociated, cut-off parts were assigned to Imogen and her anger was assigned to Lucy. Mandy would often say, *'my children are my life'.* It occurred to me therefore that a change in any aspect of the family, including Lucy's symptoms, would involve Mandy reclaiming her disowned parts that she had projected into her children and that process would be deep and painful. By externalising her feelings, she avoided the pain of processing them or getting to their root cause.

8.4 Including Father

On one occasion I attended for a session and Father and Imogen were at home. Mandy and Lucy had gone shopping, having forgotten about the session. Father took the opportunity to speak with me about his fears and

worries about Lucy and his desire to be part of the work. He seemed desperate and felt excluded. I discussed this with Mandy when we resumed at the start of the new school year and father was able to obtain permission from his work to attend the weekly sessions. In response to Father's concerns about his relationship with Lucy, we arranged some family play sessions with both parents present when Lucy turned twenty months.

The inclusion of father heralded a rapid change in the family dynamics. Father was very quiet during the first session and lacked confidence in approaching Lucy due to her past rejection of him. However, in the context of play Lucy expressed a tender responsiveness to her him. They seemed to have their own secret way of communicating. When playing with the Mega Blocks for example, Lucy seemed to trust that her father would be responsive to her and would stretch her hand in his direction, beckoning with her fingers for a block without even looking up.

Through play, Lucy's parents learned the importance of being available to her. When they became distracted or got caught up in conversation between themselves she would quickly loose her focus. I pointed out to them that Lucy was looking to engage with whomever was available to her. I could also see how difficult it was for them to maintain a position of being fully available to Lucy's needs. At times it seemed that they were the children while Lucy busied herself with the important occupation of play.

The family sessions included activities such as stacking blocks and boxes, sorting colours, singing and finger rhymes using puppets, responding to Lucy's games of hide and seek and showing her parents the significance of 'finding'

her in order to build trust in the parent-infant relationship, pretend play such as going shopping, demonstrating to Lucy's parents how to facilitate and enlarge her play, and helping Lucy to manage transitions at the beginning and ending of the sessions using the hello and goodbye songs.

Imogen was present at some of the family sessions and on those occasions it was more difficult for Lucy to maintain her focus due to Imogen's need for attention. It occurred to us that she was the baby that was *'cut off'* from Mandy's feelings and she desperately wanted to feel special like Lucy, so we were careful to include her in the activities. Despite the sessions feeling more chaotic than usual when Imogen was present, Lucy still showed excitement about playing and engaged in pretend play with her sister. It was interesting to see how Imogen competed with her mother for the parental role and how Mandy tried to prevent her from doing so within the session. I wondered what it was like when there was no outside observer.

8.5 Rebuilding Family Relationships

By the time Lucy turned nineteen months Mandy reported a change in her relationship with her other girls due to the changes they had observed in Mandy's relationship with Lucy.

PIP Session 9 – Lucy at Nineteen Months

M: The other two have started turning to me too.
Y: They didn't used to do that before?
M: Harriet didn't, no… very independent.
Y: So Harriet is coming to you for affection and to be kept safe?
M: Yes

Y: When did that start?

M: Am, I think when I got better with dealing with Lucy

Y: OK

M: She could see when Lucy was screaming and stuff before… before it just used to get to me so much that I would have to walk away from the situation.

Y: Hmm, hmm.

M: But when I sat and thought about what you had said before was that basically, she's not gonna remember why she's angry after 30 seconds… all she's gonna know is she's angry, she's upset and she's alone.

Y: Yes

M: And that really sort of… sort of really got to me cos I thought, oh my God, my child feels like that. That is not good enough.

Y: Hmm

M: And it sort … in a little way, it sort of broke my heart

Y: Hmm, hmm

M: Because looking back all them times that I had to walk away from her… all them times she felt …

Y: Because you felt that was the right thing to do.

M: Yeah, yeah… at the time

Y: You didn't know…

M: But now…now that I know different, I go to her… I hold her… I tell her it's gonna be OK… I sing in her ear… am, I put the TV with the music channel on and I put sort of a love station on, or… something really bouncy and stuff… I put something like that on and I'd stand there and rock with her and hold her and since doing that Harriet has started to slowly come to me as well…

Y: Wow… wow

M: I think she's seen that I can … I don't know… deal with things better... I dunno .

Dr R: When she comes, when she goes to you she hugs you or…?

M: Yeah… she'd sit there and she'd… it started with the whole laying her head on my shoulder… but she never even used to sit next to me

really… she would sort of sit on the chair or in her room, you know and I'd just sort of think young one turning into a teenager… wants her space.

Y: Hmmm

M: Am, but she's slowly started to come in … she watches a film in the front room with us all now am… rather than going off.

Y: So she's not isolating herself.

Dr R: And how do you feel about that?

M: I love it… absolutely… cos I live for my kids… my kids are my life so the fact that now my eldest is coming back to me if you like it's… really nice… but she's jealous (pointing to Lucy). If she sees any of the other two coming near me she's like aarrrgh. (Laugh)

Y: Yes… but at least she will realize that you're no less there for her.

M: Yes… cos they go to get up… whenever she starts getting… look like she's getting upset about something they go to move I go no, no, no, don't do that… come here.

Y: So they're afraid really… or they … they don't want to upset her.

M: They don't wanna upset her, so they're about to move, I go no, no, no, NO. We don't do that. I says, just sit up for a second…

L Turns and gives me the stacking boxes and vocalises.

Y: Yeah, can I have a turn… thank you, you're sharing… you see, mummy is talking about sharing your sisters as well.

Dr R: Thank you

Y: Yes, you're sharing

M: No I'd pick her up and I would put her on my lap or I'd put her this side and the other girls on this side and then we all kind of snuggle together.

Y: There's room for all of us… mummy has space for all of us. Sharing mummy.

M: Yep… that's right yep

Y: Good… that's right... and she'll get the idea… she'll understand that.

I felt that this was a breakthrough in family relationships because at last Mandy was allowing herself to feel and to be broken hearted about the state of affairs

with Lucy. Thus far Mandy seemed to believe that all Lucy needed in order to change was some help from us but now she could see that she also needed to change before family relationships could be affected. Harriet had felt emboldened to draw close to her because she started to see her as a real mother, whom she could 'feel' and to begin to tentatively trust with her feelings.

8.6 Separation and Individuation

Twenty to Twenty-Two Months

Lucy's relationship with her father improved significantly after the start of the family sessions and father-daughter play sessions. The increased involvement with her father supported Lucy to meet her developmental milestones and to assert her independence, but her parents were struggling with the challenge of managing the separation. 'No' had become her favourite word, and at first Mandy was amused and dealt with Lucy in a fun and playful way using the hide and seek game as in the sessions.

PIP Session 14 - Lucy at Twenty-Two Months

M: So cheeky… she's so cheeky. When you tell her off at the moment… you say to her, no, don't do that... she goes like this… peek a boo and she goes… I can still see you.

Y This is the time when she is testing all the boundaries, yeah… and no is a very important stage… because she is trying to have her own mind

M: Yeah

Y We call it individuation. It's a separation, individuation. She begins to be an individual… not merged with mummy.

M: Yeah

Y: Now, if a child does not separate… from mummy… they can't grow in a healthy manner

M: *Yeah*

Y: *Because the relationship is so…*

L: *Gives a blue block to me.*

Y: *Thank you*

M: *…intense*

Y: *It's too intense, and it's a big responsibility because, they think that they have to be responsible for mummy.*

L: *Gives me a green and yellow block stuck together*

Y: *Thank you*

L: *Takes back the block and tries to separate them*

M: *…and they don't, they need to have fun and learn and grow*

Y: *That's right.*

L: *Lucy separates the two blocks*

Y: *Cos usually it's mummy that can't bear to be separate from them… but a child really needs to am… when you say that she's saying 'no', I'm saying 'yes!', that's good.*

L: *Runs out the room with the yellow blocks*

Y: *And it sounds as if you're managing those boundaries in a really fun way… with the game… hide and seek… every child loves hide and seek…*

M: *She thinks I can't see her when she covers her eyes… I can't see you, you can't see me*

Y: *In every culture we have that. What the child is saying is… ok, are you willing to come and find me. So, whether they think you can't see them when they cover their eyes or whether they hide behind the curtain… or whether… a bigger child might think… They're sulking, and they might go and shut themselves in their room…*

Dr R: *Lucy.*

Y: *What they're saying is… do you care enough to come and find me?*

M: *Yeah. Come and make me feel better*

Y: *And… if a child has enough of the response…*

Dr R: *Gets up to go and find Lucy*

Y: *… is it OK for Dr R to go and get her?*

M: *Yeah*

Y: If a child sees that mummy or daddy can't be bothered to find them…

M: That's when they start feeling alone…

Y: …they know that… they know that, they don't care enough to come and find me.

M: Yeah

Dr R: Lucy… I'm waiting for you.

Y: So sometimes a child will play those hide and seek kind of games, because they are waiting to see if you would pursue them.

Dr R: Where's Lucy… I'm gonna get you…

Y: We play those kind of games too. Remember when you wouldn't open the door to me?

M: Yes

Dr R: Lucy

Y: That's that game.

M: Yes

Y: And if I had stopped coming you would have just gone back into your merry old ways…

M: Like sitting indoors, curtains closed, shut away…

Y: … so I kept coming back and back. The reason I kept coming back week after week is, whether you opened the door or not, I want to send you a message that you know that, I'm committed.

M: Yeah, you're here

Y: I'm not gonna disappear until we agree…

In the conversation above, we linked Mandy's journey to a trusting relationship with me with the way she was developing a trusting relationship with Lucy. She therefore seemed ready to go deeper into exploring some of the difficult issues in the individual sessions with A. She speaks of this below.

PIP Session 14 - Lucy at Twenty-Two Months

Y: So you stuck in there then… and it sounds like last week was a turning point.

M: I think I just had enough of feeling hurt and hurts and ickey and I know I need to get the help… cos I'm not in a good place. So if they turn into what I am now… they're gonna be upset and lost too.

Y: So it sounds like you're thinking of how this will affect the children.

M: I need to fix me… we're now gonna concentrate on opening up… but not opening up to the point where I end up collapsing in a bit of a bundle. Opening up little bits… dealing with that little bit… moving on from that little bit and on to the next.

This period of going deeply into her painful past coincided with Lucy's bid for independence, which made the process even more challenging. Dr R and A helped Mandy and Lucy to separate at the start of Father's play sessions with Lucy and Mandy's individual psychotherapy, and to reunite at the end of the sessions. This enabled Lucy to bond with her father and Mandy was also able to see Lucy as a separate individual, not merged with her.

PIP Session 14 - Lucy at Twenty-Two Months

Y: So remember what I said about separation… very important that

M: Yeah, cos I know that separation is, mainly me…She don't wanna leave me cos she knows that I don't wanna leave her.

Y: Right. You got that in one (laugh)

M: Yeah. And when I am separated from her, she plays so well with K in the centre and I'm not there. And she doesn't actually care. It's not that she doesn't care about me… but she's ok with me not being there.

Y: Why do you think she's ok about you separating?

M: Because she's a child, she's playing, she's having fun…

Apart from tolerating the separation from Lucy, Mandy also had to tolerate the loss of Father, who had recently ended the relationship with her. She brought her feelings of distress, sadness, loss and 'heartbreak to the individual sessions

with A, shedding tears of loss and fear because she had thought that Father was the person who truly loved her and the only good thing in her life.

Mandy was able to voice her resentment about her brother taking all her mother's attention, because he was a colicky baby. She talked about how cross and resentful she felt about being forced into the role of parenting her brother, without anyone to look after her. She grappled with her feelings of having been let down by her aunt, her mother and now by Father, and with her fears that her love for them would turn into overwhelming, destructive hate. She faced the difficult reality of having been disappointed, frustrated and betrayed by the ones who should have protected her and thought about how to allow her children, who truly belonged to her, to be separate from her.

Mandy was also pleased to see signs of improvement in Lucy's relationship with her grandmother.

Dr R: What other changes have you seen?

M: Those are the main ones really… am… and obviously that… being more talkative and things. She's getting slightly better with my mum too., which is a really good thing.

Dr R: Really?

L: Vocalising non-stop in a conversational way as she plays with toys

M: It still takes her a good half an hour ish to sort of settle with my mum being here…

Y: Is mum playing with her?

M: Yes, but am… she does give in in the end and she's not bothered by her being here.

Dr R: Oooh

M: It's getting her to actually want to approach my mum now.

Dr R: She accepts to be touched by your mum…?

M: Am…

Dr R: …Like hug?

M: I don't think my mum's pushed it just yet, cos she doesn't want to move too fast too quickly.

L: (L dismantling blocks and giving to Y) Ta

Y: Red one… blue one… blue one… blue

M: But she's ok with her being in the room after a little while, which is good… because she wouldn't settle at all if my mum was in the room…

Dr R: Oooh

M …So, we're getting there with her… it is getting better.

It seemed to me that Mandy and her mother had started to see the importance of adapting to Lucy rather than rigidly expecting her to adapt to them. They employed other strategies to help Lucy to acclimatise to her grandmother, such as Face Time on Mandy's mobile phone. The representation of a 'strict' and 'cold' internal mother was slowly changing.

CHAPTER NINE

Ending

Lucy was approaching two years and it was almost time to end the work with the family. I explained the plans for the ending with Father and Mandy and that we would review our work together over six sessions, using video clips of past sessions to see how things had changed.

9.1 Anxieties about the Ending

Our plans for the ending coincided with Lucy showing signs of independence and asserting her autonomy by saying *'no'*. At first Mandy responded with humour, but as Lucy continued to challenge her she felt that she was deliberately being defiant. They were concerned about Lucy having meltdowns when she was told 'no'. During the session Father said 'no' to Lucy and she automatically lay on the floor, ready for a tantrum. He looked at her calmly, stretched out his hand towards her with fingers splayed and waited. Lucy took hold of his finger and he pulled her up and together they continued to play with the bubbles. I was able to think with Father about how he averted a tantrum by reaching out to Lucy and offering a way to help her manage her feelings during this developmental stage of separation and individuation.

Talking about the ending provoked a great deal of anxiety in Father and Mandy. Though they said that Lucy had come on *'leaps and bounds'*; they were still worried about several major issues. It still took about half an hour before Lucy interacted with Father when he came to see her. While her parents voiced their concerns, Lucy kissed Father spontaneously on the knee. Father opened his arms and she ran forwards into them. He kissed her tenderly on the head as she climbed up for a cuddle.

Lucy was also said not to be eating and sleeping well. She used to love eating but had now gone off her food and had started to wake at night. The problem started after she bumped her lip on a table at the children's centre. I suggested a visit to the dentist or the GP for a check-up. At the follow-up visit six months later Mandy informed me that Lucy had to have her teeth removed due to the accident, which caused such sensitivity that she found it hard to eat.

Another difficult issue was Lucy's new interest in pens. She would draw on the walls, furniture and fridge freezer. I explained to Mandy and Father that Lucy's behaviour was age appropriate; she wanted to explore so they needed to provide her with the material she needed such as big sheets of paper so she could explore in a way that can be positively affirmed. Mandy responded, *'she's not interested in doing it the way she's supposed to do it. She wants to do it her way, which is on my walls'.* She felt that Lucy simply wanted to deliberately oppose her and could not see the behaviour as a developmental milestone.

Above all, Lucy was having major meltdowns when told 'no'. Mandy said she had never known a child to respond to 'no' in the same way as Lucy: as if it broke her heart to be told 'no'. She saw Lucy as seriously stubborn, and

refused to have '*a spoilt child' … that does not know boundaries'.* Her strategy for managing Lucy's tantrums was to ignore her. Father would try not to go to her and would feel guilty for *'constantly saying 'no' to her'* and '*turning her whole world upside-down'.* When I suggested practical strategies to manage Lucy's tantrums Mandy responded, *'we can't always use something as a distraction cos she needs to know that no is no'.* Father added that *'she's got to know right and wrong'.* It seemed that Lucy's developmental challenges and the idea of ending had wiped out the learning of the intervention and there was a temporary return to the parents' rigid strategies.

I noticed that Lucy's tantrums would usually take place when her parents missed her cues. During the conversation above, Lucy gave a pot of bubbles to Mandy and stood in front of her whining expectantly for more than a minute while Mandy spoke about her meltdowns. With frustration Lucy sat down and fell back on the floor, banging her head. Mandy told her to get up: showing no sympathy for her *'attention seeking behaviour'*. Lucy sobbed loudly and leaned back against Mandy. I said, *'this is a child that looks really heartbroken'*. Mandy's tone softened as she stroked Lucy's hair in comfort.

Whilst on the one hand Mandy noticed that Lucy was changing and was *'Becoming her own little person: wanting to explore and grow and learn.'* She struggled to find the internal resources to consistently support Lucy's development. However, Father was inspired by our discussion to think creatively about supporting Lucy's development and purchased a small table and chair and a wide range of learning materials for her second birthday, which brought some order and routine to her days.

9.2 The Final Session

Lucy at Twenty-Six Months

The final session with the family was the most significant of all; it was a culmination of two months' careful planning. I attended with Dr R and A to celebrate the ending of all aspects of our work. Father was able to get time off work to attend with Mandy, Lucy and Imogen. Harriet could not attend because she stayed with her father during the week.

It was noticeable that the family had prepared for the occasion. The house was extra clean and tidy and everyone was beautifully dressed. Lucy immediately busied herself with the contents of the toy bag. She would run to her father for a cuddle in between activities. She seemed to relish revisiting the familiar toys, which she had mastered over the months.

'How is Lucy doing?' I asked, *'Any progress with nursery?'* We had been working towards getting Lucy ready for nursery but now the parents were not sure that they wanted her to go as yet. Father said that Lucy went backwards for a little while but she has now picked herself up again. Her tantrums were not as frequent these days but when she had them they were '*horrendous'.* They felt that the nursery would not know how to manage Lucy during a meltdown because even they, her parents, could not manage her.

Mandy spoke about her past experience with Imogen when she first went to nursery school and how the teachers felt that her behaviour was due to something that was going on at home. Father spoke about his experience with his young autistic brother, whom the school had failed. He feared that Lucy

would be told off by the teacher rather than being helped when she has a tantrum, therefore, they could not trust the school to look after her for fear that she would lose what we had worked so hard to achieve in the past year.

I pointed to Lucy playing with Dr R and showed her parents that she was ready for nursery. Lucy needed to be in a stimulating environment; there was a danger that their past bad experiences would prevent her from Progressing. Having already exceeded the time permitted to work with the family by two months, our plan was to execute a careful handover to the nursery and the children's centre so the family could continue to be supported within the statutory network. With the promise of our support to get Lucy settled into a suitable nursery, Mandy and Father decided to enrol her.

I noticed a remarkable change in Father in the ending session; as if he had stepped into the authority of the role of a father. His previous anxiety and vulnerability around Lucy had gone and both Lucy and Mandy responded to him with more respect. At one point in the session Lucy bypassed his open arms and ran to Mandy for a cuddle. Instead of looking rejected as before, Father responded: *"I'm over here"*, and pretended to pout. Everybody laughed and Lucy jumped down from Mandy's lap, ran into her father's arms and snuggled into him for a big cuddle.

Dr R also remarked that the gaze from Mandy to Lucy and vice versa, had changed and Lucy now looked at her mother *'in a lovely and calm way'*. Mandy replied, '*I don't see a fragile little child anymore… I see a very confident child'*.

Father said that he saw Lucy as a confident child, who no longer needed the services of the PIP team, but he saw in Mandy '*a fragile mum',* still in need of

a support network and afraid of separating from Lucy. Mandy felt that she did not have the physical or inner strength to hold Lucy during her meltdowns, but Father embraced the responsibility as part of his role as her father. They both agreed that he was now a more confident father. He said: *"I won't ever let anyone knock my confidence, you know what I mean, when it comes to her, cos I know I do everything I possibly can for her… and I always would".*

Dr R asked them if they were able to hold and support one another. This was a sad moment as Father said that he was not able to 'hold' Mandy emotionally. Mandy explained that due to neglect in his upbringing, that aspect of their relationship is missing. When she reached out to him for comfort he would tease her and turn her need into a joke. I wondered whether they could take a risk and try to comfort and hold one another to feed each other emotionally.

We ended the session by completing the ending measures discussed in the next chapter.

CHAPTER TEN
Discussion and Conclusions

In this final chapter I will revisit the research questions and consider how they were addressed in this study. A discussion of my findings will consider the theories presented in the literature review, the internal and external validity, contribution to the therapeutic community in terms of clinical practice and training of parent-infant psychotherapists, limitations and gaps that require further research.

10.1 Revisiting The Research Questions

I brought to this research questions about how change takes place in a child's symptoms and whether such change is connected with an improvement in the internal representations of her main caregiver.

1. My first question was exploratory in nature, which was an in-depth qualitative study of a single case of parent-infant psychotherapy with a child showing early signs of autism.

My aim in using a single case study approach was to facilitate an in-depth exploration of one case, with the aim of developing analytic generalizability.

The second question was based on the theoretical assumptions discussed in chapter two: that there is a link between the nature of the parents' internal representations and the symptoms of the child. It asked;

2. Is an improvement in the nature of internal parental representations a key factor in therapeutic change?

I will start my discussion of the above questions by presenting my quantitative findings from the measures, which were repeated at the end of the intervention to ascertain the changes in the child's symptoms and in the parent-infant relationship.

10.2 Findings from In-Depth Exploration of Case

As discussed in chapter 4.1, the philosophical stance of critical realism adopted in this study asserts that "facts and values are not insulated from one another: each throws light on the other'. The quantitative measures inform the narrative and the narrative case study makes sense of the measures.

In presenting the changes observed in this case, I will consider whether similar results might be achieved in other cases if the same methodology was applied. As stated in chapter 4.3.1, my aim was not to achieve statistical generalization but analytic generalization based on the theoretical framework and assumptions suggested in chapters two and three. The quantitative findings are indicative only and provided a single snapshot of the family at the start and end of the intervention. No statistical significance has been assigned to them.

Changes Indicated by Application of Measures

10.2.1 Risk Factor Analysis

The risks and stresses on the family remained the same as at the beginning of the work, but what changed was the parents' capacity to manage them. Apart from addressing the parental relationship the parents modified their responses to each child and their expectations of them.

10.2.2 Ages & Stages – Social Emotional

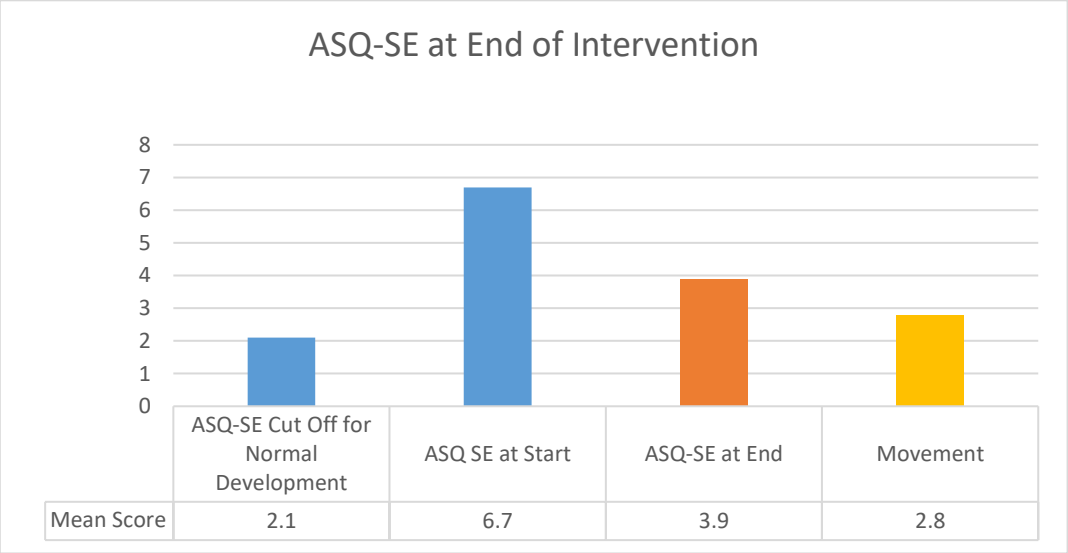

Figure 10.2.2 ASQ-SE at End of Intervention

At the end of the intervention the ASQ-SE showed a considerable reduction in Lucy's anxiety and capacity to regulate her emotions. There was a reduction in self-harming behaviour and tantrums. She was more socialised and showed interest in people apart from her mother and her sisters. She had normal eye contact but her vocabulary was not yet age appropriate. She was able to engage in pretend play and enjoyed singing and reading stories. The

ASQ-SE mean cut-off score for normal development with no concerns is 2.1 and Lucy returned a score of 3.9, which was an improvement of 2.8.

10.2.3 Hospital Anxiety and Depression Scale

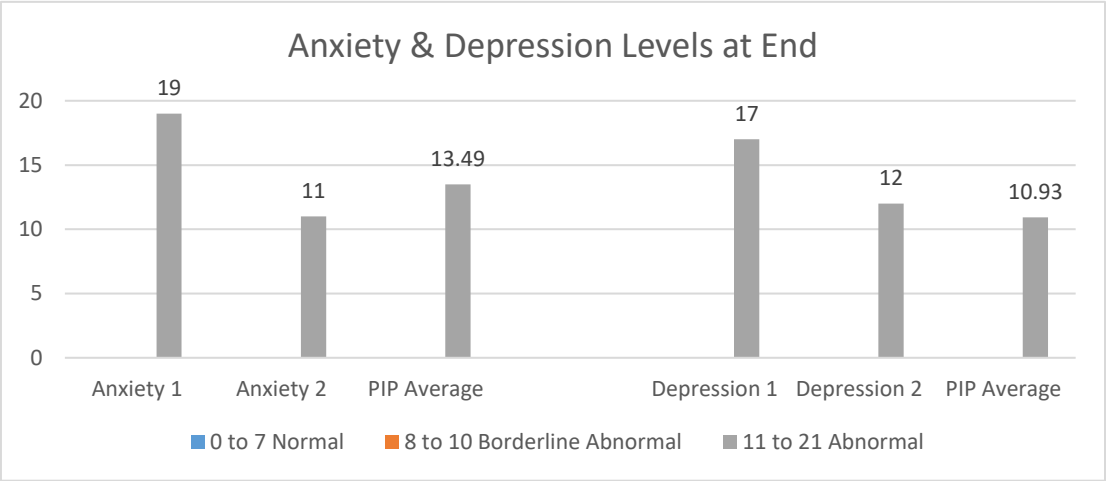

Figure10.2.3 Mandy's Anxiety and Depression score at End of Intervention

At the end of the intervention Mandy's score for anxiety was 11: an improvement of 8 points on the scale. A reduction in anxiety means more space in the parent's mind for the baby. A parent who is more relaxed will find it easier to offer a caregiving relationship that promotes secure attachment. Less general or neurotic anxiety makes it easier to deal with the normal anxiety that goes with parenting an infant. Her score for depression was 12 at the end: an improvement of five points. Depression in a parent is associated with an increased risk of insecure attachment. A decrease in the level of depression means an increase in gaining enjoyment from parenting. Depressed parents have reduced 'reflective function', and find it harder to consider and respond to the internal states of their baby.

10.2.4 Parent-Infant Relationship Global Assessment Scale (PIRGAS)

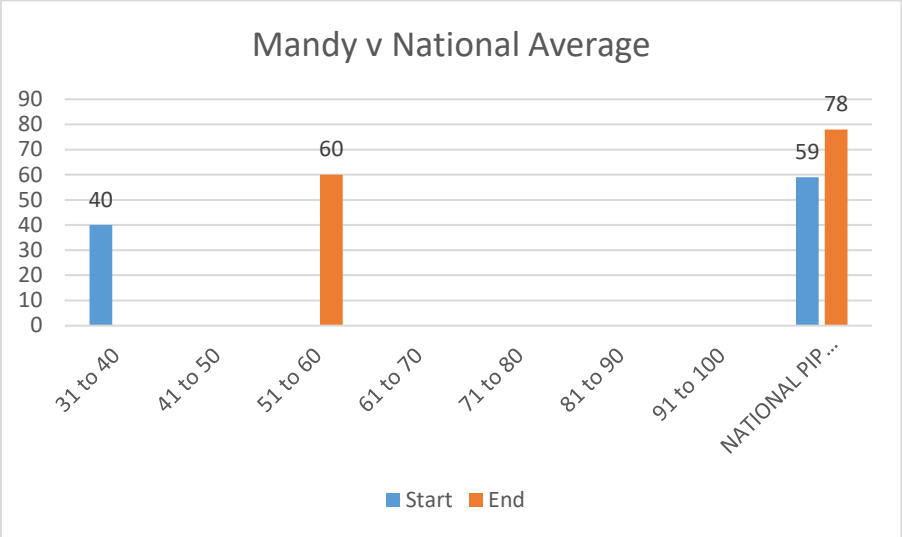

Figure10.2.4 PIRGAS Score at End

PIRGAS CATEGORIES		Start	End	Movement
O to 10	Documented Maltreatment			
11 to 20	Grossly Impaired			
21 to 30	Severely Disordered			
31 to 40	Disordered	40		
41 to 50	Disturbed			
51 to 60	Distressed		60	20
61 to 70	Significantly Perturbed			
71 to 80	Perturbed			
81 to 90	Adapted			
91 to 100	Well adapted			
NATIONAL PIP AVERAGE		59	78	

Mandy's PIRGAS score increased by 20 points, from 40 (disordered) to 60 (distressed). The average increase in PIRGAS is 19 points so Mandy's increase of 20 points is significant. The PIRGAS scale was replaced by the LOAF measures below during my research, which gives a clearer picture of the improvement in the parent-infant relationship.

10.2.5 Levels of Adaptive Functioning (LOAF): Relationship Disorder

At the start of the intervention, Lucy met the the DC:0-5 criteria for a relationship-specific disorder of infancy. This was shown with her father and grandmother and was associated with her symptomatic behavioural problems. At the end of the intervention she no longer reached the criteria for this diagnosis with regard to her father due to the decrease in her symptomatic behaviour towards him, i.e., oppositional behaviour, aggression, fearfulness, self-endangering behaviour and persistent crying. Though these behaviours did not disappear completely, they did not affect her functioning and that of her family to the same extent. She was now able to participate in developmentally-expected activities and routines. A similar reduction in symptoms towards her grandmother was observed at the follow up sessions.

Relationship Disorder?	CBSP 2	PIP AVGE
Was there a relationship disorder at start?	Yes	75%
Was there a relationship disorder at end?	No	25%

Figure 10.2.5 Relationship Specific Disorder of Infancy Diagnosis at Start

10.2.6 LOAF: Caregiving Relationships

At the start of the intervention Lucy's caregiving relationships were assessed at level 4, disordered to dangerous relationships. Her caregivers were not emotionally available to her and did not see her as an individual in her own right. They were not confident in their parenting and could not manage her symptoms.

				PIP AVERAGE	
Level of adaptive function - Caregiving relationships	Scale	Start	End	Start	End
Well adapted to good enough relationships	1				50%
Strained to concerning relationships	2		2	25%	25%
Compromised to disturbed relationships	3			50%	25%
Disordered to dangerous relationships	4	4		25%	

Figure 10.2.6 Levels of Adaptive Function – Caregiving Relationships at End

At the end of the intervention the score was 2: strained to concerning relationships, and this was due mainly to Lucy's contribution to the relationship. There were no serious concerns regarding the quality of caregiving but Lucy still displayed some temperamental behaviour and had not yet caught up developmentally with her peers. The relationship pathology was less severe because Mandy's mental health had stabilized, enabling her to respond to Lucy's need for comfort and engage her in age-appropriate exploration and learning. The negative attributions had ceased and the parent's expectations were more age-appropriate and open to reflective challenge.

10.2.7 LOAF: Caregiving Environment

The assessment of the caregiving relationships surrounding Lucy, showed an improvement from level 4 to level 2. There was an increase in harmoniousness, integration and coordination among Lucy's parents and her grandmother.

				PIP AVERAGE	
Level of adaptive functioning wider caregiving environment	Scale	Start	End	Start	End
Well adapted to good enough caregiving environments	1				50%
Strained to concerning caregiving environments	2		2	50%	25%
Compromised to disturbed caregiving environments	3			25%	25%
Disordered to dangerous caregiving environments	4	4		25%	

Figure 10.2.7 Levels of Adaptive Functioning – Caregiving Environment at End

Mandy's mental health issues no longer impinged dangerously on her capacity for problem solving, conflict resolution and caregiving communications. She had improved in her capacity to regulate the anxieties of Lucy and her siblings.

10.2.8 Keys to Interactive Parenting Scale (KIPS)

At the start of the intervention Mandy's quality of interactive parenting was low (less than 2.9 mean score) in all 12 dimensions of caregiver-infant interaction, indicating parenting concerns. At the end of the intervention all dimensions were of high quality (mean score 4 and above), as identified on the graph below. Scores are based on 10 to 15 minutes of video, and therefore replicable; each category attracts a maximum possible score of 5.

Scale	Description
1 to 2.9	Low quality (indicating parenting concerns)
3 to 3.9	Moderate quality
4 to 5	High quality

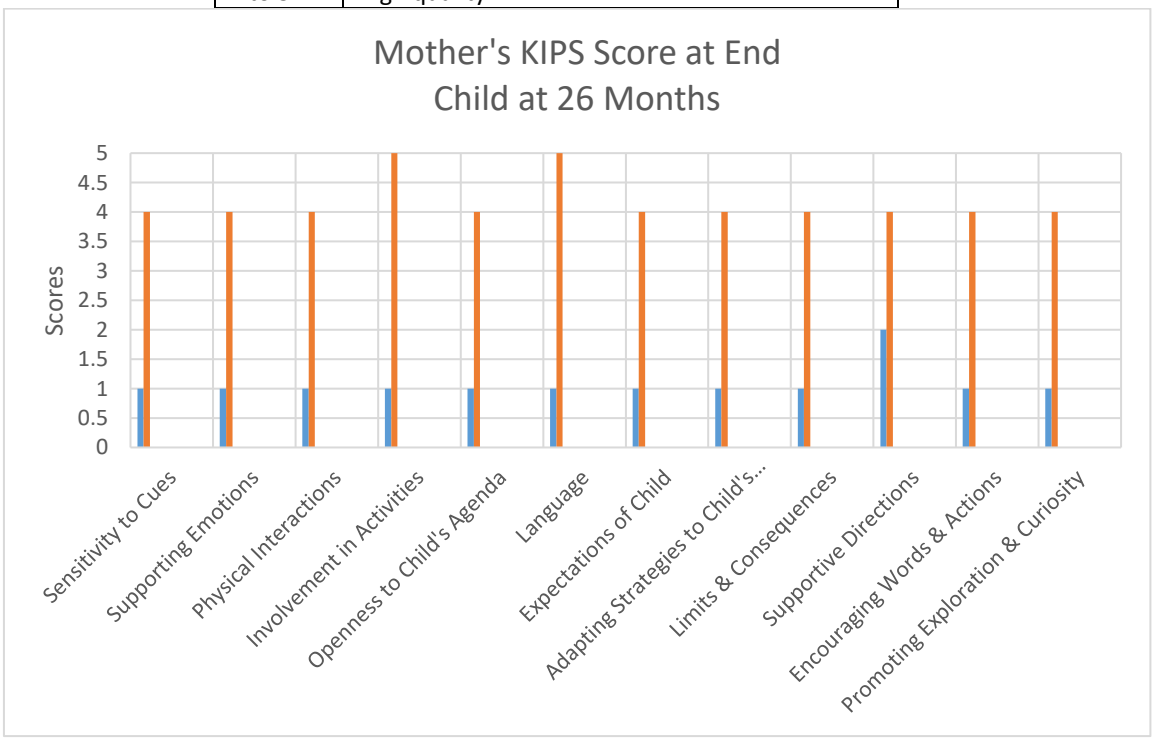

Figure 10.2.8 Keys to Interactive Parenting Scale at End

10.2.9 Parents' Feedback

Parent Evaluations – compared to 138 all-PIP evaluations

At the end of every intervention parents are invited to give feedback about the service they received. Below are the responses of Mandy and Father.

Q1. Did you find the service offered made the situation? Please tick 1 option

CATEGORY	Mandy & Father	PIP AVG
Much Worse		0%
A Little Worse		0%
No Difference		0.72%
A Little Better	✓ Mandy	24.64%
Much Better	✓ Father	72.46%

In line with 24.64% of parents, Mandy felt that the PIP intervention had made the situation with Lucy a little better; she and father had '*learnt little skills'* and '*had better things to discuss' between sessions*, things that they had agreed with and things they had not. Along with 72.46% of parents, Father felt that the situation was much better. He said, *'I started seeing her smiling more. She started seeing us happier'.* He felt that they were all smiling more as a family and '*not struggling as much'.*

Q2. Do you feel that your relationship with your small child has become?

CATEGORY	Mandy & Father	PIP AVG
Much more difficult		0%
Little more difficult		0%
About the same		6.52%
Improved a little	✓ (Mother)	21.01%
Improved a lot	✓ (Father)	70.29%

At first, Mandy said that her relationship with Lucy had '*stayed the same'*, but on reflection she admitted a little improvement, along with 21.01% of parents; she now responded to Lucy in a calmer way. I wondered whether this ambivalence was because of her past tendency to locate the relationship difficulties in father and Lucy. Father felt that his relationship with Lucy had *'improved a lot'*, in line with 70.29% of parents.

Q3. Which of these did you find was helpful?

		Mandy	ALL PIPS
A	Thinking about events from your childhood might be affecting you now		76
B	A chance to discuss your child	✓	106
C	Thinking about the relationship between you both	✓	114
D	Information about child development	✓	76
E	Being helped to see your child's point of view	✓	79
F	A sense that you were understood	✓	119

Mandy felt that thinking about events from her childhood and how they might be affecting her now, was *not* helpful for her because it was so painful, however, she said it was *'nice to be able to talk to someone about what's going on.'* Father felt that it was helpful to think about the relationship between them as parents, to learn about child development and how to see Lucy's point of view. Father said, *'you understood how we felt… how we feel to deal with the situation that's coming ahead of us'* (about sending Lucy to nursery). Mandy added, *'… and knowing that we're gonna have that help… that helps us'*.

Both Mandy and Father felt that Mandy had not yet moved beyond her abusive past and still needed to get closure. Father had been telling her to get help for a long time but she did not trust him. Now she said she sees things differently and trusted Father's opinion.

Both parents said they would recommend the PIP service to others, which reflected the views of 98.55 percent of parents who accessed the service.

What Father found unhelpful was when I showed him a graph of the improvements in his KIPS scores. Even though the aim was to demonstrate a dramatic improvement, he felt judged: that he was a '*bad dad'*. He could not see the good, but interpreted his excellent improvement as a judgment.

Six Month Follow Up

Lucy greeted me with words at the follow-up session six months later. Mandy was still engaging positively with Lucy and her ability to listen to her and to interpret her needs had improved. Her parenting skills had improved all 'round and she was feeling generally more relaxed about the day to day care of Lucy and her siblings. Lucy was enjoying going to nursery and was having sessions of speech and language therapy.

Mandy self-referred to the PIP service due to having given birth to a son at six months' gestation. With the help of the family and support network around her Mandy was managing to attend to the needs of Lucy and her siblings, as well as visiting the hospital on a daily basis with expressed milk for her baby.

Follow-Up - Lucy at Three Years

Lucy's speech had continued to improve so rapidly that she no longer needed speech therapy because Mandy's interaction with her yielded similar results. Mandy was now confident about how to avert Lucy's meltdowns and I was able to witness this in the session.

Mandy and Father were going steady in their relationship. Since the pregnancy and birth of her son Mandy said that she felt *'reborn'*, and full of love for her children. It was so different for her during her childhood.

Mandy's narrative regarding her memories of her mother during her childhood had changed further. She recalled that her step father used to beat her mother so badly that she had two brain surgeries. During the beatings her mother would shout at her and her brother, telling them to go away because she did not want them to see. *'We heard all of that'* said Mandy. She now realised that what she experienced as an unavailable mother was also a protecting mother, who struggled alone to provide for them and did not want them to witness the violence.

I was particularly encouraged to hear that Lucy was no longer screaming when she saw her grandmother, who was now able to visit every week and video call every day.

10.3 Improvement in Internal Representations – Re-writing the Story

My findings pertaining to the second part of the research question suggests that an improvement in the nature of internal parental representations is a key factor in therapeutic change. My hypothesis is that as Mandy gained increasing insight into the meaning of her own story she re-wrote the script many times during the process of the intervention, and presented changing representations of her internal mother. The focus here is on Mandy's internal object relations:

the mother she had constructed in her mind as a result of her memories rather than on her actual mother.

Using narrative psychology guidelines, the parents' narrative was organized into a story with a beginning, middle and ending, noting the quality of Mandy's internal object relations during each period. The theoretical framework outlined in section 2.5 guided this process, i.e. Stern's (1995) 'motherhood constellation', Dugmore's (2013) 'grandmaternal transference' and Fraiberg's (1975) 'ghosts in the nursery', etc.

10.3.1 The Beginning – Lucy age 12 to 16 Months

At the beginning of the story on my first visit to the family I was flooded with feelings of helplessness and anxiety and an urge to rescue Lucy from the harsh and punitive way that she was being parented. I felt the pain of Lucy's constant complaint as her parents missed her cues and sought to instill 'discipline' into her. Mandy echoed her mother's voice in her narrative about her children and in her expectations about Lucy's behaviour. The parents' behaviour was due to a genuine desire to be the best parents they could be, based on how they were parented.

As in Mandy's childhood, roles were reversed. Mandy's 10-year-old daughter seemed to occupy the mother role while Mandy appeared to be an angry little girl, overwhelmed by symptoms of EUPD.

The quality of the transference and countertransference swung from being overly harsh regarding Lucy, to being overly positive regarding Mandy's mother as Mandy denied her mother's failings during her childhood so as not to become overwhelmed by rage.

Despite her defenses of idealization and denial, Mandy's internal world was barren, with no solid internal maternal object to contain her anxieties. Mandy verbalized this 'nameless dread' (Bion, 1962), as having *'lost the glue that holds everything together'.* It seemed to us that Lucy re-enacted her mother's fears in her screams each time she was face to face with her grandmother.

10.3.2 The Middle – Lucy age 17 to 21 Months

In the middle of Mandy's Story, the data reveals subtle shifts within Mandy's narrative when she expressed her desire to be a different mother to her children. My hypothesis is that Mandy had internalized attributes of the therapists, alongside the helpful aspects of her internal mother. She had demonstrated her capacity to make good use of my interpretations by immediately changing her responses when confronted with the idea that Lucy's behaviour had a meaning and her cues must be received and responded to in order for her to develop normally. Immediately within the session Mandy incorporated my words into her narrative about Lucy, and attempted to display the same maternal sensitivity that I showed towards Lucy. I did not witness a repeat of the extreme negative attributions that was previously voiced about Lucy.

Between sessions Mandy started to implement the play activities she observed and within the sessions Lucy changed from a sullen, cut-off child to one who was excited to engage in play and for the first time displayed her affection and connection to us. Mandy felt overwhelmed by the sudden changes in Lucy and expressed honestly that she could not sustain being available to Lucy in the same manner that we were available to her in the sessions. She did not feel

that she had the inner resources to give herself so fully to Lucy. Mandy's awareness of her weak internal resources coincided with a dramatic change in Lucy's behaviour towards her grandmother. This behaviour started when they left her with her grandmother one weekend and she became unwell and impossible to soothe; as a result, grandmother brought her home. Father suggested that Lucy screamed when with her grandmother because she saw that grandmother could not keep her safe when she was at her most vulnerable and therefore could no longer trust her. He reminded Mandy that it was the same with her when she was a child; her mother had let her down and could not keep her safe.

Mandy's individual sessions with A, enabled her to experience genuine feelings of anger and sadness as she came face to face with her internal mother. She had shown us the extent of her internal deprivation in chapter seven when she talked about her relationship with June: an imaginary mother with whom she played from the age of three to the age of twelve, because her real mother was unavailable. However, in her relationship with me, Dr R and A, she experienced new mother figures and observed in our interactions with Lucy what a good enough mother-child relationship looked like. We showed her a different mother and she embraced the possibility of being that mother to her children.

10.3.3 The End – Lucy age 22 to 26 Months

Before this time, Mandy had idealized her mother in a defensive idealization, but Father's linking of Lucy, Mandy and grandmother in this way caused a shift in her perception as she acknowledged her mother's physical and

psychological weakness. This shift is in accordance with Main's (1988) theory that parents are less likely to repeat the mistakes of the previous generation if they can acknowledge those mistakes in their own parents. Mandy's acknowledgement of her mother's mistakes enabled her to see her without idealization and also to withdraw inappropriate projections from Lucy, based on how she was parented.

The internal maternal representations began to change in Lucy's siblings also as they witnessed the emergence of the characteristics of an available mother. The older girls had observed Mandy comforting Lucy in a new way and holding her safely during her tantrums and as a result they now came to her for comfort. She had read a book with Lucy for the first time and had also taken her to two sessions of Nursery Rhyme Time. Hide and seek had become Lucy's favourite game and she was enjoying being found. Her internal world was being populated by lively objects, including a father who had encountered and 'found' her within the play sessions with Dr R and in the systemic family sessions.

Towards the end of the intervention, as Mandy began to see beyond the idealization she could see that her mother had also been abused and identified with her mother's weakness and fragility. Their shared experience as victims during Mandy's childhood seemed to have allowed Mandy to identify with the good and bad aspects of her mother: to understand and forgive, and seek reconciliation and reparation. According to Dugmore (2013) and Fraiberg (1975); 'the new mother needs to identify with her own mother and remain in touch with herself-as-child in order to be an understanding and loving mother

to her infant'. In identifying with her own mother as a co-victim Mandy was able to connect with Lucy's distress about her emotional unavailability.

Neither of them had the physical or emotional capacity to hold and contain Lucy during her meltdowns, and furthermore, her mother did not have the capacity to hold and contain her during her childhood. By acknowledging this weakness in herself and her mother they both started to devise age appropriate strategies through which to rebuild the relationship with Lucy. Mandy stopped relying on the strategies that she inherited from her mother to control Lucy, such as punishment and ignoring her in the midst of her rage. Instead, she found new ways of helping Lucy to manage her feelings. Where she had been setting Lucy the 'boundaries of a five-year-old' and punishing her when she could not achieve them, she started to see her as a two-year-old and to use 'holding' and comfort in the midst of her rage so that she could feel safe and accompanied. Mandy's mother started to cautiously build an age-appropriate bond with Lucy by video calling every day and identifying with the therapeutic work by buying the same toys used in the sessions for Lucy to play with when visiting her.

By the end of the intervention Mandy was able to see that her mother was strong as well as weak; harsh and cold, yet willing to patiently reach out to Lucy in a way that she could tolerate. The sustained, appropriate responses to Lucy contributed to a decrease in her feelings of frustration, her self-harming behaviours and meltdowns and an improvement in family relationships.

It is likely that should Lucy's behaviours have gone unchecked in her first two years, they would possibly have become entrenched and later earned the label of 'autism'. Due to her having an autistic sister and uncle, her parents expected

Lucy to also be autistic. Had we not challenged this mindset it is likely that Lucy's behaviour would have continued to meet their expectations.

10.3.4 Follow Up – Lucy age 26 to 36 Months

I visited the family at six and twelve months after the intervention. Due to the premature birth of their longed-for son at six months' gestation, the PIP team was again involved. The joyful arrival of their son was shrouded by a new threat that the children could be removed from Mandy's care due to her mental health history. Mandy confidently presented evidence at the child protection conference, proving that she was able to meet the needs of her vulnerable baby and his three sisters. She publicly expressed gratitude for the help of the PIP team in making her a better mother. I was struck by the strength and coherence of her narrative, her confidence in challenging the authorities and her fierce protectiveness of her children. The case was stepped down to Child in Need, and a few months later the local authority withdrew completely, leaving her and Father to enjoy their children. They continued to call on the support of the PIP team when needed. It is nearly four years since the closure of the case and the family have continued to go from strength to strength. This suggests that the positive effects of the intervention have continued to increase over time.

10.4 Findings Based on Previous Research and Theory

As is often the case in parent-infant psychotherapy, it is the child's symptoms that raise the alarm that something is wrong, and brings the family to therapy. The symptoms are manifested within the family constellation, stirring up the

ghosts from the past. In addressing the child's symptoms, the family constellation must also be adjusted to accommodate change. We see above the gradual adjustment in Mandy's internal representations, and how she developed a new narrative about her mother and other family members.

Apart from the adjustment in internal representations my findings are in line with previous research, which identify eight common elements said to be necessary for change in in early symptoms of autism (Acquarone, 2007; Phillips and Schuler, 2005; Edelson & Rimland, 2003).

The first two elements state that there should be a clear theory of how the child's mind is functioning and once the child's symptoms are resolved, the theory should continue to guide the family. Throughout the intervention, the parents understood increasingly that Lucy was a separate person with her own thoughts, desires and feelings, and was able to communicate such to those around her. They learned to read her cues and to meet her needs and she was able to demonstrate and communicate through the development of her pretend play, through books, and through games of hide and seek, etc. that she was aware of the minds of others. As we observed her growing capacities we were able to reassure her parents that, though her behaviour resembled autism, there were also hopeful signs that her development could be brought back on track if we intervened early.

Thirdly, Lucy's father displayed a strong sense of autonomy, efficacy, mission and sacrifice (Acquarone, 2007; Phillips and Schuler, 2005; Edelson & Rimland, 2003) in that he sought me out and requested to be included in the work; taking time off work to attend sessions. Eventually, as he gained

confidence, he embraced his role as Father and made decisions such as purchasing a small table and chairs and learning material for Lucy's second birthday. This marked a turning point in her development. Mandy had sporadic outbursts of these qualities, but owing to her mental health difficulties, was not able to do so consistently.

The fourth requirement for continuous engagement with Lucy and her network, was barely met due to many cancellations of sessions, but we compensated for this by lengthening the time of engagement, to ensure that Lucy was out of danger. Also, though inconsistent with the sessions, Mandy engaged exceptionally well when she attended. Lucy's siblings were also involved because we worked mostly in the family home or the children's center attached to the local school where Imogen attended. We trusted that she would continue to engage positively when she started nursery soon after we ended.

Fifthly, Lucy's father displayed a drive to 'normalize' her by singing to her and taking her out walking to explore her surroundings. We also encouraged Mandy to get involved in community groups with Lucy, which she attempted to do, but inconsistently.

We also recognized that there were many positive elements in Lucy's characteristics on which to build, such as Lucy's sense of humour, her strength of character and her determination to strive to achieve her milestones.

The seventh requirement: the understanding about the significance of early intervention in the first 1001 critical days of life, while Lucy's brain was plastic and malleable, was particularly crucial for change, and acted as a safeguard

against the sabotage of the work, giving Mandy and Father a sense of urgency about engaging before Lucy turned two.

The eighth element requires that the child should show some signs of normal intelligence prior to treatment. Despite her symptoms Lucy was an intelligent child with a capacity to respond to our interventions.

Apart from the above, some findings are in line with other theories of change presented in the literature review in chapter three. In chapter 3.1 we see how factors in both the parent and child can contribute to a derailment in the child's development. Mandy brought her history of abuse and ensuing issues of mental health and Lucy brought a sensitive temperament and a risk of autism due to her sister's and uncle's diagnoses. Chapter 3.6 explained the importance of working in a timely way with both parent and child. Lucy could not wait for Mandy to heal due to the small window of opportunity before her patterns of behaviour could become entrenched. Mandy's issues were complex and would require prolonged intervention to shift. I was aware of this tension throughout the intervention and scheduled sessions of individual psychotherapy to give Mandy her own space to process her childhood trauma. She managed to attend five out of six sessions, which raised her awareness of a need for prolonged therapy. In our team we consider this to be a positive outcome of parent-infant psychotherapy and often refer the parents on for individual therapy when issues with the parent-infant relationship have been resolved.

Russo's (2014) perspective on transforming tough, sticky symptoms through play is also seen in the work with the family. Mandy and Lucy's symptoms were

similar to those of Russo's dyad, Jane and Helen. As in Russo's case, tough, sticky symptoms became fluid as the dyad learned how to 'play out' their difficulties. At the start, Mandy viewed play as a 'weird thing' but as she grew in her capacity to play her enjoyment of Lucy also increased.

Lucy's story illustrates how the 'ghosts' from Mandy's childhood prevented her from seeing Lucy in an age-appropriate way (Fraiberg, 1975). An important hypothesis of this research is that parental internal representations play a significant part in the way they see their child, i.e. through the eyes of their internal parents. If the child is freed from unhelpful projections from the parents' past, he or she can be seen in his or her own right, in order to develop as a unique individual. Lebovici's (1988) gives insight into Mandy's view of Lucy as the fantasmatic child, seen through her mother's rage, and the imaginary child: a two-year old on whom was placed the expectations of a five-year-old. According to Heimann (1942), we see how the parents' projections were withdrawn from Lucy and emerged in the parental relationship and projected onto therapist. The parents were then able to discuss these issues in between sessions and within the sessions the therapists were able to make links to childhood experiences, thus disconnecting the past from the present (Hopkins, 1992; Britton, 1989) and withdrawing unhelpful projections from the child.

10.5 Idiosyncratic Factors Contributing to Change

It is important to acknowledge the contribution of other idiosyncratic factors to the change in family dynamics, such as Father's involvement and my insistence

not to give up, and to consider the extent to which such factors might or might not be replicable in other cases.

10.5.1 Father's Availability

My clinical supervisor suggested that the playful presence of Father in chapter six, was a catalyst that enabled Lucy to create a space in her own mind for thinking about herself and her family, as a third person became significant in the triangle. The triangulation through Father's play with Lucy also allowed him to become a live internal object, recognized and related to in her inner and outer worlds. The change seen in the play session with father, created the momentum for ensuing sessions as it affected both parents as part of a tight, triangulated relationship. In the next play session, Father actively acknowledged that he could find (get) Lucy and she was less defended and eager to be found by him. Being found was something Mandy also longed for, but deeply feared at the same time (Balbernie, 2018 in supervision). On page 131 Mandy explained what it felt like to have been found by Father; 'cos now I see that he can see… me… He sees me now and… I can believe him'. Her belief in Father enabled her to 'take in' his help and to collaborate with him regarding Lucy's care.

The inclusion of the father in parent-infant psychotherapy and other family interventions is now seen as best practice. While this family is unique and the presence of this particular father cannot be replicated in other situations, it is generally accepted that better outcomes are usually achieved if the father's role is taken into consideration. As seen in this case, including the father can be a very slow process as the mother can be possessive of the space, however

Father's presence was a major factor that allowed change in Mandy and lucy. He was key in verbalizing feelings and thinking on behalf of Mandy and Lucy, who were not always able to do it alone.

10.5.2 Not Giving Up

It is likely that had I not withstood the prolonged period of testing by Mandy, the intervention would not have been possible. A strong alliance of trust developed between us as a result of my determination not to give up on her, despite her initial rejection of me. A, was tested in a similar way when she attempted to engage Mandy in individual therapy. After several attempts, Mandy emailed her to say *'thank you for not giving up on me'*. A, suggested that there was a transfer of the internal mother that Mandy had constructed with me, which supported her capacity to imagine that A was there waiting patiently for her, as opposed to a blank, absent mother. My clinical supervisor suggested that the *'not giving up-ness'* gave me a quality in her mind, which could be transferred to others.

It could be concluded that this aspect of the research is not replicable, however, I argue that this quality should be present to an extent in the normal practice of psychotherapy, and is the foundation for a strong therapeutic alliance built on trust. Both parents found it hard to trust because they had been let down through life and therefore expected the same from us. Therefore, to protect this fragile trust sensitivity was required when taking breaks, introducing new therapists or changing the therapeutic frame in any way, as these could be experienced as abandonment.

10.6 Internal and External Validity

Research is considered to be ‘good’ if it has internal validity: it provides rich evidence and offers credible and justifiable accounts (Richie & Lewis, 2003), and external validity: findings can be transferred to other populations or situations. Good quantitative research is replicable; if different researchers utilize the same data in the same way they reach the same conclusions. Good qualitative research is less concerned with generalizability and more concerned with a deeper understanding of the problem in its unique context. The emphasis is on truthfully reporting the participant’s perspective, thus making the narrator the writer of his or her own story. Bearing in mind the highly contextualized nature of qualitative data, to what extent can we say that this research has internal validity?

First of all, Mandy’s narrative was preserved throughout the thesis and I brought to it a set of assumptions, beliefs and theories to help make sense of the story. The theoretical framework: ‘the motherhood constellation’, ‘the grandmaternal transference’ and ‘ghosts in the nursery’, rippled throughout the narrative, hopefully making it a more credible and justifiable account (Hollway & Jefferson, 2000). While I cannot claim statistical generalizability, which draws on large numbers, I suggest that my findings possess analytic generalizability as they are based on carefully posed theoretical statements, theories or theoretical propositions (Yin, 2014).

In 10.8.1. below, I demonstrate how the learning from this study has been transferred to other similar cases with similar positive outcomes.

10.7 Dissemination of Findings and Suggestions for Future Research

Since starting this research I have been working alongside key national organizations to raise the profile of parent-infant psychotherapy, and will disseminate my findings through these channels.

As Chair of the Infant-Parent Psychotherapy (IPP) sub-committee, which is part of the United Kingdom Council for Psychotherapy (UKCP) College of Child and Adolescent Psychotherapies (CCAP) and the UKCP Faculty for the Psychological Health of Children (FCHP), I contribute to creating Standards of Education and Training for infant- parent practitioners. In achieving our goals, the sub-committee takes into consideration the work of other national initiatives such as the Association for Infant Mental Health Competencies Framework, Parent-Infant Partnership UK (PIPUK), the 1001 Critical Days All Party Manifesto and relevant research. The aim of the sub-committee is to provide a training pathway for infant-parent practitioners.

During the research I was awarded a Travel Fellowship by the Winston Churchill Memorial Trust, to travel to Prague, Sweden, Norway and the USA to observe best practice in parent-infant psychotherapy (Osafo, 2018). My goals were to learn about the historical development of PIP within the context of the nation, the different methods of delivery of PIP and the tools and measures used, the training and ongoing professional development of the PIP workforce and how PIP teams are cared for and supported to manage the trauma of the work. To achieve my goals, I met with pioneers, policy makers, clinicians,

academics and service users of projects that are working with the parent-infant relationship (0-2 years). I established meaningful links across the continents and shared good practice with my hosts during and after my travels. As a Churchill Fellow I continue to have the support of the trust to disseminate my research findings.

My findings will also be shared at conferences, in the training institutions where I teach infant observation and parent-infant psychotherapy and at my places of work where I take a lead on early intervention from pregnancy to two years.

This research will be instrumental in my vision to raise a parent-infant psychotherapy workforce. However, despite the above claims, it only provides an initial exploration of this aspect of the practice of parent-infant psychotherapy. Further research is needed to test these claims.

I recommend a long term study of at least ten similar cases to shed light on the pattern of outcomes for families over time. Though each family will be unique it will be possible to explore whether the application of the theoretical framework, measures and methodology will yield similar results.

Another question requiring further research concerns the time and resources needed in order to build trust with such families, who take time to engage. Is the investment of staff time in engaging such families cost effective in the long-term? A future study comparing the cost of working with families in this way with keeping a child in care would yield useful information.

10.8 Clinical Implications

In this section I will consider how the findings of this research could be beneficial for other practitioners and services. The story of Lucy and her family is like that of Greg and Jane, in Selma Freiburg's (1975) seminal paper, 'Ghosts in the Nursery': which showed that change is possible despite the mother's history of trauma which is often re-enacted in the parent-infant relationship to the detriment of the baby. Many such 'complex' cases have social care or adult mental health involvement or come via the perinatal team; they are amongst the most challenging to access therapeutic services. These families usually generate such high levels of anxiety within the social care system due to their traumatic histories, that signs of hope for change are not easily seen. The wheels of the system turn, and the anxiety that this evokes in the family can sometimes create the circumstances whereby the child is removed from their care. Often, the success or failure of the therapeutic intervention determines whether or not child protection services are enlisted to save the baby. This possibility also loomed over Lucy's family. I have suggested that there is hope that families like Mandy's, who have become trapped by their histories, can change and break the intergenerational cycle of trauma by internalizing more helpful ways of parenting their children. However, in holding the hope for such families, we cannot lose sight of the risks.

10.8.1 Evidence for Practice

I suggest that this study offers a methodology that allows the practitioner to safely hold the hope for the family while minding the risks.

Since starting this study, I have drawn on my learning to treat a number of parent-infant dyads at risk of separation due to historical mental health difficulties. In the case of one mother, two previous children had been removed from her care. Her third child was allowed by the court to remain with her. The judge attributed this decision to the evidence of progressive improvement in her parenting due to her engagement in parent-infant psychotherapy. A second mother had had five children removed for the same reason; two were adopted and three were fostered. The court permitted her sixth child to remain in her care due to the visible change arising from her eager engagement in the therapy. Due to her continued progress plans are under way to gradually return the three children in foster care to her. The adopted children will not return to her. Both the above parents have remained stable in their mental health. Similar results are increasing across my clinical practice.

Based on the findings of this study and my ensuing practice I offer the following suggestions to practitioners when working with similar complex cases.

- *Be prepared to spend a longer than usual time to engage the family*. Like Mandy and Father, many parents find it hard to trust because they have been let down through life and therefore expect the same from the clinician. Do not take repeated rejection personally; it is the client's defense against expected abandonment.
- *Care should be taken when making links and interpretations, especially at the beginning of the work, in order not to trigger traumatic intrusive memories*. Therefore, adopt a psychoanalytic stance: be aware of transference and countertransference; make use of close observations;

use motherese to gently speak on behalf of the baby, thereby also communicating with mother, allowing her to see the baby as subject.

- *Allow the client to regulate the pace of the outflow of the traumatic material*. This facilitates the discovery of 'angels' (good experiences) as well as 'ghosts' (bad experiences) so as not to re-traumatize client.
- *An awareness of transference and countertransference feelings does not necessarily mean that an interpretation should be made*. The clinician should hold painful insights on behalf of the parent/s until they are strong enough to receive them.
- *Make use of psychoeducation at every opportunity to educate parents about child development*. The skillful impartation of knowledge can feel empowering and less threatening than interpretations; parents are more open to receive new knowledge in a safe therapeutic context.
- *When working with early symptoms of autism assess whether the eight common elements described in chapter two and 10.4 are present.* This helps the clinician to be more perceptive and incisive when assessing a caregiver's capacity to support change, and the child's capacity to benefit from the intervention.
- *When working with child protection cases, give the professional network around the family every possible opportunity to see signs of hope and risks, so that the parent-infant dyad can be kept together for as long as it is safe to do so*. This can be done by meeting with the family and referrers before embarking on the intervention, to observe the parent/s willingness and capacity to engage and whether it is safe to support the wish that baby remains in their care.

- *If father is present in the relationship try to involve him in the intervention at the earliest opportunity*. The involvement of the father figure can be a major contribution of the parent-infant psychotherapy. In other approaches one may never see the father as it is often the mother who takes the child to a clinic, however, the PIP team has the privilege to observe and interact with all members of the family.

10.8.2 Evidence for the Training of Practitioners

If the tentative conclusions of my study are confirmed by further similar research involving a larger cohort, then there could be a case for using these findings in the routine treatment of children showing early signs of autism. However, there is a shortage of experienced clinicians that are equipped to undertake the necessary interventions and research with complex symptoms such as Lucy's. It would therefore be necessary to implement a strategy for training new parent-infant psychotherapists to ensure that there is a strong workforce to implement these findings. I offer the following suggestions regarding training of practitioners;

- *Unlike individual psychotherapy, working with the parent-infant dyad can involve more than one therapist*. It is therefore possible to involve trainees or other professionals in the intervention without losing the therapeutic alliance, but they must be introduced sensitively. In the absence of one therapist the treatment can still continue.
- *Training of clinicians*. Sessions are usually video recorded; the flexibility of the therapeutic frame accommodates the presence of a trainee in the

session to manage the camera. This gives the trainee first-hand insight into this specialist way of working.

- *Working in the family home*. It is normal practice in our PIP team to work in the family home. This can be beneficial as it reduces non-attendance and the home can feel safer for the vulnerable family. It also presents challenges as the clinician has no control over the setting or intrusions from friends and family members. Working in the home calls for flexibility in the clinician's approach: s/he can work individually with one parent if the other is absent; she can work systemically when extended family members are present; she can work with the couple relationship when required. The essence of this way of working is 'better caught than taught'.

10.9 Limitations

The findings of my study are limited to gaining an in-depth understanding of a single, complex case. Ideally, it would have been useful to have compared at least ten families of different backgrounds in order to capture the diversity of characteristics among children and their parents, including their educational and economic status. This was my original intention, however, I felt that it was important to gain depth on this occasion and strive for diversity in a future study.

Though my study appears to support the argument that an improvement in internal representations is a key factor for therapeutic change it does not imply that measuring change in this manner is the best or only means of gauging shifts in symptoms. Internal representations can be difficult to conceptualize

and even more challenging to operationalize, so to get a clear picture of change the use of a wide range of measures were necessary.

My study addresses the vague area of early signs of autism and this also felt limiting as there is no diagnosis at such an early age. At the same time if this window of opportunity for early intervention is missed, the behaviours that resemble autism are likely to become entrenched and attract a diagnosis at a later date. I decided therefore, not to focus too much on autism per se, but on the 'behaviours' or 'symptoms'.

I also felt limited by the structure of the paper. I attempted to merge all categories: namely Symptoms, relationships and representations in order to give a continuous narrative and demonstrate how each category affected the others. However, I felt that I could not give the individual attention needed to develop each area of study. By separating the categories into three chapters, it felt at times that three different stories were being told and that I was moving back and forth in time. Hopefully, this is not too confusing for the reader.

The dual focus of the research question was a challenge and I struggled to divide my attention equally between the change in symptoms and the change in maternal parental representations. Even more challenging was formulating the research question and methodology in a way that enabled me to access and evidence unconscious material from which to infer the parental internal representations. The combined use of the narrative psychology approach alongside relevant theories such as 'the grandmaternal transference' helped me to focus on the question.

The use of such a wide array of measures felt quite intrusive at times, requiring extra time to administer, record and score. However, with careful preparation it was possible to introduce them in a way that hopefully felt therapeutic for the family. For example, Mandy welcomed the use of the ASQ-SE when she was anxious about Lucy's symptoms. She was able to overcome her fear of being filmed in order to ensure that Lucy's symptoms were fully captured. Nevertheless, I feel that the use of measures should be selective and limited to those that are strictly necessary for the particular case.

10.10 Autobiographical Reflection

Undertaking this research study has been an invaluable learning experience, which has provided some key ideas that I have added to my practice. I have gained some understanding of the process of internal change and how it is connected with change in external symptoms and behaviours.

I am aware that my own particular interest in maternal representations and internal change has been a driving factor in this study, and I have come to understand the importance of being consciously aware of this bias. I recognize that;

> A therapist is never an objective observer … First she has her own countertransference. The child's appearance, personality, family, and difficulties all have personal meaning to the therapist in terms of her own history and internal representational models…The therapist can never completely escape her own perceptual schemas and biases.
>
> (Altman, N. Briggs, R. Frankel, J. Gensler, D. Pantone, P:131)

I alluded to this in chapter one, where I explained how transference, countertransference and interpretations are used reflexively when working with the very vulnerable parent-infant relationship. I try to always be aware that in the sensitive parent-infant space, direct interpretation can feel very persecutory to a client who is already struggling with a critical internal parent. I therefore endeavor to move very gently: sometimes speaking through the baby rather than directly to the parent. This reflective technique is utilized throughout the intervention, as demonstrated in this thesis.

I endeavored to adopt a reflexive psychoanalytic stance throughout the research process, not only in the collection and analysis of data but also in the selection of tools and measures. The main goal here was to be as unobtrusive as possible so as not to interfere with the flow and integrity of therapy. The use of video provided multiple levels of reflection in the transcribing, revisiting, coding and the selection of vignettes: allowing me to achieve 'nearness and distance' by "mentally stepping back to survey the whole in a mind's eye" (Froggett & Briggs, 2012). In writing the case study I analyzed as I went along in order to reflect my thoughts and feelings at every stage in response to the client's material.

10.11 Conclusion

My aim in this study was to take a closer look at a single case of parent-infant psychotherapy with a child showing early signs of autism and to immerse myself in the twists and turns of the therapeutic work. What I found was in line with my original hypothesis and the pattern that I have observed in past cases;

that improvement in internal representations is a key factor for therapeutic change.

In this particular case, there was a gradual shift in Mandy's perception of and responses to Lucy as she was supported to bear the truth about her own painful childhood. As she re-examined and relinquished harmful parenting responses that she had internalized from her mother she discovered and acknowledged with Father's help, that her mother had not been available to look after her.

This research suggests that the progress in Lucy's healthy development correlated with Mandy's capacity to reconstruct a new internal mother that was robust enough to be a container for Lucy's anxieties. A reconnection with the unavailable mother of childhood would not suffice; she had no substance, no *'glue'* and therefore no capacity to hold and contain.

I suggested that in the process of reconstruction, Mandy's perception of her internal mother gradually changed. Having also internalized the containing presence of the therapeutic team, she had gained ego strength to face and understand her mother's failings during her childhood in order to forgive her and repair the relationship. The change in her perception of her mother seemed to correlate with a change in Mandy's conscious response to Lucy as she severed the connections with the *'harsh'* mothering she had experienced and sought to be different from her mother.

The findings are consistent with previous research regarding the common elements that are necessary for change in symptoms. Further elements that are suggested in this research are the importance of father, the quality of not giving up in order to develop trust in the relationship and the capacity to engage

on an emotional level with one's internal parents. Suggestions are offered regarding clinical practice, the training of practitioners and for further research.

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Appendix 1

Participant Information Sheet

Title of Study: Parent Infant Psychotherapy: A qualitative study of what leads to change in personal relationships in a family with a child displaying early signs of autism.

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Supervised by:
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- **You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take the time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that may not be clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.**

- **The purpose of this study is to understand how and why this family treatment works to cause change in the relationship with you and your child. The study will last about two more years and you have been invited to participate because of the age of your child and the type of emotional and behavioral difficulty presented.**

- **It is up to you to decide whether or not to take part. If you decide to take part you will be given this information sheet to keep, and be asked to sign a consent form, a copy of which you will keep for yourself. If you decide to take part, you are still free to withdraw at any time and without giving a reason.**

- **A decision to withdraw at any time, or a decision not to take part, will not affect the standard of care you receive.**

- **You will be involved in this research for as long as it takes to analyze and write up the results of the treatment you received. You and your child will be seen as usual in the follow up period, for about one-hour-long sessions at monthly or longer intervals, depending on need.**

- **Previously recorded videotaped sessions of your treatment and written information about your treatment have been stored safely in the clinic**

and will be used for the purpose of this research after your family treatment has been completed, and only if you give your written consent. Only some trusted colleagues, who are involved with the theoretical aspect of this study, will look at the videos to see how the relationships in your family have changed as a result of the family treatment. Your videotaped material will be treated with great respect and confidentiality. As was agreed at the start of your treatment, you are entitled to a copy of taped material; and unless you have given permission for taped material to be used for teaching purposes all tapes will be destroyed at the end of this study.

- **This study does not require you to take any medication or any special visit to your G.P.**

- **There are no disadvantages in taking part in this research and we hope that you have been helped by this family treatment, as it is often the case in our experience, but of course, we cannot guarantee it.**

- **If you have a problem with the study, you should ask to speak to the researcher who will do their best to answer your questions (to contact Yvonne Osafo call 07764 236676). If you continue to have concerns please contact my supervisor, Mrs Susan Kegerreis, Senior Lecturer, University of Essex, Colchester CO4 3SQ (skeger@essex.ac.uk). If you are still unhappy and wish to complain further, you can do this by contacting the Research Governance and Planning Manager, Research Office, University of Essex, Wivenhoe Park, Colchester CO4 3SQ, by emailing: sarahm@essex.ac.uk.**

- **All information that is gathered about you during the course of this study will be kept strictly confidential and will remain within the professional team of Croydon Best Start Parent-Infant Partnership. We have a duty to safeguard all families and will refer to other agencies any child or adult whom we judge to be at risk of significant harm or self-harm. We will keep you informed of any concerns we have and of any referral we make. The only occasion you would not be involved is on the rare occasion that this placed a child or adult at greater risk.**

- **We intend to publish the results of this research, once it is completed, to communicate our findings to colleagues, so that better and more services for families in similar circumstances can be planned. The results will not identify your family and strict confidentiality is assured. You will be welcome to a copy of the results.**

- **In the unlikely event that you should lose the capacity to give informed consent during the study after having signed the consent form prior to the onset of incapacity, data already collected will be kept and used confidentially in connection with the purposes for which consent was**

sought. Such use would include further research after the current project has ended.

- **This study is part of academic development.**

- **This study has been reviewed by the East of England – Essex Research Ethics Committee to make sure that the rights, safety, dignity and well-being of everyone that takes part in this study are protected.**

- **Should you like further information on this study, before giving consent, please contact me on tel. n. 07764 236676 or email yvonne.osafo@btinternet.com.**

Appendix 2 **Consent Form**

Title of Study: Parent-infant psychotherapy with a child showing early signs of autism: Is improvement in the nature of internal parental representations a key factor in therapeutic change. An in-depth qualitative study of a single case.

Name of Researcher: Yvonne Osafo

Please initial box

1. I confirm that I have read and understand the information sheet dated…… for the above study and have had the opportunity to ask questions, and had these answered satisfactorily…… ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected…… ☐

3. I give permission for previously recorded video material and information about my treatment to be used in this research. ☐

4. I understand that sections of any of my records may be looked at by individuals from the University of Essex, Croydon Best Start Parent Infant Partnership or from regulatory authorities where it is relevant to my taking part in research. I give permission for these individuals to have access to my records…… ☐

5. I give permission for quotes from my feedback form to be used in publications of the study. ☐

6. I agree to a copy of this consent form being kept in my notes. ☐

7. I agree to take part in the above study……. ☐

_____ _____ _____

Name of client Date Signature

_____ _____ _____

Name of person taking consent Date Signature

1 for client; 1 for researcher; 1 to be kept with client notes