A qualitative exploration of

who the infant is in the mothers' mind.

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Abstract

Objective: This study is the first qualitative research analysing mothers' thoughts and feelings of themselves, their infant and their developing parent-infant relationship prior to receiving a brief psychoanalytically informed under-fives treatment. It explores maternal representations from mothers' narratives asking the question: Who is the infant in the mothers' mind?

Method: Semi-structured interviews were carried out with six mothers whose infant had been referred to an under-fives service. Interviews were transcribed verbatim and the transcripts were analysed using thematic analysis.

Results: The qualitative analysis of these narrative accounts generated eleven super-ordinate themes. These clustered into four areas: mother's descriptions of their infant, descriptions of problems in themselves as a mother, problems in their infant and problems in the developing parent-infant relationship.

Conclusions: There were coherent, rich, balanced representations involving mental representations of emotions and intentions in all six mothers. They all conveyed viewing their infant as a unique, growing person with a separate mind and at times separate feelings. They each showed a marked capacity for maternal reflectiveness incorporating mentalization. There were high levels of worry in all six narratives.

Key words

Infant mental health, parental mental health, under-fives, parent-infant psychotherapy, representation, parental narrative, reflective function and attachment.

Introduction

"Nothing is as beautiful as being understood by another person"

(Hermine letter to Ludwig Wittgenstein, 15 December 1920, quoted in McGuiness, 2019, p. 87).

The past whether we like it or not enters into our present reality. This is a principle deeply rooted in psychoanalysis where unconscious repetitions, remembrances and reminiscences are part of our everyday lives and no more so than within parent-infant relationships (Slade and Cohen, 1996). This Research Dissertation Project explores parental representations and how 'the there and then' presents itself in 'the here and now.'

Overview - Part I and Part II

It was through my clinical work with parents and their infants that the ideas behind this research project developed. From understanding that good parental reflective function leads to favourable outcomes for children, namely secure attachments, the original project was born. Before and after treatment measures were a repeating theme both in research being conducted and in evidencing efficacy within current clinical practice. The original proposal was an ambitious mixed methods project. It aimed to explore changes in parental reflective function from before to after having received, with their infant, a brief psychoanalytically informed under-fives treatment. Parent's pre- and post-treatment narratives would be qualitatively analysed and whether these parents showed changes in reflective functioning would be quantitatively measured using a reflective function questionnaire.

A six month wait time between each of the four separate ethical approvals delayed the commencement of the project. As some treatments were not completed in the timescale required to meet the academic submission deadline, the original research proposal was scaled back. A full dataset of pre-treatment interviews was available for analysis which enabled the research questions to be reformulated though retain a focus on reflective function. In each of the parental narratives, all of which were mothers, the thoughts and feelings being expressed clustered around three areas: of themselves as a mother, of their infant and of their developing parent-infant relationship. Through a qualitative analysis of these narratives the current project explores maternal representation asking the question, "Who is the infant in the mothers' mind?"

This study found that coherent, rich, balanced representations involving mental representations of emotions and intentions, were present in all the mother's pre-treatment narratives. Each mother showed a marked capacity for maternal reflectiveness incorporating mentalization. However, high levels of worry featured in all the narratives.

PART I – Literature Review

1. Literature review

This section will provide an overview of the existing literature on infant mental health with a specific focus on psychoanalytic interventions. I have used 'infant' and 'infancy' for simplicity throughout to refer to all babies and children within the under-fives age group apart from where 'baby' or 'child' or 'children' is absolutely necessary. The literature review highlights several difficulties with prevalence, definition and diagnosing in the area of infant mental health. A historical context to parent-infant psychotherapy is given first, followed by three separate yet overlapping areas for treatment: parental mental states, infant mental states and the parent-infant relationship. There is a focus on parental, mainly maternal representations and links these with attachment theory, reflective function and outcomes for infants. It refers to the Tavistock Clinic Under Fives model of treatment highlighting the importance of intervening swiftly, briefly and reflectively when parents ask for help having encountered problems with their infant. Current research into qualitatively exploring parental narratives is presented next. It closes with a summary of the key findings leading into a rationale for the study.

1.1 Literature search strategy

A comprehensive literature search was conducted in an attempt to 'identify, appraise and synthesize all the empirical evidence that meets pre-specified eligibility criteria to answer a given research question' (Cochrane definition, 2013). These databases were several psychology, social science and medical electronic databases including EBSCOhost, PsycINFO, The Pep Archive, Psychology and Behavioural Sciences collection, PsycArticles, PsycBOOKS, SocINDEX, UK Data Archive, Medline, PubMed and BioMed Central. There were additional search strategies which included examining reference lists of relevant journal articles and book chapters, using the search engine Google Scholar and contacting authors and experts in field to identify further on-going or unpublished studies. There were no date restrictions though there were language restrictions (English and French).

Many search terms were used in combination: infant, infancy, preschool, child, parent, mother, father, family, and then in conjunction with the following key words: mental health, psychotherapy, parent-infant psychotherapy, psychiatry, psychopathology, behaviour problems, disorders, illness, disease, disturbances, diagnoses, attachment, mentalizing, representation and reflective function. To widen the search a truncation symbol enabled a simultaneous search for words with a similar beginning. A Boolean Operator word such as OR/AND was used to separate each word or concept in order to maximise the literature search. The names of known measures were also searched; Adult Attachment Interview, Working Model of the Child Interview, Parent Development Interview and The Strange Situation.

1.2 Infant mental health

There are no current UK statistics for the prevalence of mental health difficulties in infants aged under five years old. According to the Government Statistical Service (Mental Health of Children and Young People in England, 2017) published in November 2018, one in eighteen (5.5%) pre-school infants aged between 2 to 4 years old had a disorder. Limitations apply to the interpretation of this data as these are Experimental Statistics, that is, the first estimates of disorder prevalence within England based on a stratified multistage random probability sample of infants drawn from the NHS Patient Register in October 2016.

Boys (6.8%) were more likely to have a disorder than girls (4.2%). Of these 2.5% were identified as having behavioural disorders, 1.4% with Autism Spectrum Disorder (ASD) with sleeping (1.3%) and feeding (0.8%) as other common presenting disorders. Regulatory disturbances in infancy such as excessive crying, sleeping or feeding difficulties and attachment/bonding problems were also estimated to be in the region of 18% for infants aged 18 months (Skovgaard et al., 2008; Skovgaard, 2010). The prevalence of psychiatric disorders in USA preschool infants was estimated between 14% to 26.4%, with a median value of 19.5% (Egger and Angold, 2006). There is increasing evidence that rates of psychiatric disorders in young people are rising (Collishaw et al., 2004). These disorders often begin in childhood and cause distress for both the children involved and their families (Earle, 2013). There is evidence that links behavioural problems in infancy (the first three years) with adolescent and adult psychiatric disorders (Capsi et al., 1996).

Earle (2013) identifies that at various stages in their development all infants show some degree of emotional and behavioural disturbance. These are usually part of a particular stage of

development, are self-limiting and part of ordinary growing up. However, for those infants, specifically under-fives whose presenting difficulties indicated intervention, Earle (2016) states that little has changed in the preceding three years to improve the health and wellbeing of infants, children and young people in the UK. This report highlights the need for both early identification and intervention in order to optimise outcomes for the infant. Emotional disorders in infancy are often unreported or unrecognised (Lyons-Ruth et al., 2017). In addition, they cite the lack of awareness of infant emotional disorders (assessing and diagnosing) has led to there being no accurate prevalence rates. Studying psychopathology in infancy presents a unique challenge (Zeanah et al., 1997). These authors offer several reasons for this challenge, highlighting that rapid developmental changes take place in infancy and the centrality of the relationship context with primary caregivers. Others highlight the limitations in the diagnosis classification of psychiatric disorders (The Diagnostic and Statistical Manual of Mental Disorders (DSM), International Statistical Classification of Diseases and Related Health Problems (ICD) or Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-3)) for infants under five years of age (e.g. Guédeney et al., 2003; Skovgaard et al., 2004; Skovgaard et al., 2005; Postert et al., 2009).

Stafford et al. (2003) and Postert et al. (2009) highlight the need for a specific diagnostic classification system for psychiatric disorder in pre-school infants. Salomonsson and Sandell (2011) suggest that the difficulty in diagnosing psychopathology in young children (infants <18 months old) is that mental health and disturbance takes place within the context of the parent-infant relationship. Keren et al. (2001) found the most common DC 0-3 diagnosis of infants referred to an infant mental health clinic was a combination of parental psychopathology, primary infant disorder (regulatory disturbances of excessive crying, feeding or sleeping problems) and parent-infant relationship disorder. These findings follow Winnicott's well known statement, "There is no such thing as an infant, meaning, of course, that whenever one finds an infant one finds maternal care, and without maternal care there would be no infant" (1940, in Winnicott, 1960, p. 587). Thus, maintaining that there is no such thing as psychopathology within the individual infant. This raises the question of who is the referred patient when infants are referred to mental health services? Is it the infant or the parent?

Perhaps and in keeping with Keren et al. (2001) there are three areas for treatment, the parent, the infant, or the parent-infant relationship. Stern (1998) identifies several possible "port of entry" (p.119) when working with parents who come for help with their infant. He suggested

that the treatment has an entry or focus: the parents' representations, the infant's behaviour, the parent-infant interaction, the therapist's representations and the infant's (imagined) representations. Given the first three of these entry ports for treatment loosely correspond with Keren et al. (2001) three diagnostic areas of disorder, these will therefore be used to explore who or what is the focus for treatment. There is inevitable overlap when intervening in any one of these areas as "there is no such thing as an infant…" (1940, in Winnicott, 1960, p. 587). Firstly, psychoanalytic literature about the historical context to intervening with infants will be presented.

1.3 Who is the treatment for? A historical context

Winnicott (1941), Anna Freud and Burlingham (1944) and Bowlby (1951) led the way in describing how inadequate parental care and disturbed early relationships could result in severe long-term effects. Anna Freud and Burlingham (1942, 1944) observed in the war nurseries the impact separation had on children. Spitz, (1945) described the psychological impact on infants separated from their mothers and highlighted the need for early psychoanalytic interventions. Bowlby (1951) described how crucial the early attachment between parent and infant was for development and future mental health. Direct observation of infants separated from their attachment figures either by war or by hospitalisation established that infant regulatory and attachment difficulties were best understood within a relational context (Spitz, 1945; Robertson, 1953a; and 1953b; Robertson and Bowlby, 1952). Winnicott and Anna Freud began working with the parent-infant dyad when presented with symptomatic infants. Around this time Winnicott (1953) usefully described the "good enough mother" who makes an active adaption to her infant's needs which she "…gradually lessens, according to the infant's growing ability to account for failure of adaptation and to tolerate the results of frustration" (p. 54).

It was not until 1980 that 'infant-parent psychotherapy' was first named by Fraiberg, (1980) with many of today's parent-infant treatments building on Fraiberg's method of treating the infant-parent relationship rather than either the infant or parent. Fraiberg's technique was brief, focused and psychoanalytic. Time-limited treatment or a 'trial treatment' can be traced back to Sigmund Freud (1913) with Balint et al. (1972) and Malan (1975) suggesting a clear treatment focus. Yet Fraiberg's 'infant-parent psychotherapy' owes more to Winnicott's insistence that there is no such thing as an infant.

Sigmund Freud (1908 [1907]) recognised how the past can represent itself in the present. That is, how early ways of relating can be repeated maintaining also that not only do we have a compulsion to repeat patterns of relating but repressed material "…inevitably reappears; like an unlaid ghost, …" (Freud, 1909, p. 122). Fraiberg et al. (1975) continued this thinking specifically with parents, showing how a parent's past, their unlaid ghost, can represent itself in the present, interfering with relating to their infant in the present, becoming 'ghosts in the nursery.' Fraiberg's infant-parent psychotherapy model combined psychoanalytic principles (object relations and attachment theory) and methods with "developmental guidance" (Fraiberg, 1982). Developmental guidance was a multifaceted intervention of supporting parents emotionally, promoting the importance of the infant-parent relationship and encouraging parents to observe and think about their infant's behaviour. It was a representational-orientated approach focused on liberating the parent from interfering representations from their past so "…new paths for growth and development become available for both the mother and infant" (Cramer and Stern, 1988. p. 21). As we shall see later, several useful interview schedules have been developed which assess parental representations and the extent to which they interfere with the parent relating to the infant in the present.

1.4 Why intervene with parents' mental states?

It is well established that parental mental health difficulties lead to adverse outcomes for children. A recent systematic review of the impact on families from parental mental illness (Rupert and Maybery, 2016) highlighted the effect particularly on infants, disrupting the developing parent-infant relationship. Parents with mental illness may be emotionally unavailable to children (Brockington et al., 2011). Children whose parents are mentally unwell are at a substantially increased risk of childhood psychiatric disorders (Hare and Shaw, 1965; Rutter and Quinton, 1984; van Santvoort et al., 2015). These previous three studies focused on parental mental health rather than specifically on the effects of maternal mental illness which has been shown to affect between 10-20% of women either antenatally or in the first-year post-partum (Bauer, 2015). Poor maternal mental health has serious and long-lasting effects on mothers and their infants (Murray, 1992; Oates, 2003). Maternal depression is associated with higher rates of insecure attachment in infants (Lyons-Ruth et al., 1986; Murray, 1992). There are impacts on the foetus (NICE, 2007; Talge et al., 2007; Glover, 2015; Gentile, 2017) leading to possible later child and adolescent mental health difficulties (O'Donnell et al., 2014). Murray et al. (1996) describe how maternal mental health difficulties,

such as depression in the post-partum period significantly impacts the mother-infant relationship.

In the UK developments such as the 2007 NICE Antenatal and Postnatal Mental Health Guidelines aimed to equip all health professionals to predict and detect (using the Whooley questions) those women at risk of either becoming or were currently mentally unwell in the perinatal period. As of five years ago 40% of the country (NHS England, Perinatal Mental health, 2019) did not have access to specialist perinatal mental health services. However, there has been recent financial investment as part of the NHS Long Term Plan and Five Year Forward (NHS England, 2019) in supporting further developments for perinatal mental health services. In addition, Health Education England have developed a competency framework for professionals working with women who have mental health problems in the perinatal period (Health Education England, 2019). This includes having a 'Perinatal Frame of Mind,' involving three distinct areas of interest for health and wellbeing: mother's needs, the infant's needs, and the mother-infant relationship. It suggests a whole family approach with the needs of fathers/partners and of other children also to be considered.

There is an inevitable overlap when intervening in any one of the three areas. Barrows (2003) describes it as "axiomatic" (p. 284) that the mental state of the parent significantly impacts upon the emotional and psychological development of the infant. Murray et al. (2003) highlighted how infants were at risk of the same disorder as their parent. Specific parenting difficulties in mothers with social phobia, such as the lack of maternal encouragement of their infants to engage in social interactions resulted in infants showing early signs of reduced social responsiveness. This finding of transgenerational specificity, i.e. infants are mainly at risk of the same disorder as their parent, is one of many highlighted by van Santvoort et al. (2015) on the potential transgenerational transmission from parents to infants through various risk factors such as genetics, neurobiology and psychological.

Murray and Cooper (1997), Cooper et al. (2003) and Murray et al. (2003) draw attention not only to the impact postnatal depression can have on infant development they also as part of two connected randomised control trials (RCT) (Cooper et al., 2003; Murray et al., 2003) provide evidence regarding treatment. What is of importance given the focus of this current study is that these two RCT's compared three brief psychological interventions (non-directive counselling, cognitive behavioural therapy or psychodynamic therapy) with the control

(routine primary care) on a population of primiparous women diagnosed with a major depressive disorder post-partum. Despite there being several limitations with these studies all of the treatments significantly improved maternal mood in the short term. However, there was no significant impact on a variety of outcome measures regarding the infant (security of the infant-mother attachment and infant cognitive development) and they cite the brief nature of the interventions as one reason for this. Given Fraiberg et al. (1975) comment that it is "the babies themselves who are often afflicted by the diseases of the parental past," (p.389) it is these diseases which require more than brief interventions. Emde (1988), in keeping with this premise, refers to the experience of becoming a parent wakening the dormant representations of the parent's own parent-infant relationships. The infant in the present may be experienced by the parent as either or both a representation of the parents' infant self or the parent's own parent. As Hopkins (1992) puts it, "when the early representations are negative their projection can lead to difficulties (p. 12).

Recent findings from the parent-infant psychotherapy RCT, Fonagy et al. (2016b), for parents (all mothers) with mental health difficulties, showed there were no improvements in infant development and attachment, though there were improvements in maternal mood, maternal representations of the infant, and in the mother-infant relationship. The authors go on to suggest that these improvements in the longer-term may have a positive consequence for infant development though they also cite small numbers in the treatment group at follow up (12 months n=31). Of particular interest were the improvements in maternal representations of the infant and this will be addressed later when mentioning a connected study by Ransley et al. (2019). Nevertheless, there is considerable overlap when intervening with infants.

1.5 Why intervene with infants' mental states?

Improving infant psychological health and wellbeing seems at the heart of many of these previously mentioned studies. The association between early experiences with later life outcomes is unequivocal. There is now increasing evidence that early experiences shape the developing brain and other areas of development (Schore, 2002; Zeanah and Zeanah, 2019). The effects of infant psychological difficulties can be long-lasting (Goodman et al., 2012) with 50% of mental illness in adult life starting before aged 15 and 75% by the age of 18 (Murphy and Fonagy, 2012). Stern (1998) offered us several intervention entry points with infants through his representational world concept. The infant's internal world is made up of the "subjective experience of participating in interpersonal events" creating what he called an

"object related" representational world (Stern, 1994 p. 10). Bowlby (1969) described this as an 'internal working model.' Both Stern and Bowlby's ideas of representation can be found in Sigmund Freud (1938). Objects in the infant's internal world are initially objects in the external world and "…by identification, been taken into the ego and thus become an integral part of the internal world" (Freud, 1938, p. 205). Stern (1994) illustrates his theory with a case example of a particular infant's representational world formed through different schemas of being with a depressed mother. He describes how the infant repeatedly attempts to recapture and reanimate his mother, something also seen in experimental conditions with the 'still face' experiment (Tronick et al., 1978). When the infant (and its representation system) has an accessible and responsive mother as the attachment figure it creates a secure attachment (Ainsworth et al., 1978). It is through the interpersonal events of daily life that the infant stores an experience, both cognitive and affective, of its early caregiving experiences (Crittenden, 1990). This constitutes an 'internal working model' (Bowlby, 1969) or a mental representation and it is through the early caregiving experience of a parent recognising its infant's mental state and attuning to it, that infant attachment security develops.

Some argue that infants as subjects entitled to an intervention in their own right have been lost from treatment in favour of working with the parent principally in parent-infant psychotherapy (Lojkasek, 1994). Thomson-Salo (2007), pioneering the previous work of Winnicott, argues for infants to be seen as the referred patient when being treated with infant-parent psychotherapy. This idea also follows that of Fraiberg and her technique of encouraging parents to observe and think about their infant's behaviour. Cramer (1995), in honouring the work of Lebovici, describes the creativeness inside the mind of the infant. The symptoms of the infant are seen much more as creative communications where the infant can "join in the conversation" (p. 27). Crammer advocates that interpretation, as a psychoanalytic technique needs to be used simultaneously on both mother and infant. Salomonsson (2007, 2017) suggests there are ways to communicate psychoanalytically with infants in psychoanalytic treatment.

Direct therapeutic intervention with infants has for many years been the work of child psychotherapists. It remains today an essential part of all UK trainings leading to registration with the professional body for psychoanalytic child and adolescent psychotherapists (ACP Association of Child Psychotherapists). A key component of the training involves intensive work, three sessions a week, with an infant under the age of five for a minimum of a year. Intensive direct work with infants owes much to the work of Klein, without whom we would

not have had an understanding of infantile anxiety, paranoid-schizoid and depressive positions (Klein, 1946) and the epistemophilic instinct (Klein, 1928), all invaluable concepts when working with infants. Many of Klein's case studies were with infants under the age of five years. There are several single case histories (Sussman, 1997; Youell, 2001; Calvocoressi, 2008; Allnutt, 2016; Yeo, 2016) charting some of this valuable work with infants though as yet no empirical studies. A mainstay within the training is the development of psychoanalytic observation skills. Observing infants was first introduced to the training by Bick in 1948 (Bick, 1964) with several observations of babies, infants and young children nowadays included within the curriculum. It equips the observer with skills to reflect on infantile states of mind and the impact these have on those in close proximity to infants and including the observer themselves. Bion (1962) emphasises how psychoanalytic vision (observing) necessitates the taking in of both the conscious and the unconscious. Observing various internal states and external realities simultaneously is central to many parent-infant interventions where an observer can be tuned in and emotionally receptive to the feelings of those being observed and of oneself (Pozzi, 2003). One of Stern's (1998) entry ports was working with the therapist's representations or what he refers to as a "countertransferential approach" (p, 133). He attributes his idea to that of Bion (1963, 1967) where the therapist (or mother) functions as a 'container' for the mental activity and functioning of the patient (or infant). The therapist's own subjective understanding of the infant's inner world is therefore a crucial element within under-fives work (Miller, 1992). Most of the therapeutic work with infants has been focused on the relationship between the parent and infant.

1.6 Why intervene in the parent and infant relationship?

There is increasing evidence about the significance of the early parent-infant relationship in the aetiology of childhood psychopathology (Bowlby, 1969; Sroufe, 2005; Lyons-Ruth, 2008) with evidence of the severe long-term effects of disturbed early relationships (Erickson et al, 1985; Fonagy et al., 1993; Cicchetti and Lynch, 1995; Baradon et al., 2005; DeKleyn and Greenberg, 2008; Norman et al., 2012; Cicchetti, 2016). Many parent-infant psychotherapeutic interventions influenced by these findings focus towards improving or repairing the parent-infant relationship. In describing the complex process of mutual regulation between a parent and infant, Lieberman and Pawl (1990) suggest disturbances within the infant's attachment may stem from misattuned dysregulated parent-infant relationships. They state that neither parent nor infant can be treated separately or directly regarding the presenting symptoms. Memories and experiences of their early attachment relationship are stored by the infant (Amini

et al., 1996) forming an 'internal working model' (Bowlby, 1969) for later attachment relationships. Main et al. (1985) define an internal model as a set of conscious and/or unconscious rules for assessing and organising attachment information. Structured separation-and-reunion observations (Sroufe and Waters, 1977, Ainsworth et al., 1978) produced a standardised procedure (The Strange Situation, Ainsworth et al., 1978) for assessing infants' attachment relationship at one year. Mothers who respond sensitively and are attuned to their infants' signals and behaviour in the early months are more likely to have securely attached infants at 12 months (Main and Solomon, 1986; Beebe et al., 1997).

The Adult Attachment Interview (AAI) developed by George, Kaplan and Main in 1985 enabled the assessment of attachment representations in adults and also advanced the understanding of intergenerational transmissions of patterns of attachment. In 78-80% of cases the security of the parental attachment predicted the security of the infant's attachment to them (Main et al., 1985; George et al., 1996). When the AAI was administered to pregnant first-time mothers it predicted the future attachment status of their infants at one year (Fonagy et al., 1991a). Fraiberg's 'ghost in the nursery' principle was empirically confirmed by Fonagy et al. (1993). In administering the AAI to parents in the last trimester of pregnancy it predicted the security of the infants' future attachment relationship with both parents. This was tested with the Strange Situation with the infant at 12 months with their mothers and at 18 months with their fathers. Their finding revealed correspondence between the infant's behaviour with each parent in Strange Situation and the attachment classification (AAI) to that parent. Other studies similarly have found that children may have different patterns of attachment to different parents or caregivers (Green and Goldwyn, 2002; van IJzendoorn and De Wolff, 1997).

These findings suggest that attachment security or insecurity is not a trait in the infant but rather what has been already suggested by Stern (1994) regarding the representational system of how the infant experiences the emotional availability and behaviour of each parent. This is not a new idea as we have seen. Bowlby (1969) with his 'internal working model' credits Sigmund Freud, "…psychoanalysts from Freud onwards have presented a great deal of evidence that can best be explained by supposing that it is not uncommon for an individual to operate, simultaneously, with two (or more) working models of his attachment figure(s) and two (or more) working models of himself" (Bowlby, 1973, p. 205). Disorganised attachment with one parent is not significantly associated with the same disorganised attachment with the other parent (Main and Solomon, 1990; Steele et al., 1996; van IJzendoorn et al., 1999).

One would imagine that parent-infant interventions following these finding would therefore have the focus of treatment as parents' own internal representations of attachment including work which included both mothers and fathers. However, Barrows (2003) suggests that effecting change within the parent's internal representation of their infants is thought to be the work of long-term individual psychotherapy. Schore (2001) suggests that this change is not within the infant's timescale where infants may not be able to afford to wait for change in the parents (Thomson-Salo et al., 1999).

1.7 Intervening in parental representations

Lieberman and Pawl (1993) conceptualise the 'patient' within infant-parent psychotherapy as the parent-infant-relationship. They view the key area for change is parents' representations and as followers of Fraiberg describes these the potentially pathogenic element requiring change. In their view it is the "corrective attachment experience of the therapeutic relationship" (p. 430) that changes the parents' representations. Similarly, to others mentioned, emphasis is placed on engaging the infant in the therapeutic process. The principal within Fraiberg's (1980) infant-parent psychotherapy was to alleviate the pathogenic representation (the ghost) in the actual interaction between the mother and the infant as it unfolds and shows itself during the sessions. Sigmund Freud (1914) suggested "...the patient does not *remember* anything of what he has forgotten and repressed, but *acts* it out. He reproduces it not as a memory but as an action; he *repeats* it, without, of course, knowing that he is repeating it" (p. 150). Behaviour in the infant which is reacted to by the mother can then be interpreted by the therapist within sessions - alongside an understanding of underlying unconscious internal representations and their tendency to repetition. Intergenerational transmission of relationship patterns is well documented in the literature some of which has already been mentioned (Ainsworth et al., 1978; Bowlby, 1973, 1988; Fraiberg, et al., 1975; Fonagy et al., 1991a; Main et al., 1985).

Intervening relationally particularly regarding the representations of parent and infant in relation to each other is a model developed at the Anna Freud Centre (Baradon, 2002; Baradon et al., 2005). It offers parent-infant psychotherapy primarily to parents with infants from birth to aged 2 years. Evidence supportive of this intervention as we have seen, demonstrated various improvements in maternal mood, maternal representations of the infant, and in the mother-infant relationship within a high-risk group of mothers with mental health problems who were also experiencing high levels of social adversity (Fonagy et al., 2016b). The recent systematic

review of parent-infant psychotherapy for improving parental and infant mental health (Barlow et al., 2015) concluded that parent-infant psychotherapy was a promising model for improving infant attachment in high-risk families. Parent-infant psychotherapy was no more effective than other treatments such as Video-Interaction Guidance.

Zeanah et al. (2000) suggests a model for parent-infant psychotherapy of not just focusing on observable behaviours between the mother and infant but also on the internal representations of the relationship of both parent and infant. Zeanah et al. (1994) developed the Working Model of the Child Interview (WMCI) a structured interview schedule examining the subjective narratives of parents' descriptions of their internal representation of the infant pioneered by the work of Main et al. (1985). Not only does it gather parental thoughts and feelings regarding their infant's personality and characteristics it also captures parental perceptions of their infant's behaviour. There are eight narrative features aimed to elicit the parent's representations of their infant: richness of perception, openness to change, coherence, intensity of involvement, caregiving sensitivity, acceptance/rejection, infant difficulty and fear of loss (Zeanah et al., 2000). An advantage of using the WMCI rather than the AAI is its focus on parents' narrative descriptions of the infant rather than the parents' narrative of their own childhood. It is considered a valid and useful tool both clinically and for research purposes (Vreeswijk et al., 2012). Attachment researchers began to study correlates between mothers' narrative descriptions, particularly their insight and awareness of their infant's mental states and of the attachment. Initially there was the Parental Attachment Interview where the focus of attachment was shifted from the filial to the parental perspective which provided a new understanding of parental experiences of the attachment relationship (Bretherton et al., 1989). The Child Attachment Interview (Target et al., 2003) has purposefully not been mentioned. As with other measures such as Family Photos and Drawings (Main et al., 1985), Story Stems (Bretherton et al., 1990) and Doll Play (Solomon et al., 1995) it is an instrument used with older children, not infants. The Child Attachment Interview was modified from the AAI. Nevertheless, all these measures aim to elicit mental representations of attachment.

Other developments by those researchers already studying intergenerational transmission of relationship patterns demonstrated the significant concordance between parental and child patterns of attachment (Fonagy et al., 1991b). A parent having an understanding of their infant's internal mental life will help the parent 'mentalise' and so regulate their infant's internal world. Various new terminology emerged, e.g. 'mentalization' and 'reflective

function' to refer to a theory of mind. Fonagy (2000) uses the Cartesian cogito to describe the birth of the infant's psychological self as, "My caregiver thinks of me as thinking and therefore I exist as a thinker" (p.1129).

Another interview schedule was developed called the Parent Development Interview PDI (Aber et al., 1985; Slade et al., 1991; Aber et al., 1991; Slade et al., 2004) which set out to examine parental narratives of their representations of themselves as a parent, of their child and of their current developing relationship with the child as well as questions about the parent's relationship with their own parents. The scoring produces a level of parental reflective function (Fonagy and Target, 1998; Slade et al., 2004). Fonagy et al. (1994) re-analysis of the data that had previously confirmed Fraiberg's 'ghost in the nursery' (Fonagy et al., 1993) showed that all the mothers with a history of trauma and deprivation who showed good reflective function had infants classified as securely attached. They conclude that parental reflective function is protective and "If the mother is able to reflect on the infant's mental state the infants' need to use defensive behaviours (insecurity) will be reduced" (p. 249). A sense of security is developed in the infant when complex mental states, including feelings and intentions, are held in the mother's mind. In holding these in her mind she can begin to reflect on her infants' behaviour in light of these mental states (Slade, 2005) with opportunities for her infant to understand and process mental states (Fonagy et al., 1991b; Fonagy and Target, 1996).

Barrows (2003) suggests improving parental reflective function is the area for direct work with parents rather than changing the representations themselves. Others suggest the task is to identify and bring to prominence in the mind of the parent more benign mental representations, the 'angels in the nursery' (Lieberman et al., 2005), principally to benefit the parent's relationship with that particular infant. Even though Fonagy et al. (2016b) RCT showed no improvements in child development and attachment, Sadler et al., 2013 RCT 'Minding the Baby' mentalization home-based intervention did show over the course of the intervention increased rates of mother-infant secure attachment. Barlow et al. (2015) systematic review recommends the need for further parent-infant psychotherapy research to establish its impact especially in the areas of parental mental health, reflective functioning, and parent-infant interaction.

1.8 Why intervene briefly?

Fraiberg's (1980) infant-parent psychotherapy as we have seen was brief, focused and psychoanalytic. Others have adapted this over the years, Cramer and Palacio Espasa (1993) refer to pathogenic representations as "conflits de la parentalité" (conflicts of parenthood, quoted in Barrows, 2003, p. 288). The focus is on identifying the mental representations as they present themselves between the mother and infant in the sessions. It is the mother's past that contaminates her present interaction and relationship with her infant. Decontaminating or disconnecting the reappearance of the past representation in the present is what Hopkins (1992) described as "…unhooking the baby from the parents' hang-ups (p.12). It is the disconnection of the past from the present that is possible in brief work and not in changing the parent's internal representation of their infants which as we have seen is the work of long-term individual psychotherapy (Barrows, 2003).

An intervention with a brief, focused and psychoanalytic model is The Under Fives Service, at the Tavistock Clinic. It initially began as an under-fives counselling service over 40 years ago working in child and family clinics in the local community. The intervention is brief, usually five sessions which may with some families function as an assessment when more serious problems are evident and require longer term work within Child and Adolescent Mental Health Service (CAMHS). There is a wealth of clinical expertise and experience within case histories and books charting the history and developments of the model. This is a different type of evidence which brings to life the rich and valuable work undertaken with families and their infants (Daws, 1985 (i) and (II); Saltzberger Wittenberg, 1991; Hopkins, 1992; Hopkins, 1994; Daws, 1999; Emanuel, 2002; Likierman 2003; Pozzi, 2003; Emanuel, 2006; Emaunel and Bradley, 2008). There have been attempts more recently to rigorously evidence the work both quantitatively and qualitatively. Firstly, the Brief Intervention Project (BIP) (Emanuel and Lee, 2013, personal communication 4 November 2014) used quantitative research methods analysing a variety of routine outcome monitoring measures (Goal Based Outcome Measures (GBOM), Strengths and Difficulties Questionnaire (SDQ) and clinician's observed relationship of parent to infant at the beginning and end of treatment). There were improvements in all the measures in all 24 infants. Then qualitatively, Youell (2018, personal communication 27 August 2018) is asking, 'Can the (Under Fives Service) model be manualised?' Like Barlow et al. (2015) recommends, there is an urgent need for further parent-infant psychotherapy research.

1.9 What can parental narratives tell us? Current research

From studying mothers' narrative descriptions, particularly their capacity to reflect upon their own experience as a parent and on the experience of their infant, researchers began to know more about the intergenerational transmission of attachment patterns. As Slade (2005) puts it, "it is the parent's internal working model of her child and his mental experience that will help her to mentalise and thus regulate her child's internal world" (p. 275). Most studies to date have used a recognised interview schedule such as the PDI, to understand a parent's representational model from their narrative descriptions. However, given what has already been presented about 'ports of entry' for intervention, the majority of studies use samples where there is a pre-existing concern in one or more of the three areas for intervention.

Two studies that did not have a clinical concerning sample are the connected studies of Slade et al. (1999) and Aber et al. (1999) who identified mothers through birth announcements in a local newspaper. Their sample even though large (n=125), exclusively involved mothers who were all Caucasian, middle and working class, married and with a first born male infant. What these two studies did was to pave the way for the later revision of the PDI 1994 to the 2004 version with a new coding system still used today in measuring reflective function. This adapted the Fonagy et al. (1998) manual for coding reflective function on the AAI to use with the PDI Aber et al. (1994) which became the revised PDI version Slade et al. (2004).

There are several findings from Slade et al. (1999) and Aber et al. (1999) though the most relevant for the current study was that, although relatively stable, mothers' representations of their relationships with their sons are still open to change in infancy (Aber et al., 1999). Nevertheless, this was on a non-clinical sample, receiving no intervention (other than the research itself) and solely on mother-son dyads. These researchers suggest that maternal representation of infants can be impacted on by aspects of daily life such as; parental daily struggles, infant behaviour changes with each developmental stage and the varying quality of the parent-infant interactions. The latter two of these areas of impact could be very loosely connected with Stern's (1998) entry ports for intervention, namely the infant's behaviour and the parent-infant interaction.

There have been several empirical studies analysing parental narratives pre and postnatally (Ammaniti, 1991; Benoit et al., 1997; Huth-Bocks et al., 2004) linking these with later attachment security in their infants. Even though these are different samples, i.e. expectant

mothers, to the sample in the current study a few points are warranted. They all used the corresponding coding system such as AAI, PDI, WMCI or Interview of Maternal Representations during Pregnancy (IMRAG, a structured interview developed to explore mother's mental representations of herself as a mother and of her future baby) to analyse parental narratives. In the Benoit et al. (1997) study a pervasive sense of coolness, indifference or an emotional distance were the characteristic of mothers with unbalanced (disengaged) representations. Additionally, even if the mothers recognised their infant's experience it was not valued by her. Those mothers who were pre-occupied or distracted by other concerns e.g. confusion or being anxiously over-whelmed by their infant, demonstrated these features in their unbalanced (distorted) representations. In a later study Ammaniti et al. (2013) used a revised version of the IRMAG-R (Ammaniti and Tambelli, 2010) and found balanced (integrated) representations of their infant in non-risk mothers and a higher frequency of ambivalent (not integrated) representations in at-risk mothers. Additionally, Foley and Hughes (2018) meta-analysis gathered data from 14 studies exploring the link between mothers' and fathers' prenatal thoughts and feelings about their infant with the quality of parent-infant interaction. Associations were significantly stronger for mothers than for fathers. These authors call for greater consistency in the measures used, greater sample diversity and the examination of associations with child outcomes. There is a dearth of research exploring pre-birth parental narratives given what we already know, and this has been stated previously, such as Fonagy et al. (1991a) and Fonagy et al. (1993).

Zeegers et al. (2017) meta-analysis on parental mentalization and sensitivity as predictors of infant–parent attachment helpfully separates out definitions of the three parental mentalization constructs. These are parental mind-mindedness, parental insightfulness and parental reflective function. They suggest distinct assessment approaches for each of these three areas all of which assess mentalization through a variety of measures; the PDI (Slade et al., 2004) is used in the current study and the Parental Reflective Functioning Questionnaire (PRFQ) (Fonagy et al., 2016a) was a measure intended for use in the originally proposed study. Apart from the PRFQ, which require parents to say to what extent they agreed or disagreed with several statements, all the measures use parental narratives, coding them in order to determine levels of either mind-mindedness, insightfulness or reflective function. It is from parental narratives, with a particular focus on the infant's mind, that parents' representations of their infant's internal states of mind and parental mentalization can be assessed. As Zeegers et al. (2017) point out, there is a scarcity of empirical studies comparing these three parental mentalization constructs.

What is even scarcer are studies that analyse parental narratives using qualitative methodology rather than with the corresponding coding system for the specific interview schedule. Despite the scarcity there are three studies where maternal narratives of their infants and of their parent-infant relationship have been analysed qualitatively (Bretherton et al., 1989; Slade and Cohen, 1996; Baradon et al., 2008) and specifically regarding maternal representations. Interestingly they all used additional measures to either verify or refute the qualitative findings.

Before going on to describe these studies there is one study where maternal narratives were analysed differently. Oppenheim and Koren-Karie (2002) used the Insightfulness Assessment (IA) to assess mothers' capacity for insightfulness. It is an interview schedule though also involves analysis of maternal narratives following being shown video-taped vignettes of themselves with their infant. There are three main features which measure: insightfulness regarding the motives for the child's behaviours, an emotionally complex view of the child, and openness to new and sometimes unexpected information regarding the child. There are empirical studies reporting on its validity and reliability (Oppenheim et al., 2001; Koren-Karie et al., 2002). Mothers who are categorised as positively insightful on the IA were most likely to have securely attached children. A barrier to maternal insightfulness particularly when present at high levels during the interview was anger and worry. One important finding of the study was that, "IA classification was unrelated to maternal vocabulary or educational level" (Oppenheim and Koren-Karie, 2002, p. 603). This finding is also addressed below with other authors suggesting a possible instrument bias.

The study by Bretherton et al. (1989) was mentioned previously when highlighting the shifting focus from studying attachment from the filial to the parental perspective. Using the PDI, plus several other measures, (n=36) middle-class mothers were interviewed regarding their attachment relationship with their 25-month-old infant. There were two separate analyses of the interview data, firstly a content analysis with a focus on maternal thoughts regarding attachment and secondly a global analysis intended to detect differences in the quality of the parent-infant relationship. What is of particular importance for the current study are their findings around sensitivity/insight. High scores for sensitivity/insight were awarded when mothers conveyed appropriate and sensitive responses to their infant's communications and had insight into both their own and their infant's behaviour and personality. They highlight what has already been noted here, viz. parental accessibility and responsiveness as well a parental capacity to give coherent descriptions of their own childhood attachment relationships

have been excellent distinguishers between secure and insecure relationships (Ainsworth et al., 1978; Main et al., 1985).

Slade and Cohen (1996) present qualitative data from three mothers chosen to reflect the three main attachment styles of secure, insecure-avoidant and insecure-resistant (Ainsworth et al., 1978; Main et al., 1985). Their study was a large (n=66) low-risk sample of women from pregnancy followed-up longitudinally until their infants were 42 months. The sample was recruited at random from pre-birth classes, flyers or newspaper advertisements. Numerous interviews schedules were completed which included an AAI, PDI's at ten and 28 months and a Strange Situation. Only the data collected before birth and at ten months was analysed qualitatively though the methodology used to analyse the data is unclear. What is clear is their statement on their in-depth qualitative data analysis where they say, "We believe that these types of analyses are a necessary complement to large-sample statistical analyses; analyses of the type we have undertaken here add depth and richness to the overall findings of the research" (Slade and Cohen, 1996, p. 220). Their findings support that of Fraiberg et al. (1975) in that the parent-infant relationship is influenced by the mother's representation of her own past experience and of her own representation of caregiving. This current study needs no better rationale than their unequivocal statement calling for further qualitative analyses of maternal narratives.

Baradon et al. (2008) sample of 15 mothers were all incarcerated (with their infants) and considered a high-risk group. A variety of measures were used pre and post a brief 'New Beginnings' treatment to study changes in mothers' reflective function and narratives about themselves and their infant. The treatment was an accredited learning and experience-based group parenting programme of eight two-hour sessions, run over four consecutive weeks aimed to address impingements on the mother's internal world and impingements that distort her bonding with her baby. The aim of the 'New Beginnings' treatment was to intervene within the intergenerational transmission of disordered attachments. As we have seen earlier some argue that this work requires long-term interventions. A pre and post-treatment PDI was analysed qualitatively (thematic analysis) and quantitatively measured for levels of reflective function. There were five main themes some of which will be referred to later in the discussion. One theme of high levels of anger, hostility and negative attributions in the narratives is described by the authors as, "emotions, perceptions, expectations and described behaviours clearly form part of the mothers' internal working models" (p. 253). Videoed interactions of

mothers with their infants captured behaviours meeting the criteria for frightening behaviour (Main and Hesse, 1990) and negative-intrusive behaviour (Atypical Maternal Behavior Instrument for Assessment and Classification AMBIANCE; Bronfman et al., 1999). Both of these coding procedures study maternal behaviours associated with disorganised infant attachment.

Despite Baradon et al.'s (2008) small sample size there was a significant increase in levels of maternal reflective function following the intervention. However, the levels of reflective function post-treatment were below the level normally considered adequate for good parental functioning and secure attachment relationships. Qualitative analysis of the post-treatment PDI by researchers blind to the quantitative improvements in reflective function found mothers descriptions of their infants more realistic with improved capacity to substantiate these descriptions with examples. Both the infant and the parent-infant relationship were less idealised post-treatment with mothers sharing more mixed feelings and an awareness that their infant was a separate individual with a different mind. In terms of the overall outcomes for the infants in this study the results were not promising. As we know from Fonagy et al. (1993) it is not the events of the past that determined attachment security in the infant but good reflective function.

Before going on to give the rationale for the current study a further five studies are considered relevant to mention for a variety of reasons. Most of these studies use the WMCI. Firstly, Wood et al., (2004) used the WMCI at three months postpartum on a small sample (n=8) of mothers recruited antenatally, all whom had met certain diagnostic criteria for a current or past history of Major Depressive Disorder, i.e. were at high risk of postnatal depression. The proportion of balanced representations of their infants was substantially lower than in a non-clinical population. Of the six mothers who were depressed postpartum none had balanced representations of their infant.

Schechter et al. (2005) also used the WMCI in a high-risk sample of mothers (n=41) with infants between 8-50 months. Additional probing questions were added into the WMCI aimed at eliciting thinking about mental states. The WMCI interviews were analysed with the corresponding coding system though also with the PDI coding system to measure reflective function. They suggest that a prerequisite for the formation of balanced mental representations

is of a mother who on the whole views her infant as having a distinct and separate mind from her own.

Sokolowski et al. (2007) assessed maternal representations again using the WMCI in a high-risk sample of African American mothers (n=100) with 17-20-month-old infants. Mothers with balanced representations of their infants had narratives that were coherent, rich in detail and caregiving sensitivity. These mothers were more likely to have had higher educational attainment. One possible explanation given for this was regarding instrument bias where they cite the WMCI tending to favour those more educated with a higher level of verbal fluency. Depression and maternal hostility were found to be significantly related with the researchers calling for more research to further explore the impact hostility and depression either together or differentially have on maternal representations.

Bekar et al. (2018) study does not focus on maternal representation though they do analyse maternal narratives. The content of maternal narratives is analysed through the lens of mentalization. Mothers who labelled positive and negative emotions along with other mental states and make connections between mental states (in the task of storytelling given to them in the study) were associated with more prosocial behaviours and fewer social-emotional problems in their infants. These authors usefully remind us of what we have already seen in the literature from Fonagy et al. (1991b) and Fonagy and Target (1996), viz. a secure attachment develops in the infant when complex mental states, including feelings and intentions, are held in the mother's mind and when there is a "capacity to incorporate them into coherently organized, nonidealized, truthful narratives, the child finds abundant opportunities to play with, understand, and process mental states (Bekar et al., 2018, p. 119-120).

Finally, Ransley et al. (2019) is a mixed methodology secondary analysis of data from the parent-infant psychotherapy treatment arm of the RCT Fonagy et al. (2016b). It explores the relationship between parental expectations, engagement, and clinical outcomes from treatment. The findings in themselves are interesting though are not considered relevant here though the study is noteworthy for other reasons. They analysed all the pre-treatment interviews, one of which was a PDI, with content analysis, a type of thematic analysis (Braun and Clarke, 2006) and the generated themes were tabulated with the engagement and outcome data. What is surprising given one outcome of the Fonagy et al. (2016b) study was improvements in mothers' representation of their infants, is why the secondary analysis did not do what Slade and Cohen

(1996) advocated 24 years ago, i.e. a necessary qualitative analysis that complements the large-sample statistical analyses adding depth and richness to the overall findings of the research.

2. Summary of the key findings

This literature review highlights difficulties with prevalence, definition and diagnosing in the area of infant mental health. Presented are several areas for treatment with inevitable overlap when intervening in any one of the areas mentioned. A context to offering an under-fives brief psychoanalytic informed treatment is given through charting the early history and development of psychoanalytic infant-parent interventions (Winnicott, 1941; Anna Freud and Burlington, 1944; Spitz, 1945; Fraiberg, 1980). In keeping with the research question of, "Who is the infant in the mothers' mind?" the literature reviewed demonstrates how in early infancy an object related representational world becomes an internal working model for future attachment relationships. This, as shown, is of particular importance when becoming a parent, as dormant representations of the parent's own parent-infant relationships can be awakened (Fraiberg et al., 1975). Evidence from seminal research reviewed reveals intergenerational transmission of attachment patterns as Ainsworth et al. (1978); George et al. (1985), Main et al. (1985) and Fonagy et al. (1991a) have demonstrated.

A further key finding is that attachment researchers began to use terminology, such as mentalization and reflective function, which furthered our understanding of how infant attachment security develops (Fonagy et al., 1991b; Fonagy et al., 1993). Interview schedules were created, studying the correlates between parental narrative descriptions, particularly their insight and awareness of their infant's mental states and of the attachment (Aber et al., 1985; Slade et al., 1991; Aber et al., 1991; Fonagy and Target, 1998; Slade et al., 2004). A final key finding of the current literature review is a particular emphasis on qualitative studies analysing maternal narratives with a focus on maternal representation. However, within that, there was a scarcity of studies qualitative analysing parental narratives without the use of the corresponding interview schedule coding system.

Overall the studies reviewed demonstrate how parental representations of their infant's internal states of mind and parental mentalization can be assessed by analysing parental narratives. Balanced maternal representation of their infant were by and large found in mothers in non-clinical low-risk samples and linked with secure attachments (Bretherton et al., 1989; Slade et al., 1999; Aber et al., 1999; Ammaniti and Tambelli, 2010). Yet, the review revealed a need

not only for more qualitative analyses of maternal narratives but also for greater consistency in the measures used, greater sample diversity and examination of associations with later child outcomes, all of which are put forward for areas for future research.

3. Rationale for the study

There is a scarcity of qualitative research exploring maternal narratives with a focus on maternal representations. The Under Fives Service, at the Tavistock Clinic as has been described uses a model of time-limited psychoanalytically informed treatments for parents who present with difficulties with their infants. This treatment model is well documented in case history material though as yet not in empirical qualitative or quantitative research. There have been some recent attempts to do this as stated earlier. An important voice not yet heard is that of parents using an under-fives service. In asking, what can be learned from interviewing parents, this research aims to explore parental thoughts and feelings about their infants, themselves as a parent and about their developing parent-infant relationship.

PART II - Qualitative Research Report

1. Introduction

Presented here is a qualitative research report analysing mothers' thoughts and feelings about themselves and their infant prior to receiving a brief psychoanalytically informed under-fives treatment. There was a scaling back of the original proposal to adhere to the academic submission deadline. Changes to the original proposal will be mentioned at relevant stages throughout Part II and will also be addressed in Part III.

As mentioned, a full data set of pre-treatment interviews were available to the researcher. It was at an early stage of analysing the data from these interviews that themes began to be identified in an inductive way (Frith and Gleeson, 2004). These clustered into four areas: mother's descriptions of their infant, descriptions of problems in themselves as a mother, problems in their infant and problems in the developing parent-infant relationship. These three problem areas were in keeping with what has been previously discussed, specifically Keren et al. (2001) that infants referred to mental health clinics are diagnosed with a combination of difficulties and Stern (1998) offering several possible 'ports of entry' when working with parents who come for help with their infant. Additionally, some of these areas were linked to previous research, specifically around exploring mothers' narratives regarding their representation of their infant and how mothers describe their difficulties.

2. Methodology

2.1 Aim

This study explores maternal representations from mothers' narratives prior to a brief psychoanalytically informed treatment. It asks the question: Who is the infant in the mothers' mind?

The four research questions are:

1. How do mothers describe their infant?
2. How do mothers describe their problems in the following three areas:
   2a. How do mothers describe their problems?
   2b. How do mothers describe their infants' problems?
   2c. How do mothers describe their parent-infant relationship problems?

2.2 Methods

2.2.1 Design

This study utilises a qualitative methodology in order to investigate parental thoughts and feelings about their infant, themselves and their relationship with their infant. It analyses, using thematic analysis (Braun and Clarke, 2006) the qualitative semi-structured interviews carried out prior to treatment with an opportunistic sample of six mothers whose infant had been referred to an under-fives mental health service.

2.2.2 Setting and procedure

The study took place within an inner-city community child and adolescent mental health service (CAMHS). Referrals for infants aged under-five had previously been observed as appreciably lower than referrals of other age group of children. In 2016 financial investment from the local Clinical Commissioning Group (CCG) aimed to transform the current CAMHS under-fives mental health provision through a designated service providing: consultation, specialist assessment, evidence-based treatments and inter-agency partnership working. It was a bi-borough initiative covering an area of 33.6 km^2 with an estimated population of 411. 521 (UK Office for National Statistics (ONS), 2018) with an estimated population of under five year olds of 26, 558 (ONS, 2018).

The under-fives service intervenes swiftly in response to parental concerns about their infant offering families a brief, focused psychoanalytically informed intervention. Offering a timely response for families in accessing under-fives treatment is a key theme aimed to promote resilience, prevention and early intervention (Department of Health Guidance Framework, Future in Mind, 2015). This under-fives service was recently re-commissioned with extended funding until end March 2021. It offers six sessions, usually fortnightly which in some instances could also function as an assessment (when more serious problems are evident and may require longer term work within CAMHS). The evidenced based treatments existing within this under-fives services are:

1. Parent-infant psychotherapy (Barlow et al., 2010; Barlow et al., 2015) with Association of Child Psychotherapy (ACP) registered child and adolescent psychoanalytic psychotherapists.

2. Tavistock Under Fives Service model developed over the last 35 years (see page 21).
3. Video-Interaction Guidance (VIG) (Fukkink, 2008; Barlow et al., 2010; Kennedy et al., 2017). An attachment-based intervention recommended in the UK by NICE (National Institute for Health and Clinical Excellence). Those families being treated using VIG are also offered six sessions.
4. Within all of these three evidenced based treatments a key component of the clinical work is the application of psychoanalytic observational skills as a clinical technique (see page 16).
5. Additionally, the under-fives service offers consultations to: families with infants aged under five, Early Years practitioners within Children's Centres and to all professionals working with infants under the age of five in this bi-borough area. Under-fives therapists attend stay-and-play groups in Children's Centres and provide reflective practice groups for Early Years practitioners.

Parents whose infant had been referred to this under-fives service were invited to take part in this research prior to the commencement of any treatment from the service. Parents agreeing to take part were asked to sign a consent form saying they would participate in two interviews, one before and one after treatment alongside agreeing to the use of information routinely obtained by the under-fives service, e.g. information on forms and questionnaires used within the service. Additionally, they were asked to complete a brief questionnaire (RFQ 54, Fonagy et al., 2016a) requiring them to say to what extent they agreed or disagreed with several statements. This questionnaire will be referred to in Part III as it was data collected for the originally intended study. A qualitative methodology was used to investigate what parents said about themselves, their infant and their relationship with their infant.

2.2.3 Participants

Within a designated period 39 infants were referred to this under-fives service.

2.2.4 Exclusions from the study

A total of 14 of the 39 infants referred to the under-fives service in this designated period were initially immediately excluded from the study and did not receive an under-fives treatment for the reasons outlined below in Table 1.

Table 1: Reasons for study exclusions

Immediate Exclusions	Reason for exclusion
7	Redirected to Child Development Service/Speech and Language Therapy
1	Redirected to Early Help for Families Service based (Children's Social Care)
1	Infant was physically unwell and already receiving psychological care
1	Infant was receiving parent-child interaction therapy
Subsequent Exclusions	Reason for exclusion
1	Parent declined infant being referred
3	Parents were unreachable by telephone and letter

Of the remaining 25 infants, 13 infants were also excluded from the research for the reasons presented in Table 2. These 13 infants did receive a treatment from the under-fives service.

Table 2: Reasons for study exclusion - did receive an under-fives treatment

Number of Exclusions	Reason for exclusion
1	Infant turned five one day after the referral. Considered too old for this study
2	Parents already received an under-fives service consultation from the service
2	Re-referrals having had previous treatment in the service or similar service
2	The younger/same age sibling of two other referred infants. Their mothers consented to participate in the study becoming Parent 3 and Parent 4
6	Processed referrals whilst the researcher was on leave/had been referred previously and had not engaged/ actively not selected by the researcher due to gender.

The latter was an attempt to increase the number of female infants within the study. There are more male than female infants referred to this under-fives service. For the designated period, 76.9% of referrals were male infants (30 of 39). Emanuel, 2008 describes more male infant referrals as a feature of under-fives services. She suggests this is due to boys tending to externalise their distress and are referred for behaviour difficulties whereas girls tend to internalise their conflicts.

Within the designated period, 12 out of 39 infants referred to the under-fives service were considered for study inclusion with 12 parents (30.7%) contacted by telephone by the researcher. These parents were offered information about the research, both spoken (telephone) and written (posted/e-mailed participation sheet. Appendix 1) and asked if they would participate. Parents were requested to arrange childcare for their infant for the duration of the interview.

Two parents verbally declined to take part and opted not to receive written information and ten parents (25.6%) verbally consented to take part and received written information. Ten pre-treatment interviews were scheduled. Of these, a further four were not included into the study as scheduled pre-treatment interviews were not successfully conducted as detailed in Table 3.

Table 3: Reasons for study exclusion – interviews were not conducted

Number of Exclusions	Reason for exclusion
1	Infant removed from parental care (court proceedings) prior to interview*
1	mother acutely mentally unwell and not well enough to be interviewed
1	mother had no childcare available for baby sibling
1	mother attended interview with 13 month old infant/no childcare available

Apart from *this infant the three remaining infants did receive an under-fives treatment.

2.2.5 Inclusions in the study

Thus, six parents (15.8%) of infants referred to the under-fives service in this designated period consented (verbally and written) to take part in the study. All six infants with their families went on to receive an under-fives treatment.

2.2.6 Sample size

Six parents, all mothers consented to take part by signing the consent form (Appendix 2) and six pre-treatment interviews were conducted.

2.2.7 Infant sample

All the participants were parents of infants aged between 21-44 months at the time of the referral. The infants were five male and one female with a mean age of 34 months. All infants were first or twin born children to these mothers. Four infants had a younger or same age sibling with two of these younger/same age siblings already or subsequently a referred infant into the service. All six infants either had a full sibling (all younger or same age) living in the family home or a half-sibling (all older) not living in the family home. Of the infant to Parent 4, the full extent of his sibships with his biological parents was not fully apparent. All six infants were in some form of childcare at the time of the referral and the pre-treatment interview.

There was a range of presenting difficulties. Four infants, all male were reported to have disruptive or dysregulated behaviour and included reports from parents of their infant's

physical aggression to others or to themselves. Of the two infants with a younger or same age sibling either referred or subsequently referred (Parent 3 and Parent 4), it was the male infant who parents reported the most concern for and who became the infant of focus when being interviewed. Two referrals reported difficulties either in the parent, such as parental anxiety (Parent 3) or in the parent-infant relationship (Parent 4).

There was similarly a range of ICD 10 diagnoses with one diagnosis featuring twice, F 93.9 of an unspecified emotional disorder of childhood. Reactions to stress, that of parental separation (Parent 1) and sudden death of a sibling (Parent 5) also featured twice. Those occurring once were those of an attachment disorder and a developmental disorder. A description of the total sample is provided in Table 4. Table of participants.

Table 4. Table of participants

	Age	Ethnicity	Partnered co-habiting	Infant age	Referral reason	Referral from	ICD 10	Sibling
Parent 1	35Y	Middle Eastern	Divorced Single	3Y 6M Male	Spitting hitting enuresis encopresis	GP	F43.8 Other reactions to severe stress	Paternal older half-sibling (1)
Parent 2	35Y	White British	Married	2Y 2M Male	Hitting pushing pinching &tantrums	Health Visitor	F93.9 Childhood emotional disorder, unspecified	Paternal older half-sibling (2)
Parent 3	41Y	White European	Married	2Y 7M Male	Parental anxiety GDD IVF twins premature	Family Worker Children Centre	F84.9 Pervasive developmental disorder, unspecified	Sister 2Y 7M Born first
Parent 4	43 Y	Asian	Married	3Y 8M Male	Self-harm, parent-infant relationship adopted	Music Therapist CDC	F94.1 Reactive attachment disorder of childhood	Sister 2Y 4M adopted Older siblings LAC
Parent 5	34 Y	White British	Married	3Y 8M Female	Bereavement of sister SIDS	Health visitor	F43.0 Acute stress reaction	Sister 5W Deceased
Parent 6	32 Y	Asian	Married	1Y 9M Male	Hitting Biting eating & sleeping difficulties	Home Start Worker	F93.9 Childhood emotional disorder, unspecified	Brother 2M

CDC child development centre, GDD global development delay, LAC looked after child

2.2.8 Parent Sample

All six mothers were the primary carer for their infants. The mothers were aged between 32 to 43 years with a mean age of 36.6. years. Three mothers were currently in paid employment including one who was on paid maternity leave. One mother had stopped work when she became a parent, two mothers were seeking paid employment. Both mothers who were seeking paid employment reported low income with one receiving state unemployment benefits. Five mothers had spouses financially contributing through paid employment to the joint household. Given that the two mothers who were seeking employment were educated to graduate/post-graduate level, all five mothers, who were either in paid employment or were seeking paid employment, would be categorised as AB (using the six categories A, B, C1, C2, D and E of the socio-economic classification produced by the ONS) of higher and intermediate managerial, administrative, professional occupations.

Of the six mothers, five were married to the fathers of the referred infant, with one recently divorced. Two mothers were White British, two mothers were Asian, one mother White European and one Middle Eastern mother. English was the second language for three mothers though they did not require an interpreter. Four mothers were born and either spent all or most of their childhood outside of the UK. A full description of the total sample is provided in Table 4. Table of participants. Additional descriptions of participants such as becoming mothers and of raising their infants is reported in the results section.

2.2.9 Interviews

The interviews took place in local health clinics with the researcher using a semi-structured interview schedule. The interview consisted of the following six questions.

1. Parent's view of the infant
2. Parent's view of the relationship
3. Parent's affective experience of parenting
4. What is the problem
5. How did the problems arise
6. How can the problems be remedied

Questions 1-3 are three questions from the Parent Development Interview (PDI, Slade et al., revised 2004) and questions 4-6 are all the questions from the Private Theories Interview (PTI,

Werbart and Levander, 2006). For a detailed version of the semi-structured interview see Appendix 3.

The PDI is a semi-structured interview which asks seven questions about parent's representations of themselves as a parent, of their child and of their current developing relationship with the child as well as questions about the parent's relationship with their own parents. A PDI coding system was further developed to assesses the quality of parent's mentalizing capacity and levels of reflective function (Slade et al., 2004). The PDI was used as the original proposed research study had parental reflective function as its focus. Despite using a qualitative research methodology to analyse the data generated from the PDI (rather than the PDI coding system) the questions were considered important to enable the researcher to explore parental states of mind in relation to themselves, their infant and of the parent-infant relationships. The PDI has been used extensively in research. Fonagy et al. (2016b) used the PDI coding as a measurement of reflective function pre and post treatment. Those using a qualitative methodology in analysing the PDI are Slade and Cohen (1996) and Baradon et al. (2008). There are several accounts of using the AAI clinically (Steele and Steele, 2008) though no references for using the PDI clinically. The researcher has experience of using the PDI clinically.

The PTI is a semi-structured interview which asks participants about their own narratives and private ideas about their difficulties and how they have arisen. The PTI (Werbart and Levander, 2006) collects concrete illustrative examples from participants' narratives in the following three areas: problem formulation, private theories of pathogenesis, and private theories of cure. The PTI aims to capture the 'private theories' of the participants, particularly their conscious and pre-conscious ideas (Sandler, 1983) in these three areas. A private theory can be understood as a significant degree of explanatory insight lying within the mind of the patient at either a conscious or pre-conscious level: it may be thought of as a personal theory of the self. The PTI has been used in research and particular research into psychoanalytic or psychotherapeutic treatments (Werbart and Levander, 2005; Fonagy et al., 2015; Rost et al., 2019 (personal communication); Rost and Ahlers, 2020 (personal communication)).

The interviews took between 80-105 minutes. Further time was made available after each interview for participants to speak about how they felt as the interview may have stirred up some emotions. This was also recorded. The interviews were transcribed verbatim by the

researcher, omitting any identifying data like names, professions, dates or places. Participants were assigned a name such as Parent 1, Parent 2, Parent 3.

2.2.10 Data analysis

Thematic analysis was used to analyse the data in the current study as it offers a highly flexible and an extremely accessible approach to analysing the qualitative data available within the timescale for this study. Furthermore, it has a qualitative methodology that can be modified yet provides a detailed, complex and rich interpretation of data (Braun and Clarke, 2006). There were however some limitations with this methodological approach given the sample size.

The transcribed interviews were analysed using Braun and Clarke's (2006) step-wise thematic analysis. This is a qualitative method of closely examining the data to identify and organise patterns of meaning (themes) within the data. It was chosen because it allows for the systematic identification of collective or shared meanings or experiences of a particular group of individuals and to be made sense of by the researcher (Braun and Clarke, 2006). In other words, it is a suitable method for analysing data that focuses on what people say and on the content of their language used (Braun and Clarke, 2006). As outlined above, for the current study it was suitable for investigating parental thoughts and feelings about their infant, themselves and their relationship with their infant.

Thematic analysis should not be confused with other qualitative analytic approaches, including amongst others interpretive phenomenology analysis, narrative analysis or grounded theory. Whilst the latter are methodologies for creating qualitative theories, thematic analysis is a particular data analytic technique. The overall framework for the current research is, as outlined, primarily psychoanalytic. The current study uses a reflexive approach of thematic analysis, following Braun and Clark's widely used approach outlined in their 2006 publication. It was chosen over coding reliability approaches (Boyatzis, 1998) and code book approaches, such as framework analysis (Gale et al., 2013) for various reasons. In addition to the reflexive approach being one of the most widely used approaches, the latter emphasize the measurement of the coding reliability or accuracy through using a structured codebook and several coders. Given the scope of the current project this was not feasible. Moreover, Braun and Clarke (2006) argue that whilst helpful to code data with another researcher, it does not promise more accurate or better coding.

Sandelowski, 1995 highlights the importance of sample size, maintaining it needs to be large enough to provide, "…a new and richly textured understanding of the experience" (p.183). Taking her advice into consideration in addition to Braun and Clarke's (2013) suggestion that small projects using thematic analysis of interview data utilise a sample size of 6-10 participants, the present sample size was deemed adequate for a small-scale study. Overall the analysis of the data presented in the results section demonstrates a rich analysis that not only addressed all the research questions but also kept a central organising concept around maternal representation and reflective function. However, as discussed later one needs to bear in mind issues of generalisability (see page 102).

Themes or patterns within data were identified in an inductive way (Frith and Gleeson, 2004). An inductive approach enabled the themes to be strongly linked to the data rather than using a deductive approach which is driven by the researcher's theoretical understanding in the area. The following steps were taken in analysing the data: First, each transcribed interview was read in its entirety by the researcher; second, each transcription was re-read by the researcher several times in order to get an overview of the data with some initial brief notes being made. Once the data was familiar early codes began to be identified in respect to any one of the research questions and were associated to something of importance in the data from each participant. These early codes were reviewed several times enabling them to be organised into recurring, broader or more defining themes. From these themes additional analysis by the researcher ensured the themes were accurate and present within the data and also associated to each of the research questions. Frequency of themes, relationship between themes and reoccurrence of themes were recorded. During the next stage themes were named, sometimes renamed, with some themes being identified as sub-themes clustering around a more defining and larger super-ordinate theme. At this stage credibility checks were carried out by the research supervisor. This separated some themes though also combined others. The final stage was naming all the themes so they were easily understandable to the reader with links between themes clearly defined.

In terms of analysing data from the pre-treatment interviews it is important to mention why all the post-treatment interviews were not completed in the timescale. Firstly, the four separate ethical approvals took six months and so delayed the start of the project. Also, purposefully recruiting girl infants to the study pushed back the potential date for post-treatment interviews. In addition, two participants had their treatment interrupted due to their under-fives clinician

having a prolonged period of sickness/absence. Finally, the CAMHS service where the study took place underwent three simultaneous changes all of which caused significant clinical disruption and affected the recruitment to the study. These were: the clinic moved, an introduction of a new NHS patient records database and the transformation into new care pathway sub-teams. A decision was made to focus this study solely on the pre-treatment interview data.

2.2.11 Implications arising from changes to the original proposed study

The proposed changes between the original study and the one presented here were not amendments constituting significant changes. It did not require a re-application for ethical review. The researcher intends to continue with the proposed research in the future. There were no changes to the research approach or the methods used to gather the data. However, as we have seen there were changes to: the available data for analysis, the questions being asked of the data and the methodology used to analyse the data.

DeCarlo (2018) describes a feature of qualitative research which is that the research questions can change over the course of the study. Qualitative research is a reflexive process. According to Agee (2009) good qualitative questions are refined and developed at many stages during the investigative and reflexive research journey. Flick (2006) describes how reflecting and reformulating your research questions is crucial for assessing the appropriateness of the decisions taken at various stages on the journey. Despite what has already been highlighted regarding the reasons for changes in this study, two further processes happened simultaneously which shaped the project into its current form. These parallel processes were the analysis of the pre-treatment data alongside searching the literature in the area. Even though the submission deadline initially necessitated the changes there was in addition an iterative approach which shaped this project. DeCarlo (2018) in keeping with this, suggests that it is normal for the focus of a qualitative study to shift as the researcher gains information from the participants.

The implications of this change in the study fall into several areas. Personally, as the researcher it led to frustration and disappointment that the original study was not achievable in the timescales. Participants are not aware that there has been a change to the study. If they had been told they may also have felt similar feelings though these could be offset by knowing there is the intention to complete the original study. Additionally, frustration and disappointment may also be experienced by colleagues within the under-fives service who

alongside the researcher were highly invested in this research. Finally, the research supervisor may feel similarly.

2.2.12 Ethical considerations

There were four separate stages within the ethical approval process with ran consecutively:

a) IRAS (REC ref. 18/LO/0795, Appendix 4)

The study research protocol was registered with the Integrated Research Application System (IRAS ID 242538). The application was not suitable for proportionate review and required review by a full ethics committee. Minor changes were required prior to and following a review by the NHS London Queen Square Research Ethics Committee. These changes were mainly topographical regarding layout and wording on the documents for participants. Permission was granted 14 June 2018.

b) Health Research Authority (HRA) and Health and Care Research Wales (HCRW) (Appendix 5).

Further documentation was required for approval by the Health Research Authority (HRA) and Health and Care Research Wales (HCRW). A named local collaborator was required as the researcher was seconded on an honorary employment contract to the NHS Trust where the data was collected. A statement of activities and a schedule of events were required. These made clear which activities would be undertaken where and by whom with a declaration regarding costs attribution from each activity. Permission was granted 06 July 2018.

c) NOCLOR - The local Research Support Service (Appendix 6)

Noclor required changes to be made to the statement of activities and schedule of events documents. Timescales were required for the start and end date of the study. Permission was granted 31 August 2018.

d) Tavistock Research Ethics Committee (TREC) ethical approval (Appendix 7)

It received Tavistock Research Ethics Committee (TREC) ethical approval and was sponsored by the Tavistock and Portman NHS Foundation Trust. There was a delay of 3 months between notification to TREC and permission granted on 23 November 2018 (Appendix 8).

The ethical approval process took six months from the first to the last of these approvals being granted. This resulted in obvious delays for the study which was one factor that contributed to having a reduction in data available to analyse. It required a change to the original research questions. An apology was received from TREC for the delay.

All data used within this study was anonymized prior to data analysis.

3. Results

The thematic qualitative analysis of the interviews highlighted a wide range of parental thoughts and feelings. In total, 34 themes were deemed relevant and were recorded. From these 34 themes, eleven super-ordinate themes were defined and are summarised in Figure 1. These themes were categorised into any one of the four research questions with some themes linking with other themes. Each super-ordinate theme will be described in detail with extracts from mothers' interviews in turn.

3.1 Question 1. How do mothers describe their infant?

There were eleven themes called sub-themes considered relevant which clustered around the mother's descriptions of their infant. From these eleven, three super-ordinate themes were defined as: *Infant is a feeling person, Dependence/Independence, and, Curiosity - wanting to know*. All six mothers described their infants within these three super-ordinate themes.

Theme 1: Infant is a feeling person

All six mothers described their infant as a feeling person in his or her own right. All the mothers illustrated an understanding that feelings could be hidden or unobservable or that feelings could be triggered by something external or internal to the infant. When describing their infant as a feeling individual five mothers described their parental responsibility to help their infant understand feelings, such as naming them, acceptance of them and that others have feelings too. This demonstrated that mental states could be reflected upon and therefore associated with thinking.

Four sub-themes defined this super-ordinate theme.

Sub-theme 1.1 Awareness of infant states of mind

All six mothers described an awareness that their infant had a range of different states of mind. They all described the fluctuating nature of these mental states. This sub-theme is characterised by this mother:

Parent 2: "I'll say, 'I can see you [infant] are angry because you've done this but what you've done is not good.' Or if he's crying because of something I've said I'll say, 'I know I can see that you're upset.' I'm trying to understand in case it is frustration where he doesn't have the vocabulary to say something."

Sub-theme 1.2 Understanding feelings from the behaviour

All six mothers described being curious about their infant's behaviour sharing also their attempts to understand what their infant might feel by observing their infant's behaviour. This is illustrated by this mother when she says:

Parent 3: "[Infant was] happy too, because he loves playdoh, he's in his element then. Sometimes I struggle to understand what the issue is, so maybe if he's crying and I don't quite know what it is because obviously he cannot always tell me, so it's more trying to do things and see. Also, if he's trying different things, he can tell me and eventually he does, it's so amazing, but probably there are moments of not knowing."

All the mothers made reference to their infant having separate feelings from them. Five mothers described how their infant's behaviour can be an intentional attempt on behalf of the infant to communicate an emotional state as characterised by this example:

Parent 5: "Obviously when she [infant] falls or hurts herself she'll cry and sometimes you'll just interpret something so if you say what are you thinking about then she'll say, 'Oh I was thinking about Rebecca [died at 5 weeks old SIDS. For reasons of confidentiality all names have been changed] and I was sad.' So, there's also that kind of, where you don't see, where there are no tears, but you see that she's a bit preoccupied, so there are kind of scales of things really.

Sub-theme 1.3 Whose feelings are these?

All six mothers described at times distinguishing between what their infant feels and their own feelings. All infants were described as being dependent (theme 2) with this dependency being described sometimes as an emotional dependency on their mothers. This was age appropriate given all the infants were ≤ 44 months. Four mothers described wanting to protect their infant from their own emotionally dependent 'needy' feelings. Despite all the mothers distinguishing

infant from parental feelings they all in contrast described how feelings can become mixed-up and muddled at times (sub-theme 6.1). This mother describes how she can sometimes feel what her infant feels:

Parent 5: "If she [infant] is upset about something at school or she's upset about something to do with Rebecca whatever it might be, perhaps something she can't articulate, so sometimes I find it worrying. I think most of the time my main feeling is that instinctive wanting to help her, understand basically what's happening for her. I think if I can't necessarily understand those, sort of more pressing feelings, you know a bit of frustration or concern or worry comes through."

Sub-theme 1.4 Meaning given to feelings

There were descriptions in all six interviews of mothers' giving names, understanding and meaning to the feelings their infant expressed, as represented by this mother:

Parent 4: "He [infant] will suddenly say something as he's adopted it a little bit, where he'll say his heart's a bit…it hurts a bit or it's a little bit messy. I always say when he's having a tantrum, when he does calm down, I'll say, 'You know, is your head feeling messy or is it your heart or is it your belly.' So, I'm trying to get him to understand that it's ok to have all of these feelings but to start identifying them."

All the mothers described difficulties at times doing this especially when they as the parent struggled to distinguish between what they felt from what their infant might feel or vice-versa, (sub-theme 1.3 and 6.1). This mother describes how giving meaning to feelings (and behaviour) in the present can be linked with feelings (and behaviour) in the mother's past:

Parent 1: "Sometimes, I feel when he [infant] wants to kiss me and I ignore him because he did something naughty, I feel I want to kiss him, but I can't. It reminds me of my mum's behaviour, she didn't like us to kiss her or to be close to her... I am not like that with him at all, I show him a lot of love. But when I don't show him love and care straight away, I feel guilty because I remember my mum and I feel that I am doing like her."

Theme 2: Dependence/Independence

All six mothers described their infant needing them and being dependent on them. There were also descriptions of their infant's ability to function independently of them with others, such as when in childcare. Four mothers described their infant's dependence and independence within the same descriptive sentence. All the mothers described their infant's development within this theme as having both positives and negatives associated with dependence and independence. All six infants were in some form of childcare provision for some or all of the

week. All the mothers described their infant having relationships with other children. The five mothers who described their infant's behaviour as unacceptable, challenging or non-compliant (theme 8) expressed concern for their infant's future peer relationships.

Four sub-themes defined this super-ordinate theme:

Sub-theme 2.1 Developing agency

All six mothers described their infant's growing capacity as an intentional human being making choices in the world. This theme does not solely come from the mothers descriptions of their infant's capacities to physically act autonomously in the world but was also evident as described in sub-theme 1.2, where five mothers described how their infant's behaviour can be an intentional attempt on behalf of the infant to communicate an emotional state. The following mother describes her shock when realising her infant had developed a capacity to do something almost without her knowing:

Parent 2: "When he's [infant] happy, when I see that he's mastered something or like the other day, I hadn't actually seen…I've never seen him ride a scooter until the other night and he literally flew across the forecourt on this scooter and you know it's like quite a proud moment. I'd never seen it before and I was like, Oh, I didn't even know you could do it slowly, let alone very fast."

This sub-theme is linked to theme 11, a co-constructed relationship, where the mother and infant are co-creating their relationship.

Sub-theme 2.2 Separation/individuation

This sub-theme links with sub-theme 2.3 safety vs danger (as below). All six mothers described their infant as a separate growing up infant and also recognised that their infants wanted also to remain the baby that they once were. This is represented by this mother:

Parent 1: "He [infant] feels very happy, straight away he wants to be like a baby, he starts behaving like a baby. He feels happy but at the same time he does not want it to last for long because he wants to play."

Sub-theme 2.3 Safety vs danger

This sub-theme links with the sub-theme 2.2, where all the mothers described challenges in tolerating their own feelings associated with their infant's developing sense of autonomy. All the mothers described the dilemma of, on the one hand keeping their infant safe yet also

recognising their infant's need to discover the world for themselves. A dilemma expressed by this mother:

Parent 6: "I took him [infant] to the park one week before the baby was born. I was still carrying him, he will never be in the pushchair, he would never be in the cot. I am always carrying him, even with a big belly, in my lap…then in the park I was very tired, and I sit on the bench and he will not sit here, up-and-down, he will start running up-and-down, he will start running… some old lady stop me saying, 'You will lose this boy' they were telling me."

This dilemma was represented by mothers expressing their concern for their infant's physical safety alongside tolerating their infant's exploration of the world around them. This mother captures a sense of her infant's psychological safety and of her own recognition of her infant's attachment relationship to her:

Parent 3: "I guess he [infant] would feel more secure like, because last night he woke up. I didn't close his nappy properly, so he was slightly wet, so he cried. I went into the bedroom and he took my hand. He was very quickly settled. I don't know, I feel like, it's just having your parent around, I think settles your child, I mean."

Sub-theme 2.4 Losses/gains of development

The infants were all between 21-44 months old. All the infants were at different developmental stages. One infant was diagnosed by a paediatrician with Global Developmental Delay (GDD). All the mothers described development either by making reference to one or more aspects of their infant's development, i.e. physical, cognitive, emotional or social. Development is not linear and despite all the mothers describing development largely in positive terms, all the mothers acknowledged their infant's dependency. This mother describes how her infant is independent yet dependent:

Parent 2: [Describing independent] "Just from very young, always wanting to have a go at whatever you do. Walking very early, whenever you ever do anything with him [infant] it is always, 'My turn now' or, 'Me have a go,' so he always wants to do what you do. Generally, it's with you, I think he likes that, the attention, so he doesn't necessarily go off and do something on his own."

The mother of the oldest infant (45 months at the time of the interview) linked her infant's independence with that of her infant's birth history, having been born at 27 weeks and 5 days gestation, weighing 562g due to intrauterine growth restriction (IUGR). This mother said:

Parent 5: "Just generally a very independent sort of character, she [infant] doesn't like having too much done for her so quite often, she'll say, 'No I'll do it myself,' and she does have, you know, quite a complex history. She was very premature, so I wonder whether sometimes a little bit of it is her independence that comes

from having had that care [special care baby unit] right at the start you know, not clingy either."

Theme 3: Curiosity - wanting to know

All six mothers described their infant as curious. They all described their infant seeking new experiences and of their infant's love of knowledge. This was presented largely as something mothers experienced as positive in terms of: their infant's development or in relating to and interacting with their infant. However, three mothers described difficulties answering their infant's questions, such as explaining what is happening now from what happened before, i.e. an absent father following divorce, missing older siblings and how to talk about death. One mother described their infant having a very keen interest in certain activities which she thought was indicative of autistic spectrum disorder (ASD).

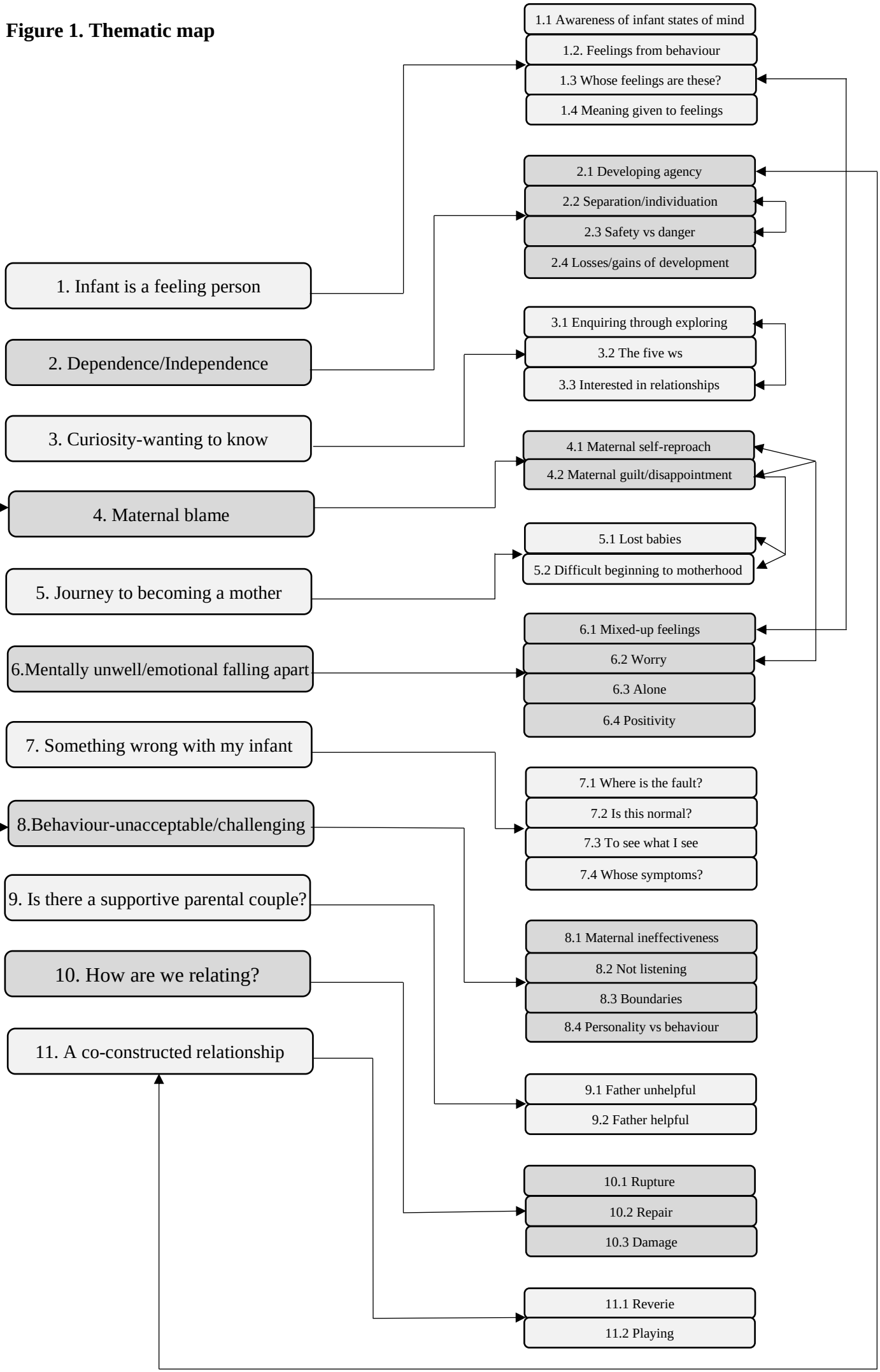
Three sub-themes defined this super-ordinate theme:

Sub-theme 3.1 Enquiring through exploring

Five mothers described their infants as learning through exploring the world around them. These five spoke about their infant's confidence and of their interest in relating to others (sub-theme 3.3). This mother describes her infant physically exploring the world yet also being curious about people:

Parent 1: "I just feel that he [infant] has to touch and ask and he's very, he's very curious about things about him, even about people, anything he just wants to know. He wants to know, in all areas, he's very, very curious."

Figure 1. Thematic map



Sub-theme 3.2 The Five Ws (who, what, when, where, why) and how

All six mothers described their infant seeking from them answers to who, what, when, where, why and how questions. They all described a responsibility to answer them though at times recognised that their patience wears thin. These two mothers illustrate their infant's thirst to know:

Parent 4: "He [infant] retains information very, very well…so when he used to look at the aeroplanes in the sky, he used to say, 'Are they like leaving footprints?' Oh, that's really clever, yeah they are leaving footprints…and then daddy said…'They are called contrails,' so now every time he [infant] looks up at the sky, …[it's] 'Look, look at the contrails, look at the contrails.'.."

Parent 5: "Like her [infant] curiosity, her love of life, her insatiable desire to know everything. She's quite at the minute into the 'why' question, so it's sort of why and then you give her an answer and why and why. It's infuriating but at the same time quite hilarious, but she keeps going, she seizes everything and wants to know everything."

Sub-theme 3.3 Interested in relationships

All the mothers are the primary carer for their infant and all described knowing that their infant needed them as characterised by this mother:

Parent 6: "When I was fetching him [infant] from the nursery and at night, it was so calm, so peaceful, he didn't misbehave in the bus, even at night he silently took all his milk, he was like this...[demonstrated stroking mother's face] saying mama, mama and he silently went to bed."

All the mothers described their infant's relationship with others. This included descriptions of the infant relating to their fathers though also with other children including four mothers who described the infant's relationship with their siblings. This mother celebrated her infant's bold announcement of arriving for a Christmas gathering at a friend's house, particularly as this was soon after their baby had died:

Parent 5: "…and as she [infant] came in she went straight up this stairs and said, 'Oh, Kate, it's me, it's Ruth,'… you know, this house full of people, but you know this kind of sense of characteristic of her…[laughs] boldness, she's very sociable and very outgoing."

3.2 Question 2. How do mothers describe their problems in one of the three areas?

3.2.1 Question 2a. How do mothers describe their problems?

There were eight themes, called sub-themes, considered relevant and which clustered around the mothers' descriptions of their own problems. From these eight, three super-ordinate themes

were defined: *Maternal blame, Journey to becoming a mother, and, Mentally unwell - emotional falling apart.* All six mothers described their own problems within these three super-ordinate themes.

Theme 4: Maternal blame

All of the mothers interviewed in this study expressed the theme of blame, fault or failure in some aspect of their role as a mother. They felt they had not sufficiently helped, protected or adequately 'mothered' their infant and in some instances their younger infant. This was linked with coming for help. This theme is linked with struggling to solve their infant's problems especially concerning behaviour (theme 8). All the mothers described self-blame though five described blame also in relation to the infant's father. There were positive descriptions of the infant's father in five interviews (sub-theme 9.2) with negative descriptions in five interviews (sub-theme 9.1).

This theme was linked to other themes with the location of the problem fluctuated from being in themselves (theme 4), in the infant (sub-theme 7.1) or within the parent-relationship (sub-theme 10.3). This theme more so than any other was marked by an emotional reaction in five of the six mothers. i.e. crying, numerous pauses and sometimes not being able to speak.

Two sub-themes defined this super-ordinate theme:

Sub-theme 4.1 Maternal self-reproach

All the mothers expressed negative, critical and disparaging comments about themselves as a mother with an over-arching feeling that they had failed and were continuing to fail in being a mother. This mother describes these feelings:

Parent 6: "I am myself a very stressed person, and that is why he [infant] is like this. Do you think so? Maybe I tend to attract negative vibes, maybe tend to think negatively most of the time. That's why I don't attract the positive. There are things which I have not told you, maybe why he [infant] has become like this."

Sub-theme 4.2 Maternal guilt/disappointment

All the mothers described the enormity of the task of being a mother and of the responsibility that comes with this. All six mothers described feelings of guilt and/or disappointment about themselves as a mother. In all the interviews mothers described a difference in the mother they

imagined they would be and the mother they now were. This sub-theme links with Theme 5 - Journey to becoming a mother. This sub-theme is exemplified by these two mothers:

Parent 2: "I've always kind of hoped I would be a nurturing mother like mine. I just feel like I've failed. I feel like for quite a long time obviously I've always wanted a child, it's just I feel like maybe like I haven't been very good at it."

Parent 4: "I feel a lot of guilt which everyone says I'm too hard on myself but it's really hard not to because they have been with us two years now… and I think now at the end of the second year, I'm taking on a lot of the burden of, if he [infant] is feeling troubled or sad it must have been my fault because I'm the main carer, I'm there every day and I don't know what I feel, I feel I'm not equipping him with what he needs."

Theme 5. Journey to becoming a mother

All six mothers described always knowing that they would become a mother. All six mothers had different journeys involved in the actual physicality of becoming mothers. All six expressed how important it was for them to have a baby and to become a mother. Two spoke directly about the importance for them culturally to become a mother. The mothers in this study are all heterosexual and all were legally married at the time of the infant's conception/adoption. All six mothers spoke about conceiving or not-conceiving. Apart from one infant in the study all were planned pregnancies. The remaining infant was a planned adoption and also may have been a planned pregnancy. All six infants were these mothers first experience of motherhood. Two mothers simultaneously became a mother to a same age twin/adopted sibling. Four mothers were born and either spent all or most of their childhood raised outside of the UK. Three of these described raising their family in the UK as culturally and emotionally challenging in contrast to how they were raised. Three mothers made reference to the absence of their birth families in the raising of their infants.

This theme captured something important in the data from five mothers physical and emotional journey to becoming a mother. Of the remaining mother who spoke of conception being straightforward and without complications she said:

Parent 2: "My partner already had two children when we got together. I was always very open that maybe one day, I would like one."

Two sub-themes defined this super-ordinate theme:

Sub-theme 5.1 Lost babies

There were varying degrees of loss expressed by five mothers associated with conception, pregnancy and birth. Three mothers had lost previous pregnancies through miscarriage and one mother had experienced a failed IVF cycle. Two of the infants were born prematurely requiring intervention within SCBU. One infant had lost a younger infant (SIDS). A question raised here is: Was this theme truly an inductive analysis of the data given what the researcher already knew theoretically about the effects of perinatal loss and the difficulties for the next infant (Bourne and Lewis, 1984, 2000). This will be raised later (see page 73). These two mothers describe their loss in these ways:

Parent 4: "We tried, it a took a year and then I did fall pregnant, but when I came up for my 3-month scan there was nothing there. So due to my age they ran some tests and then they said there are signs of infertility which I had a little inkling about just because I've just never fallen pregnant."

Parent 6: "I had a miscarriage then I had an ovarian cyst, I had to be operated on. After six years of marriage he [infant] came, so all this time I was alone, my husband is a civil servant and he's most of the time not here, from one country to another, he has gone for a long time and when he [infant] came, it was as if it was now different. I had previously been alone all the time."

Sub-theme 5.2 Difficult beginning to motherhood

Four mothers described the start of motherhood as either traumatic, stressful or not as they had imagined it. For all six mothers the arrival of these six infants whether through labour, assisted delivery or an adoption they all entered into unknown territory having never been a mother before. This is illustrated by these two mothers describing their infant's arrival:

Parent 3: "They couldn't hear his [infant] heartbeat, so they immediately took me…they rushed me through…it was 1 minute between them and she [twin sibling] was born no problem but he had to have a bit of CPR [cardiopulmonary resuscitation]...who knows if he was starved of oxygen in the middle of the night [before delivery]."

Parent 4: "We agreed on the Friday, then went to court on the Monday and then by the following Friday they [adopted infants] were with us. It was pretty sort of traumatic in a sense for everyone, we were ecstatic because we had a family and we had these two beautiful babies, but it was suddenly like [loud exhalation] what happened, we [parents] did not have enough time to prepare for it. I remember on the Thursday the day before the court order the social workers were pretty sure it would go in your favour saying, 'Go and buy a cot, go and buy nappies, milk just to get through the night.'…"

Theme 6: Mentally unwell - emotional falling apart

All six mothers used words to describe either being mentally unwell (such as describing a range of mood, anxiety or trauma-related disorders) or they described feeling that they had emotionally fallen apart (such as describing a range of symptoms associated with mood, anxiety or trauma-related disorders). Two mothers described pre-existing mental health difficulties prior to becoming a mother. All six mothers described their own emotional state impacting on the emotional state of their infant. Three mothers described Adverse Childhood Experiences (ACE) in their own childhood: i.e. death of a parent, victim of child abuse (physical and emotional), murder of parent's sibling and death of a sibling (one mother described 2 separate ACE).

Four sub-themes defined this super-ordinate theme:

Sub-theme 6.1 Mixed-up feelings

All six mothers described an inter-play between feelings as mentioned (sub-theme 1.3). Within this theme mothers describe noticing that parental feelings get mixed up with infant feelings as represented by this mother:

Parent 4: "I've been a bit more upset and a bit more emotional like I've probably cried every day and [the effect of these feelings on infant]…he's probably mirroring me a lot…I think he feels, I think in his mind he doesn't think I love him."

All six mothers described a dilemma around shielding their infants from parental feelings as captured by this mother:

Parent 5: "…and very suddenly we were very, very shocked. I think we probably still are quite shocked, still going are those processes, so I think you know, our problem is really, just is dealing with that shock that grief that suddenness of loss…and you know how that affects… potentially Ruth longer term, and our family as well."

Sub-theme 6.2 Worry

All the mothers described a range of emotional states associated with some aspect of being a mother and at times linked to maternal blame (theme 4). They all demonstrated at times an awareness of these emotions and similarly as above wanted to shield their infants from these feelings. This mother describes the constant nature (past and present) of feeling worried:

Parent 2: "I'm very distracted, a lot of the time, I'm constantly worrying, I don't feel myself a lot of the time. It's there all the time, it's just hard to concentrate and

it's hard to put in the back of your mind and forget. I'm worrying all the time. I probably think it's literally just there, worrying all the time, it's 90% of my time."

Sub-theme 6.3 Alone

All six mothers described at times feeling alone and without help particularly around their mixed-up feelings associated with either their infant's difficulties or their own difficulties. This was associated with coming for help. This theme is represented by this mother:

Parent 4: "I started to struggle with how to keep calm, how to communicate with him [infant]. That then impacted on me and my mental health and my own grip on things…I'm just very lonely, I have no real motivation, I'm very lonely at the moment, I feel I'm lost, I'm always upset I'm always sad, I'm always tired."

Sub-theme 6.4 Positivity

All six mothers, in contrast to sub-theme 4.1-maternal self-reproach, described maternal self-belief. That is, they all described qualities within themselves which were positives when responding to question 6.3 semi-structured interview, what can you do for yourself to remedy the problems? This is captured by these two mothers:

Parent 1: "I suffered from depression anyway, for a long-time, before when he [infant] was a baby I used to stay in bed, you know, but now I push myself more to be out, to call a friend, now I am making myself busy and stop thinking, replace the negative thought, you know, with another positive one."

Parent 6: "I have become emotional today but tomorrow I can be very strong, because something happened this morning with him [infant] and I really don't want to relay my personal matters with someone else, I did it with you, but now, I don't want to relay to others. I want to tackle my problems and I know one day I will be a winner."

3.2.2 Question 2b. How do mothers describe their infant's problems?

There were eight themes, called sub-themes, considered relevant and which clustered around the mothers' descriptions of their infant's problems. From these eight, two super-ordinate themes were defined: *Something wrong with my infant, and, Behaviour-unacceptable, challenging or non-compliant.* All six mothers made reference to their infant's problems within these two super-ordinate themes.

Theme 7: Something wrong with my infant

Five mothers made reference to a worry that there was something wrong with their infant. The remaining mother, Parent 5 feared that without help there would be a problem in the future. All the mothers had contact with other health professionals prior to the referral. The infant being the referred patient may have increased the mother's worry that there was a problem with the infant. All six mothers described this as a reason for seeking help from the under-fives service. This included Parent 5 who feared that without help there would be a problem in the future.

Four sub-themes defined this super-ordinate theme:

Sub-theme 7. 1 Where is the fault?

Five mothers described a difficulty with their infant's behaviour (theme 8) and a range of feelings associated with their infant's behaviour. These five mothers described problems which they attributed to their infant in some way either about behaviour, character or personality. This theme was linked to other themes. These themes have been separated as the location of the problem fluctuated from being in themselves (theme 4), in the infant (sub-theme 7.1) or within the parent-relationship (sub-theme 10.3). This mother locates the problem in her infant's behaviour and his personality:

Parent 1: "It can happen like on daily basis like when he [infant] is not tidying up, when I take the iPad. He starts like tantrums, screaming and hitting and this is where I feel I just can't cope with it and I get very angry and I feel that I'm doing everything for him and whatever I do is just, he wants more. He is this kind of personality, as much as you give him, as much as he wants more, he keeps on pushing boundaries and this puts me off, you know and makes me sometimes think, you know, he is not going to be an easy child."

Sub-theme 7.2 Is this normal?

As previously mentioned in sub-theme 2.4 regarding development, all the mothers made reference to their infant's development and this was described largely in positive terms. However, all six mothers described a worry about their infant's development in one or more aspects of development, i.e. physical, cognitive, emotional or social. The over-arching question mothers were asking was, 'Is this normal?' as illustrated by this mother:

Parent 6: "I can accept that he has hit but I can't digest it that he's not eating. This tends to make me become a lot of worries and I'm a worrier. I worry that I should take him to the doctor. Why is he behaving like that? [hitting and biting] Why is he not eating? Why is he not sleeping?"

One mother had very specific worries about her infant's development as expressed here:

Parent 3: "So, it's the not knowing, then I see so much progress and then I think, can I see so many aspects, so normal, so surely he cannot be autistic? Maybe he's on the spectrum but maybe just slightly I just don't see him because of his affection, the way he looks, the way he interacts with people."

Sub-theme 7.3 To see what I see

All the mothers described seeing something in their infant that was not seen by others. These descriptions were both positive and negative. The positive descriptions were a source of joy to them. These are not included here as this theme concerns descriptions mothers gave about their infant's problems. These two mothers describe seeing something others did not see:

Parent 2: "My husband doesn't always understand things, because he doesn't take him [infant] to group setting or anything like that. Obviously, I reached out to my husband, to say do you kind of see now, was that [infant's behaviour] called for, to get him [husband] to understand what I'm feeling because I don't necessarily think he does understand."

Parent 4: "I feel lonely, not in the way like a new mum might feel because your friends suddenly go off out and you can't go… I just feel like, no-one's quite hearing and no one is taking it seriously enough and so I think I've then taken that burden on myself because no-one's gone, 'Yeah I can see this,' and 'this is the problem,' and 'this is what we see in adopted children,' or, 'this is what we see in young vulnerable children,'…"

Sub-theme 7.4 Whose symptoms?

All six mothers described that there was something wrong with their infant currently or that there might be in future. However, the location of the problem fluctuated from being in themselves (theme 4), in the infant (sub-theme 7.1) or within the parent-relationship (sub-theme 10.3). All six mothers made explicit reference to their own birth families. All the mothers drew parallels with their own childhoods and upbringing (positives and negatives) with four mothers describing previous trauma having occurred either in their own birth families or in their infant's birth family (Parent 4 and Parent 5). All the mothers described uncertainty in locating the current symptoms. This mother refers to her own history:

Parent 5: "I mean I lost a sibling also…in very different circumstances, he [mother's brother] was the eldest of four of us, I'm the youngest… and interestingly Rebecca is buried with him now…so I think there is an inevitable thinking about Ruth and her situation and me and mine."

Theme 8: Behaviour-unacceptable, challenging or non-compliant

Five mothers described this theme as the main reason for coming forward for help. The descriptions were around their infant's unacceptable, challenging or non-complaint behaviour which significantly impinged on daily family life. The descriptions were either: wanting to understand the behaviour, fearful it would never change and worries that behaviour equalled personality. The remaining mother who did not describe unacceptable, challenging or non-complaint behaviour described concerns regarding behaviour longer-term due to the impact of trauma and loss. Four mothers described their infant's behaviour as less unacceptable, challenging or non-compliant when the infant was with their father. One mother described the infant's father being less preoccupied by their infant's behaviour (possible ASD).

Four sub-themes defined this super-ordinate theme:

Sub-theme 8.1 Maternal ineffectiveness

Five mothers explicitly described their own ineffectiveness in being able to influence their infant's unacceptable, challenging or non-compliant behaviour. All five had tried a variety of strategies, techniques or punishments as advice given to them by family, friends or professionals. One mother was physically chastising her infant prior to the under-fives service referral and stopped this on professional advice. This mother describes her ineffectiveness and at a loss to know what to do:

Parent 4: "He was spinning in the water going round like a boat and he kind of just banged the side of the bath and it was so minor and…he then just looked at me and then that was it, it carried on, doush, doush, doush [head on the side of the bath]. I say, 'Why are you doing that?' and he says, 'I like it, I like it.' These have been really bad triggers for me."

The remaining mother not describing unacceptable, challenging or non-compliant behaviour in her infant did describe behaviour in her infant that was not allowed though goes on to describe maternal effectiveness through aiming for co-operation with her infant:

Parent 5: "You know certain behaviours are not ok, she [infant] needs to do certain things, she needs to be ready on time and we need to work together to do that, so I think overall, what I aim to be is fair and understanding, and to enjoy it and too also [laughs] give her what she needs in terms of guidance as well."

Sub-theme 8.2 Not listening

The same five mothers all described their infant seeming to ignore them. They all described a subsequent range of feelings from frustration, anger, upset, helplessness and being worn out. This is represented by this mother:

Parent 1: "He [infant] does not listen to me. He's very…this confidence you know can play also a bad role, he just feels that, he can push the boundaries a lot. This is what I don't like, I don't like, you know, that in nursery he just knows that he can't push boundaries but at home with me, he just keeps on giving me a hard time and he just keeps on and doesn't listen."

Sub-theme 8.3 Boundaries

All six mothers described the importance of limit setting with their infants around behaviour. Five mothers spoke of their infant's behaviour being less unacceptable, challenging or non-compliant when the infant was with the infant's father. Five mothers described different parental responses to their infant's behaviour between themselves and the infant's father. All the mothers described their infant's behaviour changing over time, sometimes improving though also worsening. Five mothers described changing their response to their infant's behaviour by using strategies, techniques or punishments. This mother illustrates the importance of boundaries linked with behaviour:

Parent 2: "There's confusion in a sense, of sometimes because there are older children as well at the childminder's, sometimes they are allowed to rough play, and like he [infant] does love to be thrown around and things like that and I've stopped all of that at home with my husband…I've kind of stopped that a while ago…don't rough play with him because I'm trying to teach him, to not be so heavy handed."

Sub-theme 8.4 Personality vs behaviour

All six mothers spoke of their infant's future with five describing their responsibility towards and worries about their infant's future development or personality. Four mothers described coming for help linked with a concern about their infant's behaviour impacting on the infant's future. Five mothers described the events of: divorce, IVF, removal from birth parent's, sibling death and sibling birth and linked it to their infant's behaviour. Five mothers had worries about their infant's behaviour in the future. This is characterised by these two mothers:

Parent 3: "Are we [parents] doing now the right [thing]…so I try to look forward not backwards but sometimes I look back too much, from does he [infant] have autism, my mum said maybe he has attention deficit… now she's planted that idea that I didn't even have in my head but now maybe he has attention deficit, so…it's the not knowing."

Parent 5: "Helping her [infant] to develop, you know, these particular parts of her personality that are, you know, unique to her and helping her become Ruth, I suppose, in the best possible way…and helping her to channel those things that are both strengths and can also be difficult like her strong will or that boldness can also be, stubbornness, can also be quite difficult sometimes, if she really asserts herself and things."

3.2.3 Question 2c. How do mothers describe the parent-infant relationship problems?

There were seven themes, called sub-themes, considered relevant and which clustered around the mothers' descriptions of the parent-infant relationship problems. From these seven, three super-ordinate themes were defined: *Is there a supportive parental couple, How are we relating, and, A co-constructed relationship.* All six mothers described their infants within these three super-ordinate themes.

Theme 9: Is there a supportive parental couple

All six mothers described the infant's father being physically present in their infant's life and involved in the shared raising of their infant. There were positive descriptions of the infant's father in five interviews. The father of this infant was described only positively:

Parent 5: "I think an ongoing sense of being able to heal really I think, you know having time is actually really valuable for me, just to work myself out, just to be able to take that time during the day when she [infant] is at nursery to do whatever really…and to have a husband whose also emotionally supportive of that and wants me to take my time."

In contrast there were negative descriptions of fathers in five interviews where mothers at times felt dissatisfied with how fathers parented their infant (and other infants) and also described feeling unsupported as co-parents of the infant. Fathers were described as having other responsibilities, i.e. employment, older children and birth family responsibilities.

Five fathers requested being included in the under-fives treatment with four fathers attending some or all of the treatment sessions. There were positive and negative descriptions of fathers which clustered around descriptions of the parent-infant relationship problems and which were defined as sub-themes.

Two sub-themes defined this super-ordinate theme:

Sub-theme 9.1 Father unhelpful

Five mothers described the father undermining the mother in her relationship with her infant as illustrated by this mother:

Parent 2: "You know rather than kind of playing good cop, bad cop…sometimes if he [infant] asks for the iPad…He [father] will often say, 'No mummy said no, mummy won't let you have it,' rather than it being, 'No, you are not allowed to have it because of this reason" or, 'You can have it at this time.' It's very much, 'I don't know where mummy's put it and mummy's hidden it,' so I feel very much like I'm always the bad person and that's not good."

Five mothers described fathers as not understanding the struggles involved in being a mother where fathers being described as emotionally unavailable in supporting mother's relationship with the infant as illustrated by this mother:

Parent 3: "Well probably it's my husband, we are two different persons and so the way he handles things are different from me. He [father] struggles when I start talking about autism or if I start talking about, can it be this can it be that. He gets really angry at me. I start talking about something that I don't like about what the nanny did and I feel like questioning our decisions, our plans or doubts, like are we doing the right thing?"

Sub-theme 9.2 Father helpful

Five fathers were described positively in their shared contribution to the raising of their infant. In four mothers there were descriptions of a parental couple attempting to work co-operatively in raising their infant. One mother, who was recently divorced from the infant's father, was praising of the father-infant relationship as described here:

Parent 1: "He's [infant] so very attached to his dad, because his dad was not working for three years, so he was home all day so basically he was waking up with him in the mornings and in the mornings together, pick him up from nursery, spending afternoons together…"

These mothers describe the contribution the infant's father made to creating and supporting the relationships they were making individually and collectively with their shared infant:

Parent 4: "He [father] took a heavy chunk, he took about 10 months off in that first year, to stay at home and stabilise the home and bond with the children."

Parent 5: "You know when my husband is there he's very involved as well and if for example when he gets back from work he'll always come and play with her and she looks for that…he'll read to her and we'll swap around so, he'll do teeth and I'll do stories with her."

Theme 10: How are we relating?

As described in sub-theme 2.1, all six mothers described their infant's growing capacity as an intentional human being making choices in the world. The capacity for agency and intentionality develops during infancy and applies also to relating to another. All six infants were on a continuum as they were at different developmental stages/ages. There were descriptions in all six interviews of mothers and the infants tolerating the inevitable ebb and flow as they attempted to relate to one another. This ebb and flow or mismatches in relating, where momentary ruptures in relating could be repaired was evident in all six interviews. All the mothers described a concern about the developing parent-infant relationship describing worries that it could be damaged by parental emotional states, parenting styles, their own past experiences of having been parented or trauma and loss. One mother having described her relationship with her infant using the adjective 'emotional' went on to describe this as the memory/incident that came to her mind:

Parent 4: "I think like now, whenever I talk about him, when he's there, I find it demanding, because I never quite know how to connect, but then when I talk about him, even loads of times, even when he's asleep and I talk to David [infant's father] I always get a lot of emotion, and emotion is not just, it's not sadness, you know, he just annoyed me, it's just kind of maternal emotion of, how can I help my son, how can I save him almost, because I want to protect him, I want to make him strong and confident regardless of his beginning."

Three sub-themes defined this super-ordinate theme:

Sub-theme 10.1 Rupture

Ruptures in relating to one another was described by all six mothers. They all described mixed feelings associated with being a mother, i.e. frustration, anger, guilt, pride, joy, helplessness, exhaustion and at times despair. Some of these feelings disrupted how they related to their infant in a given moment as characterised by this mother:

Parent 1: "He starts on saying sorry and I say sorry doesn't really….it's not the right solution, you just need to behave and I see him like looking at my eyes and my facial expression and trying to see if I am happy and he keeps on asking are you happy after apologising and so I know that he's also frustrated, so he understands what is happening and he just can't take the fact that I am upset with him, or angry or you know."

Sub-theme 10.2 Repair

Repairing ruptures in relating between the mother and infant was described by all six mothers. This mother describes repairing a previous rupture:

Parent 6: "If ever he [infant] has hit I will sit like this, because I am fed up of saying, 'No, what you have done is wrong.' I am fed up looking like this [cross face] …I just will stop talking. He will…he knows what he has done was not right and he will start cuddling you, give you kisses. So, this forms the loving part of him."

Sub-theme 10.3 Damage

All the mothers described a concern about their developing parent-infant relationship. The location of the problem fluctuated from being in themselves (theme 4), in the infant (sub-theme 7.1) or within the parent-relationship (sub-theme 10.3). All the mothers expressed concern about their own emotional well-being (theme 6). Five mothers described concern that their emotional state might in some way damage their relationship with their infant. Three mothers expressed concern that trauma (parental arguments, removal from birth parents, death of infant's sibling) could damage the parent-infant relationship. Two mothers described their own experience of how they were parented impacting on their relationship with their infant. These two mothers illustrate concerns about damaging the relationship:

Parent 1: "I think just learning from experienced people about new ways of handling some situations with him [infant] just to try to understand how much is the impact, or the damage, you know, of the divorce and these daily arguments between me and him [infant] on his life… I feel that I am losing control, and I feel that, we are ruining our relationship."

Parent 4: "My mind has just become, maybe even talking now, although I know that I'm struggling, I hope, well it's probably linked, that my struggles are impacting on…well it's linked on the relationship…well I do feel like there is something that we need to help with… because we haven't, we didn't have much help."

Theme 11: A co-constructed relationship

Despite questions in the semi-structured interview inviting mothers to describe problems this theme was evident and has been included. All the mothers described positives in their relationship with their infant praising themselves and their infant's contribution to the relationship. All six mothers described the parent-infant relationship as a mutually constructed relationship. They all described the normal pattern of interaction in which both mother and infant initiate and respond to mutually complementary behaviour. This theme more so than other themes was marked by parental expressions of joyfulness, laughter and delight. All the

mothers conveyed both their own and their infant's affection, compassion and concern for one another.

Two mothers described a role reversal within the parent-infant relationship where their infant took care of them and/or met or partly met some of their needs. These mothers acknowledged that they had an awareness of this. The confusion in 'who takes care of who' was not a permanent confusion and the data did not suggest that these infants were parentified. This mother describes being defended by her infant:

Parent 1: "You know when I used to have arguments with the dad, you know rowing, he [infant] used to come and defend me and many times he has sat with his dad and says, 'I'm not going to allow you to shout at mummy anymore.'…"

Two sub-themes defined this super-ordinate theme:

Sub-theme 11.1 Reverie

There were descriptions in all six interviews of mothers having moments of 'reverie' with their infant. There were descriptions of mothers making sense of what was going on inside their infant, in themselves and also between them. These three mothers described moments between themselves and their infant which they were co-creating:

Parent 3: "He's [infant] very gentle, he's just a contented boy. Even as a baby he was the one who started breastfeeding the first, even when he was 34, 35 weeks, he went immediately, he went all by himself, he knew what to do and he's just like…oh the way he looks at you."

Parent 4: "He [infant] went whizzing around and he had a little skid, a kind of little fall and that normally will be for me…I can see it was sort of a minor fall… I can see but what do I do here, do I, brush it off or do I, you never know. So I had a giggle, I was like, 'Oh you skidded,' and he just got up and he said, 'I'm not hurt mama,' and I said, 'Get back on,' and I was like, oh my goodness and that was the most insane and we had a hug and I think it was also my relief that it didn't escalate. I was really proud of him and I think he just loved it because we had deliberately gone out when there was a bit of snow still left."

Parent 6: "[Describing having clicked] when I was fetching him from the nursery and at night, it was so calm, so peaceful, he didn't misbehave in the bus, even at night he silently took all his milk, he was like this...[demonstrated stroking mother's face] saying mama, mama and he silently went to bed."

Sub-theme 11.2 Playing

All mothers described with joy playing with their infant and of the mutuality and togetherness they experienced co-constructing a game or an activity. There were descriptions of shared feelings as described by these two mothers:

Parent 2: "We [mother and infant] decided to do some painting and I think he had kind of accidently waved the brush and caught my nose…[laughs] and then he was just, we were both in fits of giggles…and then he wanted to do it a lot more. So, I probably ended up with a lot of paint on me and I just really, really…love those moments, he went into a real belly laugh."

Parent 5: "Just like singing with her [infant] this morning on the bus. We had this odd joke about actually nicely being on time today [for nursery] … so we just sort of strolled up to the gate which is quite nice. Sometimes we have to do a little run. We just generally have quite a lot of fun together, fun things."

4. Discussion

The purpose of this study was to qualitatively explore the voices, not previously heard, of parents whose infant had been referred to an under-fives service. This study offers a new perspective capturing rich data from the narratives of six mothers showing how they viewed their infants and their range of thoughts and feelings prior to receiving a brief psychoanalytically informed under-fives treatment. Overall the mothers spoke extensively, emotionally and thoughtfully about their experiences.

As has been presented the themes were identified inductively and clustered into any one of the four research questions. As the overall research question was: Who is the infant in the mothers' mind? the findings from the results have parental representations as their focus. Each research question is addressed acknowledging that there is evitable overlap between them; it contrasts some of the findings to that of other studies.

Taken as a whole the findings show that these mothers explicitly thought about and referred to mental states in themselves and in their infant describing how feelings could be shared, mixed-up, confusing, unobservable, separate and could change over time. There were coherent, rich, balanced representations involving mental representations of emotions and intentions in all six mothers. They all conveyed viewing their infant as a unique, growing person with a separate mind and at times separate feelings; they each showed a marked capacity for maternal reflectiveness incorporating mentalization.

4.1 Representations of the infant

All six mothers had a sense of their infant as a separate feeling and thinking individual, with a mind of their own, appropriately developing a sense of agency and eager to understand themselves and the world around them. This was understood in two ways, firstly in terms of the epistemophilic instinct (Klein, 1928) i.e. of having an appetite for knowledge and curiosity about the world and other relationships. This is also linked to Fonagy and Target's (1996) description of an infant slowly building up a sense about itself in relation to others. All six mothers described their infant learning about his/her own feelings and about relationships. There were several themes in which parents described their infants growing capacity as an intentional human being making choices in the world. All the infants in this study were under the age of four years. Fonagy and Target (1996) state that the ability "to attribute intentional mental states (goals, desires and beliefs) to oneself or others, as an explanation for actions, is not fully developed until around four years of age" (p. 217-218).

Secondly, there was a coherence in the mother's narrative descriptions of their infants. Aber et al. (1999) states that in the context of parental representations, "coherent representations are ones that permit parents to reflect on and make meaning of their own and their toddlers' experiences" (p. 1045). This was evident is all six mothers and seen as a form of "reflective self-understanding" derived from the coherence in their narratives (Main, 1991; Fonagy et al., 1995, quoted in Aber et al. 1999, p. 1045). In contrast to the narratives in Baradon et al. (2008) where there was a shallowness in those mothers' representation of their infants, all six mothers in this sample gave narrative accounts of their infant that were coherent, rich with detail and caregiving sensitivity. These, according to Sokolowski et al. (2007) were features of mothers with balanced representations of their infants. All six mothers on the whole viewed their infant as having a distinct and separate mind from her own. Schechter et al. (2005) suggests this is a prerequisite for the formation of balanced mental representations. Similarly, in contrast to the mothers in Benoit et al. (1997) study, the mothers in this sample did not display a coolness, indifference or an emotionally distant position from their infant's experience. Their infant's experience was of great value to them with all of this indicating balanced representations.

In addition to narrative coherence all six mothers' narratives contained the use of mental state language such as the labelling of emotions in themselves and also when referring to their infants' mental states, e.g. emotions (happy, sad), cognitions (thinking) and perceptions (seeing) (Bekar et al., 2008). This included labelling negative emotions. All the narratives

contained “I think…” which demonstrated that they saw their minds as a separate mind. In addition, all the mothers shared examples where at times they were not certain they knew what their infant was feeling and were attempting to work this out from their infants behaviour. Recognition of the opacity of their infant’s mental states is just one of several features Slade (2005) says is evident in the narratives of highly reflective mothers. In contrast to other studies, particularly Baradon et al. (2008) where there were high levels of anger, hostility and negative attributions these were not evident in the narratives of this sample of six mothers. One advantage in the studies using the WMCI as the instrument assessing parental representations is in capturing affective tone of the representation expressed by the parent (along with the narrative content). Nevertheless, the researcher in the current study is an experienced clinician, albeit her task was as a researcher not as a clinician, affective tone was something recognised and commented on when it was present, e.g. Theme 4 - Maternal blame and Theme 11 - A co-constructed relationship.

Slade et al. (1999) in their findings found mothers who engaged in less positive parenting were those who expressed more direct anger. Aber et al. (1999) discovered that those parents whose representations of their infants were high in anger found it more difficult to make meaning of and reflect on their infants’ experiences. Unlike the Slade et al. (1999) and Aber et al. (1999) sample where mothering was directedly observed (of parents going about their everyday household routine) for two 1-hour observations at two time points (15/21 months and 21/27 months respectively) this study did not measure mothering directly. What the current study does capture through the addition of the PTI questions is the mothers’ conscious and pre-conscious ideas of themselves and particularly those at a representational level. Mothers were enabled through these questions to ‘free associate’ their private explanatory systems about their infants. This revealed their sensitivity to their infants’ experiences and their attempts to make meaning of it.

In terms of the mothers’ capacity for maternal reflectiveness there are several caveats about the use of the PDI questions; not all the questions from the PDI were used, the researcher is not trained to administer nor code the PDI (for reflective function) and the data was analysed with a qualitative methodology not with the coding system. Nevertheless, the data did indicate that all the participants demonstrated a capacity for maternal reflectiveness. Unlike some other studies previously mentioned, the current study did not analyse parental narratives twice (both qualitatively and coded, e.g. for reflective function). Because of the caveats mentioned above,

can the qualitative analysis alone assert that the level of maternal reflectiveness was at a level normally considered adequate for good parental functioning and secure attachment relationships? It is suggested that they can. This is supported by Zeegers et al. (2017) who state it is from parental narratives that this can be assessed describing parental mentalization as the degree to which parents show frequent, coherent or appropriate appreciation of their infant's internal states of mind. All six parents showed frequent, coherent and appropriative appreciation of their infant's internal states of mind.

4.2 Representations of the mother's own problems

Unlike other studies such as Schechter et al. (2005); Sokolowski et al. (2007) and Baradon et al. (2008) this sample was not considered a high-risk group for several reasons. Demographically there are differences in terms of age (mothers and infants), economic and other social risk factors. There may also be differences in educational attainment. All six mothers described either symptoms associated with or actually being mentally unwell, yet none had previously or currently been referred to adult mental health services. As already stated, high degrees of anger, hostility and negative attributions were not evident in the six mother's narratives though there were a range of feelings such as frustration, anger, guilt, pride, joy, helplessness, exhaustion and at times despair. Slade (2005) describes that it is those parents who in relation to parenting, rarely deny their own experience of it and readily acknowledge the common feelings associated with it such as guilt, anger and joy, that are highly reflective. The assertion about these feelings substantiating the view that this sample of mothers were highly reflective and therefore had balanced and secure representations is supported by Huth-Bocks et al. (2004). In their study it was mothers who recognised their strengths and limitations and the challenges inherent in being a mother who had the most balanced or secure representation of themselves as mother (self-as-mother). It is worth noting here that Infant 4 arrived aged 18 months to this particular mother-infant dyad with what appears to be pre-existing attachment difficulties. This infant went onto receive a diagnosis of a reactive attachment disorder of childhood. His mother's representations of him were considered balanced despite his difficulties.

Feelings of blame and guilt were evident in this sample though these differed to those in other studies. Blame and guilt in the mother's narratives in Baradon et al. (2008) were expressed specifically regarding being imprisoned and depriving their infants of a 'normal' life outside prison. In Bretherton et al. (1989) a small number (6%) of the sample expressed guilt in relation

to separation from their infant specifically leaving them in order to work. Feelings of guilt and blame in the six mothers were expressed in relation to their worries about their infant's difficulties. Oppenheim and Koren-Karie (2002) suggest a barrier to insightfulness particularly when present at high levels are anger and worry. There were considerable levels of worry expressed by all six mothers, yet the results suggest these mothers were insightful. Coming for help from the under-fives service has not been discussed directly here as it was not the focus of the research questions nor did the word count allow for it, though it was linked with the feelings of blame and guilt.

All six mothers spoke of their own parents and how they were parented. In Theme 5 (and its 2 sub-themes) the majority of the mothers spoke of their struggles to become mothers. All six infants were these mothers first experience of motherhood. As we know dormant representations of the parent as either or both a representation of the parents' infant self or the parent's own parent can be awakened by motherhood. Those three mothers who had experienced adverse childhood experiences spoke of their attempts to understand the impact that this might have had on them and were able to distinguish their own experience from that of their infant (Parent 1 and Parent 5). Despite these events in their childhood we know from Fonagy et al. (1993) it is not the events of the past that determined attachment security in the infant but good reflective function. The findings of Slade and Cohen (1996) are helpful to contrast with the findings from this study. They describe a mother who scored secure on the AAI (her infant was judged Secure in the Strange Situation) as, "her representations of her childhood experiences were coherent and open; she did not minimize the difficulties nor did she exaggerate the positives. In fact, she was quite able to discuss negative aspects of her relationship with her parents" (p.226). All six mothers offered representations of their childhood experiences that were coherent and open. Parent 1, who had experienced two separate adverse experiences of childhood, spoke about her childhood in a similar way to the mother in this example. Unlike Slade and Cohen (1996) this study is reliant on parental narratives alone to make this assertion.

In terms of parental educational attainment, the mothers in this sample were educated to a high level of educational attainment. It was not possible to rule out instrument bias with the PDI as like the WMCI it might tend to favour parents more educated who have a higher level of verbal fluency. What goes some way to offset this is that three of the mothers had English as their second language.

4.3 Representations of the infant's problems

Of all the areas of concern for these six mothers it was the fear that there was something either wrong with their infant now or might be in the future that was their primary concern. This fear is well documented as a concern expressed by parents. Pozzi (2003) cites this as a familiar fear expressed by postnatally depressed mothers. Fearing there is something wrong with the foetus/baby was similarly expressed in some of the narratives of expectant mothers in Ammaniti, 1991 and one mother in the Slade and Cohen (1996) study. Descriptions of suffering for the sample mothers was noted across all three identified problem areas and was sometimes located within other family members (infant's father and infant's sibling). Emanuel and Bradley (2008) as their title suggests, 'What can the matter be?' describe finding explanations for infant's difficulties in early life a "challenge" (p. 7).

The data continues to support a view that these six mothers had balanced representations of their infants. In the narratives from all six mothers there was empathy, warmth and affection when describing their infant and their infant's difficulties. Neither were they overly negative nor idealistic in their descriptions which Oppenheim et al. (2001) refer to as a category called the 'One-sided group.' Within this 'One-sided group' there is a sub-group called 'One-sided/Overwhelmed' where the narratives show associative thinking, many digressions and difficulties focusing. Of all the mothers in this sample, Parent 6's narrative was not one-sided though was marked by several digressions and at times not focused on her infant. She digressed to topics such as her newborn baby, employment, her mother-in-law and the loss of living in her birth country. This could be understood in the context of her being 13 weeks postnatal, feeling alone in a foreign country with two infants < two years old. Though this may not fully explain her digressions.

The PDI strives to ascertain parents' understanding of their child's behaviour, thoughts and feelings and asks for examples from real life interpersonal moments (Slade, 2005). As has already been mentioned all six mothers demonstrated a capacity to see beyond their infant's behaviour showing that they all wanted to understand their infant's mental experience. Four mothers in the sample described their infant's aggression to themselves or others as particularly challenging. In Emanuel and Lee (2013), 33% of their sample infants (8 of 24) presented with aggressive behaviour to others or self. Aber et al. (1999) refers to parents describing toddlerhood or 'the terrible twos' as a very stressful time. They connect this to specific

behaviour marked during toddlerhood with "increasing assertions of autonomy and expressions of negativity" (Aber and Baker, 1990; Lieberman, 1994, quoted in Aber et al. 1999, p. 1039). Others such as Huth-Bocks et al. (2004) suggest that in some groups like their sample (domestic violence during pregnancy) rambunctiousness which is age appropriate may be misinterpreted as aggressive by mothers who have experienced domestic violence. It is suggested that this did not apply to Parent 1 even though her infant had witnessed parental arguments and parental separation.

As stated previously this sample of mothers did express high levels of worry and this was across themes. Oppenheim and Koren-Karie (2002) cites worry as a barrier to insightfulness. They suggest that worry acts as a 'filter' and therefore can distorts the mother's capacity to accurately perceive her infant and their internal experience. They refer to worry associated with themselves or other issues such as marital relationship worry that is the most distorting as it then leaves little room for the mother to see the infant from the infant's point of view. It would be of value to explore the issue of maternal worry further as it was linked to coming for help. This was not explored for the reasons mentioned previously.

4.4 Representations of the parent-infant problems

Continuing with the idea that these six mothers were neither overly negative nor idealistic in their descriptions of their infants, this too on the whole applied to their descriptions of the infant's father. As we have seen, fathers were by and large seen as helpful and unhelpful in the shared parenting of their infant. Of the negative descriptions of the infant's father the researcher wondered if participants projected their own maternal feelings of blame, fault or failure onto the infant's father who then became either blamed or seen to be at fault or failing in some way. With the use of the IRMAG-R in Ammaniti et al. (2013), albeit used with expectant mothers, the interview schedule specifically explores certain aspect of the mother's representation in a variety of areas including the infant's father and partner as a father.

As we have seen in the literature presented, having an accessible and responsive mother who holds and contains her infant's experience creates a secure attachment (Ainsworth et al., 1978). It is the absence of this in infancy which leads to disrupted attachments and the development of a range of personality and borderline disorders in adulthood (Fonagy, 2000). The ruptures and repairs or the ebb and flow of the everyday interpersonal moments that these six mothers shared when speaking about their relationship were considered as coming from their "good

enough mother" (Winnicott, 1953, p. 94). When describing the difficulties of relating with their infant these were neither too negative nor too idealistic. This was in contrast to the Baradon et al. (2008) mothers whose narratives contained idealisation of the infant, themselves and the parent-infant relationship. The authors thought this might be specific to incarcerated mothers. The sub-theme of fearing that the developing parent-infant relationship was being damaged was interesting for several reasons. Firstly, a faint spectral presence from a parent's past was expressed by two mothers when they described wanting a better relationship with their infant than they had had with their parent(s). Also, there were considerable levels of worry expressed by all participants which was captured across several themes. Fear of damage was linked with coming for help from the under-fives service.

As the results show there were expressions of joy, laughter and delight in all six mother's narratives when describing the positives in their developing relationship with their infant. This may have resulted from the PDI questions as one of the parental representations of affective experience being measured is the experience of joy and pleasure (Aber et al., 1999; Slade, 2005). Aber et al. (1999) noticed a dynamic relationship between levels of anger and pleasure which they related to a particular phase of infant development - the 'terrible twos.' Those mothers whose levels of joy increased over toddlerhood were likely to be less angry and vice versa. As stated, this sample of six mothers did not express high levels of anger though did express considerable levels of pleasure in their developing parent-infant relationship.

Intentionality has already been mentioned though in addition it is important to be reminded of Fonagy's (2000) description of the birth of the infant's psychological self, "My caregiver thinks of me as thinking and therefore I exist as a thinker" (p.1129). All the mothers in this sample described in varying degrees their infant's growing capacity as an intentional being making choices in the world. These infants will internalise a representation of their mother seeing them as an intentional being. This bodes well for these six infants' ongoing development.

5. Strengths, limitations and future research

This is a valuable qualitative study which despite the small sample size has many findings useful for informing clinical practice and for further research. As we have seen there is a scarcity of qualitative research exploring maternal narratives with a focus on maternal representations. Research within this area of infant mental health of qualitatively exploring the never before heard narratives of mothers whose infants were referred to an under-fives service,

is unique. Despite Slade and Cohen (1996) advocating for analyses of this type almost a quarter of a century ago it is surprising and seemingly inexplicable why it has taken so long.

Given the sample size there would be value in replicating this study with a larger sample. One way to have increased its sample size was to have included the infant's fathers. Five fathers requested being included in the under-fives treatment with four fathers attending some or all of the treatment sessions. A comparison between the emerging themes from the narratives of these infants' mothers and fathers with a focus on representations of their infant would be valuable given the evidence presented earlier. The original intention had been to compare pre-treatment with post-treatment narratives which would have increased the data analysed though not the overall sample size. There is additional data from the original study yet to analyse including some quantitative data. Nonetheless, one of the strengths of this study is the uniqueness of the results deriving from a purely qualitative analysis.

In terms of methodological strengths there are others. The use of the questions from two recognisable interview schedules in the semi-structured interview enhanced the richness and depth of the narratives then available to analyse. The PDI questions elicited the mothers' representations in a variety of areas despite not all of PDI questions being asked. It was possible to demonstrate that these six mothers had a marked capacity for maternal reflectiveness incorporating mentalization through the qualitative analysis alone. Additionally, the PTI captured the mothers' subjective meaning making regarding their current difficulties and problems. This allowed for free associations from their pre-conscious material. The combination of these two interview schedules enabled a wide range of maternal representations across several areas. It clearly showed that these six mothers had balanced representations of their infants in their minds. Furthermore, it was possible through the analysis of the data to reveal their own representations of themselves as mothers and representations of their developing relationship with their infant. What might be of value would be to replicate this study using a different interview, such as the WMCI which has been clearly shown to describes parent's working model of the child. However, a disadvantage with using these schedules, such as the PDI or WMCI with the corresponding coding systems, is that they require training to administer, record/transcribe and code.

This particular sample of mothers as we have seen were older and with higher educational attainment with the latter being found to increase the likelihood of more balanced

representation of their infants. Sokolowski et al. (2007) raise many suggestions for the possible reasons for this which are interesting given their study controlled for ethnicity. Further exploration of a possible instrument bias with the PDI would be of value. It is also merited to include an exploration of the use of the PDI with parents whose first language is not English and non-Western cultures. There is a need within this field of research for greater consistency in the measures used, greater sample diversity and for the examination of the associations with child outcomes as suggested by Foley and Hughes (2018).

As previously stated, there are several accounts of using the AAI clinically (Steele and Steele, 2008) though no references for using the PDI clinically. One possible advantage the researcher may have had in this study was her previous experience of having used the PDI clinically. In a recent personal communication with Arietta Slade (email 10 December 2019) she says, "I have always meant to write a paper on the clinical uses of the PDI!" This research hopefully goes some way to highlighting the gap in this area with particular relevance to work with under-fives and in parent-infant psychotherapy.

It is important to acknowledge that the researcher is a clinician working within the under-fives service with considerable experience in working with mothers and their infants. The thematic analysis of the data was carried out using an inductive approach. It is acknowledged that in one area, such as the effects of perinatal loss and the consequent difficulties for the next infant, may have been subject to influence arising from the researcher's previous clinical experiences or theoretical understanding in this area. However, credibility checks were carried out by the research supervisor.

The findings of this study have clinical implications. The study demonstrated that these six mothers' representations of their infants were not over-shadowed by a haunting presence from their past. It did though identify considerable levels of worry in these six mothers across all of the three problem areas. The researcher specifically refers to this as 'worry' rather than other words e.g. 'anxiety', which might suggest an underlying psychopathology. Coming for help from the under-fives service was not discussed directly as this was not the focus of the research. Nevertheless, the high levels of worry expressed by these six mothers could have been a useful focus for their and their infant's treatment within the under-fives service.

Worry might have been a more perceptible feeling during the interviews for a variety of reasons. All the mothers had concerns about themselves, their infant, of how they were relating to their infant and hence had come forward for help. Additionally, they all consented to take part in this research which resulted in added contact with a clinician, albeit researcher, in the service, before and after their treatment. The contact between the researcher and these six mothers elicited a wide range of feelings. This process may have been unknowingly and simultaneously influenced on both sides of this relationship. The researcher may have used questioning skills ordinarily used clinically and mothers may have because of the style and content of the questions responded as though the researcher was a clinician.

Nelson et al. (2013) propose a model for this type of interviewing or therapeutic conversation, calling it the "therapeutic interview process" (p. 2). These authors assert that these data collecting interviews can generate meaning for the participants that is equally as important as the data itself suggesting this has potential to be curative and therapeutic. McVey et al. (2015) usefully describe how practitioners as researchers have therapeutic skills which has the potential for enriching not only the data obtained but also their understanding of the participants. The practitioner researcher is placed in a unique position where a deep and meaningful connection is likely. It is not possible to explore the impact the researcher had on these mothers; especially given they were to meet the researcher again after the treatment. Nevertheless, the therapeutic impact of the research interviewing process must not be understated and is another area for further exploration.

As we know parenting is a skill we learn through experience. Worry across all of the three problem areas was significant enough for these mothers to come forward for help. For all six mothers the infants in this study were their first experience of motherhood. Also, there were two who simultaneously became mothers to other infants (a twin and another adopted infant). As there were four mothers with other infants, what this study did not explicitly explore was whether or not the worry expressed extended to these younger infants. The interviewing format of asking them to focus on the referred infant may account for this. The results however showed Parent 4's preoccupation with her eldest infant yet she spoke extensively about her younger infant expressing concern about both of her adopted infants. Similarly, Parent 5 spoke throughout about the impact the death her youngest infant had on all of the family, individually and collectively. However, Parent 3 and Parent 6 expressed high levels of worry about their eldest or referred infant which might suggest that there was little space in their minds for their

other infant. This may have been an area useful to explore clinically in their treatment. As we have previously seen, Parent 6 did digress to talk about her newborn baby. Nevertheless, what may go some way to offset their ostensible preoccupation with one infant and their availability for another infant is the involvement of these infants' fathers in their treatment. Winnicott (1953) describes how the 'good enough' mothers holding of their infants physical and emotional states is made possible through another attachment figure, such as the father, being available to hold her in mind. Having both parents involved in the treatment of their infants is hugely beneficial to providing a holding environment where the whole family's physical and emotional states can be explored.

Many of the studies previously presented regarding reflective function describe how a capacity for maternal reflectiveness is not simply applied to a particular infant but can extend across children. Some studies do suggest that infant temperament may play a part in determining the levels of maternal reflectiveness within a particular dyad. What bodes well for other infants these mothers might have now or in the future is their capacity for maternal reflectiveness which incorporated mentalization.

Another way in which the findings from this study could help inform clinical practice is to further explore the levels of worry expressed by these six mothers. Gaining more of an understanding of whether or not their worry was directedly related to loss would be useful. Five of the infants in this study were either born or adopted to a mother who had experienced fertility, conception or pregnancy complications. Could this worry be an expression of their lost hopes, of mourning something that had gone before or not gone as planned? It is a well-established principal within the psychoanalytic tradition that when unbearable feelings are put into words they can be thought about, reflected upon and can lose their toxicity. There may have been a therapeutic dimension within the interviews when these mothers spoke of lost, sick or hoped for babies. One clinical recommendation from this study in terms of under-fives infant mental health practice would be for clinicians to take a full gynaecological and obstetric history. With Fraiberg et al.'s (1975) model we have seen how relating to an infant in the present can be confused by memories of traumatising figures from the past. If these memories are of lost, damaged or unfulfilled babies these have the potential to affect the current parent-infant relationship. Even though Schechter et al. (2005) study focused on violence-related posttraumatic stress and reflective functioning their findings might be useful here. These researchers found that unprocessed posttraumatic stress has the potential to interfere with the

development of coherent and balanced representations of the infant. The infant is largely perceived as a source of stress or threat rather than of joy. Coherent, rich, balanced representations involving mental representations of emotions and intentions were found in the six mothers in the current study. This suggests that the infant in their mind was not over-shadowed by their previous lost or longed for babies.

6. Conclusion

This thesis presents a review of the literature and of a small-scale qualitative research project with both showing the evidence that when a parent understands their infant it bodes well for their infant's ongoing development. I have demonstrated that these six mothers had an understanding of their infant's internal mental life and revealed their capacity to 'mentalise.' Through a qualitative exploration of these mothers' narratives their internal representations of their infants were understood. This exploration was in keeping with the principles at the heart of psychoanalysis, that is, making a commitment to think about and to try to understand another's subjectivity.

I leave you with a definition from Fonagy, (no date, p.1)

"To mentalise: To assume the existence of thoughts and feelings in others and in oneself, and to recognise these as connected to outer reality (but only loosely)."

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PART III – A framing, contextualising, linking and reflecting paper

A 4,000-word framing, contextualising, linking and reflecting paper on the various components of the Clinical Research Portfolio.

Stephen Fry once said, "If you talk about something it gets it out and like a wound, once you start getting the oxygen on it, it starts to heal." He was asked by Kirsty Young on Desert Island Discs (2015) about talking:

Kirsty Young: "Healing and talking then, we know you are very good at talking, more than any other castaway that I think I have spoken to, your life is out there. You've written so much about it in quite a revelatory way. Has all that made you feel better?'

Stephen Fry: "Gosh it's so hard to tell isn't it, because I can't have a parallel life in which I haven't spoken to compare it with, but it seems to be that I have this…this desire to bring out all the sores, [laughs] as you put it, I can't understand it. I think it may have started as a fear of being found out, so I thought I might as well be open about everything to do with myself so no-one could discover it."

Introduction

It is with the above in mind that I approach this contextualising, linking and reflecting paper and for many separate yet related reasons. It is an enormously rich piece of verbatim dialogue accurately recorded and worthy of attempting to understand the meaning within it. It refers to the healing value of talking, something that can be traced back to the birth of psychoanalysis and Berta Pappenheim's reference to it as a 'talking cure' (Breuer and Freud, 1893-1895). Talking is at the very heart of many psychotherapeutic treatments. As Sigmund Freud (1916) wrote, "In psycho-analysis, alas everything is different. Nothing takes place in psycho-analytic treatment but an interchange of words between the patient and the analyst. The patient talks, tells of his past experiences and present impressions, complains, confesses his wishes and his emotional impulses" (p. 17). Fry's words suggest a 'free associative' stance on life though also intimating that it is only spoken words that reveal truths about oneself. What is more, it highlights an enormous difficulty in comparing two things, such as talking and not talking, when these two experiences cannot be compared in the same person. Talking, such as someone's narrative is a thread that runs through the whole of this Clinical Research Portfolio.

The paper starts with a brief history of the difficulties researching psychoanalysis and psychotherapy. There are two further sections which explore the separate methodologies used as part of the portfolio, that is, a single case study methodology for the qualifying paper and a small-scale qualitative methodology research project. Both sections explore some difficulties with these two methodologies. Both methodologies attempt to gain an understanding from the interchange of words or from a narrative account. Secondly, another thread that runs through the whole doctoral submission is the clinical and research usefulness of understanding representations, that is a representation from the past as manifest in the present, whether that be in the transference or in a narrative. A final thread is working with infants under-five and the many different permutations there are working with this age group and their families. There are concluding comments where I highlight the gains for my clinical practice from the completion of the Professional Doctorate.

History

There are those who refer to the birth of psychoanalysis as a revolutionary paradigm shift seismic like that of Copernicus' assertion in spite of appearances it was the sun rather than the earth at the centre of the universe (Alderson, 2018; Rustin and Rustin, 2019). It was unobservable phenomena that were at the centre of the internal universe for Sigmund Freud, something hidden which through the application of scientific enquiry could be revealed (Alderson, 2018). As psychoanalysis was established as both a science and a clinical treatment there are those who are critical that it does not apply the type of research methods used in other fields of scientific enquiry. Popper (1963) likens Sigmund Freud's Ego, the Super-Ego and the Id to those of Homer's stories from Olympus saying, "These theories describe some facts, but in the manner of myths. They contain most interesting psychological suggestions, but not in a testable form" (p.38). Szasz (1963) considers that the claims that psychoanalysis is a discrete and separate science is an "absurdity" (p. 156). Some argue that the resistance to research within psychoanalysis is from those within the profession with a belief that treatment effectiveness is self-evident (Busch et al., 2009).

Child psychotherapy research does feel new, yet some would say that child psychotherapists have been conducting research as clinical practitioners for years (Rustin and Rustin, 2019). Research in child psychotherapy started at a case report, observational level. Sigmund Freud (1917) asserted that psychoanalysis was in itself a unique and new form of science requiring different yet equally robust scientific enquiry methods. Tracing the early published case reports

which describe psychoanalytic work with children takes us to the work of Anna Freud, Melanie Klein and Donald Winnicott. There is not only a presentation of their wonderfully rich clinical work but also evidence of them developing the very nature, practice and techniques now used today by child psychotherapists.

It is perhaps more so in the field of child psychotherapy with many ACP (Association of Child Psychotherapists) registered child and adolescent psychoanalytic psychotherapists working within NHS multidisciplinary settings where the need for a solid evidence base for treatment really exists. Despite qualified child and adolescent psychotherapists at the Tavistock and Portman NHS Trust conducting doctoral level research since the mid 1990's, it was not until the 2015 intake of 21 trainees where the clinical training in child and adolescent psychoanalytic psychotherapy was integrated with a professional doctoral programme. Of these 21, approximately ten doctorates will be submitted in January 2020. More and more commissioners of mental health services are requiring clinicians to provide scientific evidence of treatment efficacy. It is this that on reflection my originally proposed small-scale mixed methods research project seemed to get caught up in, in other words, the growing need to prove 'what we do works.' I suggest that child psychotherapists need to be creative, inventive and unrelenting in order to prove their value and efficacy though in doing so not to privilege research over clinical practice but to find a way to combine the two. Rice and Greenberg (1984) capture this when they say, "What is needed is a research method that can tap the rich clinical experience of skilled therapists in a way that will also push them to explicate what they know, yielding a rigorous description of the important regularities they have observed" (p. 7). These authors advocate for a research method which accords with the essence of the method of psychotherapy itself.

A single case study

An assumption asserted by Rustin (2001) is that child psychotherapy clinical practice taking place in the consulting room is the principal source of knowledge. He likens the consulting room to that of a 'laboratory,' where "the phenomena of the unconscious have been most clearly identified" (Rustin and Rustin, 2019, p. 4). In thinking about the 'laboratory' I used in the clinical work described in my qualifying paper I want to say a few things about method, generalizability, and some other concepts considered relevant given this was a piece of observational, case report research with its own methodology.

The writing of this clinical work for qualification was a retrospective analysis of the clinical notes for a clinical case study paper. However, during the three times a week intensive psychotherapy with Ernest (not his real name), an infant who was my under-fives intensive case, over a 20 month period there was a considerable amount of a particular type of consideration, exploration and analysis of the material of the sessions. There was both an 'in the moment' and a 'just beyond the moment' exploration where the work was thought about extensively. This was individually in the 'laboratory' as the work unfolded and also beyond the consulting room in both conscious and unconscious moments. Along with others this case was thought about in minute detail in a variety of supervision spaces and also thought about in my own personal training analysis.

The data that exists even now 2 years after the completion of the psychotherapy involving 154 written accounts of each 50 minute session, some are detailed process recordings of what happened and include my counter-transference experiences. Additionally, there are 61 supervision session notes. Even through it was a psychotherapy treatment and a core part of the clinical component of the training it can be thought of in terms of qualitative research, not dissimilar to a piece of ethnographic research. In my role as clinician though also researcher I observed and interacted with a participant, a patient, in a real-life environment of his intensive psychotherapy. One of the aims of ethnographic research is to 'render strange' (Mead, 1930) the subject(s) real-life experience and to gain insights into what lies beneath the surface appearance. Sigmund Freud (Breuer and Freud, 1893-1895) used the metaphor of archaeology to refer to uncovering what lays buried beneath, buried within the unconscious mind as he writes, "This procedure was one of clearing away the pathogenic psychical material layer by layer, and we liked to compare it with the technique of excavating a buried city" (p. 139). Midgley (2004, p. 90, referencing Rustin, 2003) says that, "The clinical case study was, and probably still remains, the most widely used and accepted method of 'psychoanalytic research' among practising clinicians."

Nevertheless, there are difficulties with case study methodology for three main reasons as Midgley (2006) suggests: the data problem, the data analysis problem and the generalisability problem. With the first of these problems, even though I think my 154 session notes are accurate data there is evidence to suggest they are not. Creaser (2019) using the 'comparison method' found inaccuracies between therapist's written session notes and audio recordings of the same session. What was lost though in the audio recordings were the moment-by-moment

transference and counter-transference experiences. Secondly, in analysing the data I approached it in a fairly unsystematic way. I had at the outset a reasonable clear story that I wanted to tell about my experience of being this little boy's therapist and the profound impact he had had on me. Additionally, I wanted the data and my analysis of this data to meet an academic standard worthy of qualification. Thirdly, generalisability of which there are many pitfalls of generalising from one case study as Midgley (2006) details. One pitfall being that what is found in one might not be found in a wider group. My single case study was unique, idiosyncratic and hugely beneficial to Ernest, his family and me. Perhaps also beneficial to a reader too. Surprisingly there are only a few (less than 10) published single case histories describing intensive child psychotherapy with infants under five.

One indication of the efficacy of the work was that this little boy's unbearable feelings related to an early trauma did become bearable as shown using Bion's (1962) theory of containment. Using a core psychoanalytic concept in this way incorporates 'research' into this paper. Rustin (2003) suggests we are at risk of violating our own tradition if we do not acknowledge our pioneering forebearers, Freud, Klein, Bion, for their research both in and out of the consulting room. At the beginning of Ernest's psychotherapy I was unsure of what I hoped for, but it was not far from "not only the wish that the child will find relief from suffering, but the hope that the therapist will improve the child's behaviour so that questions about whether the child will remain in the [school] will dissipate" (Heineman et al., 2013, p. 2). Another proof might be changes in his Strengths and Difficulties Questionnaire (SDQ- parent) moving from 'high risk' (beginning of treatment) to 'low risk' (at end of treatment) for any emotional or behavioural disorder. Yet some would argue that if this is proof it needs to go further. Law and Wolpert (2013) suggest real proof would be a statistically reliable change using the reliable change index of the SDQ scores.

In keeping with the theme of representations I want to make a few brief points. I suggest at a representational level Ernest was afflicted by the diseases of his father's past. This was understood through Fraiberg's et al. (1975) 'ghosts in the nursery' concept, where a parent's mind is over-shadowed by a haunting presence from the parent's past which then interferes with and influences relating to the infant in the present. Ernest's father was separated from his family when almost an infant himself and his experience at boarding school had been brutal and painful. Yet these memories seemed now not available, somewhat cut off, as father made plans to send his son away to boarding school to solve the difficulties. There was proof of

change; Ernest did remain in his school, he was not sent to boarding school and him and his family have not required support and intervention from CAMHS for two years.

A small-scale qualitative project

Khan et al. (2001, quoted in Midgley and Kennedy, 2011, pp. 235-6) provides a research hierarchy categorisation which Midgley and Kennedy (2011) title "Quality of evidence: levels of evidence of effectiveness" (p. 236). Midgley and Kennedy draw our attention to flaws within the 'hierarchy of evidence' suggesting that a study's position does not automatically reflect its quality. The table they suggest therefore reflects a hierarchy of design rather than of research quality. The observational study mentioned above for the Qualifying Paper would not make Level 5, the lowest level of evidence in the hierarchy. It would need to have included some form of independent outcome and/or process. These authors place all qualitative studies, irrespective of quality at Level 4.

As stated earlier my original proposed small-scale mixed methods project seemed to get caught up in the growing need to prove 'what we do works' and for good or for ill. There are several reasons for making this statement. Firstly, given this research hierarchy, a mixed-methods study, on reflection, I viewed as a more credible study where qualitative data could be correlated with quantitative data. Secondly, the under-fives service where the study took place had time limited funding with pressure to provide data to commissioners of its reach and effectiveness. The final reason is the chosen study area, that of reflective function and how it links with attachment theory was because this has been set on a more 'scientific' research basis for several years (Rustin, 2003). Additionally, even though the project does not focus on neuroscience and infant development research there is a huge body of scientific evidence that the child psychotherapy professional has to be part of.

Before going on to reflect on the current study I want to say a few things about the original study. It had intended to explore parental narratives about themselves as a parent and about their infant, pre and post a brief psychoanalytically informed under-fives treatment. It was hypothesised that parental thoughts and feelings about themselves and their infant changed as part of this treatment. A second aim was to measure changes in reflective function as measured on the RFQ 54 (Reflective Functioning Questionnaire 54 (Fonagy et al., 2016a) pre and post treatment. Added to this it intended to quantitatively analyse participants' data from a variety of other outcome measures routinely collected pre and post treatment within the under-fives

service, such as summary scores of: Goal Based Outcome Measures (GBOM), Health of the Nation Outcome Scales for Children and Adolescents (HONOSCA), Strengths and Difficulties Questionnaire (SDQ 2-5 years) and Mother's Object Relations Scales (MORS). Rustin (2009) highlights the urgency within child psychotherapy research to consider outcomes and effectiveness of treatment. He links this with the point already made of the current culture of 'evidence-based' health care with commissioners demanding data to back up the claims. Those requiring the data seem much more interested in quantitively presented numbers than in a qualitative exploration of thoughts and feelings.

In retrospect, it is important to recognise that the original proposed research was produced by a mind not yet fully developed in terms of being research savvy. Rustin (2009) suggests that there are some who imply that psychotherapists are methodologically naive compared to others from a human science discipline. I do think I was methodologically naive. That is said because of the evidence that I have presented already in Part I of this submission. That is, the combined RCT's of Cooper et al. (2003) and Murray et al. (2003) (brief treatments) and the Fonagy et al. (2016b), parent-infant psychotherapy RCT (longer-term treatments) had poor outcomes for the very thing that my original proposed research was exploring. Namely, there was no significant impact on the security of the infant-mother attachment and no improvements in attachment and reflective function in these studies respectively. It seemed unlikely that the original study would show treatment impact between the pre and post reflective function scores as measured with the RFQ 54 on a small sample of six mothers. The aspiration to have two data sets, qualitative and quantitative, correlating one with the other is interesting given what the literature search in this area demonstrated. You will have already seen the scarcity of studies exploring parental narratives specifically from a representational perspective. Of those studies deemed relevant to mention regarding maternal narratives and representation there was not one which analysed data solely qualitatively. I suggest that this is further confirmation that the original study got caught up in a growing trend to prize numbers over meanings.
Furthermore, completing the proposed study within the timescale along with the other demands of the training, such as the clinical and educational components including the personal/training analysis was not possible. The original project required four ethical approval processes which are briefly detailed in the methodology section with documentation in the appendices. The original research proposal was scaled down in order to adhere to the academic submission deadline. Despite these constraints, some argue such as Agee (2009) that good qualitative questions are refined and developed at many stages during the investigative and reflexive

research journey. Flick (2006) describes how reflecting and reformulating your research questions is crucial for assessing the appropriateness of the decisions taken at various stages on the journey. There was a reformulation of the original research questions though despite this it held onto qualitatively exploring parents' thoughts and feelings about themselves and their infant. The original focus had been on reflective function and it was possible to reformulate the research questions incorporating this with a new focus on maternal representations. Nevertheless, there remains a considerable yet valuable amount of data from the original study yet to analyse. Rustin (2003) called for clinical practitioners and those committed to more formal research methods to have externally funded projects. Finding the space to make research a key part of our practice will require a child psychotherapy workforce not only to be creative, inventive and unrelenting but also to be bold. Can I be bold enough to ask for the continuation of this project to be funded? Or, is it bold to suggest that the qualitative research in and of itself constitutes credible evidence?

Midgley (2004) describes qualitative research as interested in discovery and in expanding our understanding of the human world. This technique he says is "especially useful when the focus of study is to elucidate or illuminate the meanings which people employ to make sense of their experiences and guide their actions" (Midgley, 2003. p. 92). The modification and prioritisation of hypotheses in qualitative research is also supported by Rustin and Rustin (2019) who highlight the usefulness of this methodology in looking at certain issues with a broad, open-ended approach. Midgley's (2004) statement above is at the very heart of the current study. The focus of it joined together my previous experience of working with parents with mental health difficulties, and particularly mothers with my current work now more directly with infants, children and adolescents and their families. Also, Midgley's (2004) statement is at the very heart of psychoanalytic psychotherapy. In my practice of working psychoanalytically I make a commitment to think about and to try to understand my patient's subjectivity. This is what the current study also did. It was during the data analysis through the process of immersion in the narratives of these six mothers that the current study gained its shape. This is in keeping with Carlsberg's (2007) idea of the 'turning points' in therapy, where in applying this principle to research the data being examined provides the researcher with a path to follow. I suggest that the current research through this process did precisely what Rice and Greenberg (1984) advocate for, "a rigorous description of the important regularities they have observed" (p. 7).

The aim was to understand the meanings these six mothers had of their experiences with their infants', of what guided their actions, how they understood, related to and cared for their infants (and also linked with coming for help). This aim was achievable through the application of qualitative research methods in which a path lead to an understanding about these mothers internal working models and to their representation of their infants in their minds. This cannot be researched by reducing the data to a numerical form or by quantifying it in some way (Midgley, 2004). Midgley (2004) referencing McLeod (2001) describes one of several shifts in psychotherapy research from 'discovery to verification,' with Midgley suggesting we are now in another era of 'uncertainty and opportunity'. This current study has in my view straddled these two shifts. I am part of the new cohort of trainees emerging from combined clinical and doctoral training who are no longer methodologically naive and are now research savvy. The current study demonstrates that qualitative methodology can discover truths and verify its findings though it has done so in a way so as to not detract from the essence of the principles deeply rooted in its psychoanalytic history. There are, as mentioned elsewhere problems with generalisability from the findings given the sample size. The use of the Private Theories interview (PTI, Werbart and Levander, 2006) adds to the claims being made as it accessed a degree of explanatory insight lying within the mind at either a conscious or pre-conscious level. As Slade and Cohen (1996) highlight, the past whether we like it or not enters into our present reality and no more so than within parent-infant relationships. This through the process of qualitative exploration made itself available though did so in a way that was in keeping with the tradition of psychoanalysis itself, that is, through the interchange of words (a recorded verbatim account of six mothers' experiences) which tells of their past experiences. With this small-scale project I have demonstrated that child psychotherapists can do qualitative research without resorting to numbers to prove that what we do works.

Conclusion

In summary, this framing, contextualising, linking and reflecting paper brings together several threads though celebrates what is at the heart of our psychoanalytic tradition, that is the enormous understanding that can be obtained from the interchange of words or from a narrative account.

Finally, I raise a point made by Rustin (2003) who suggests that the title of a symposium called 'The Clinical Relevance of Research in Child Psychotherapy' implies misleadingly the following, "If psychotherapists had or did research, what bearing might it have on their clinical

practice?" (p. 138). Perhaps he is right though I want to answer his question. The research presented here in the whole portfolio has and will have an everlasting bearing on my clinical practice. An understanding of internal representations, of 'the there and then' in the 'here and now' is of tremendous value in continuing my personal, clinical and theoretical understanding of transference. The child psychotherapy discipline does have a challenge on its hands in this era of uncertainty and opportunity.

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Appendix 1 - Participant Information Sheet

The Tavistock and Portman NHS
NHS Foundation Trust

Participant Information Sheet
Version No. 5 dated 08/06/18
Brief study title: Parents' RF
IRAS ID 242538

Research Project
An exploration of parents' reflective functioning and their view of themselves and their young child.

Has your young child been referred to the under 5s service?
Would you like to take part in this research on what you think and feel about; being a parent and of your young child's worries or struggles?

You have been given this information sheet because you are being invited to take part in a research project. This information sheet describes more about the research and what taking part would involve.

What is the purpose of this project?
It aims to explore parental thoughts and feelings of both yourself as a parent and of your young child before and after receiving a brief treatment at the under 5s service.

Who is conducting the research?
My name is Jane Lowe. I am a child & adolescent psychotherapist in doctoral training employed at The Tavistock and Portman NHS Foundation Trust and validated by Essex University.

What will participating in the research involve?
If you agree to participate you will be invited to two interviews. The first will be before your first appointment and the second will be after your last appointment with the under 5s service. The interviews will take place at a time and day convenient to you. The first interview can be either in at our clinic or at a Children's Centre. The second interview could be in in any of these places or in your home. Ideally these interviews will be without your young child present. The interviews will be audio reordered. This is to help me as it means I will not need to take notes during the interviews.

Additionally, I will ask you to agree to the use of information routinely obtained from you which you provide to the under 5s service. This is information on forms or questionnaires used within the under 5s service and will also include information such as age, gender and ethnicity.

Additionally, I will ask you to complete a brief questionnaire requiring you to say to what extent you agree or disagree with several statements. You will complete this before your first appointment and after your last appointment with the under 5s service. The time commitment will be 1½ hours, on two occasions (pre and post treatment) in order to complete the interview and the questionnaire.

Do I have to take part?
No, it is completely your decision about whether you would like to take part in this research. Taking part or not will not change the service you and your young child receive from the under 5s service. If you agree to take part you are free to change your mind without giving a reason.
What will happen to the information I give?

The transcript of the interviews will be anonymised. Any personal details which could identify you or your young child will be removed from the transcript. Any extracts from what you say in the interviews that are quoted in the published research will be anonymized. I will store information I receive from you during the interviews or from the questionnaires securely and in keeping with the Data Protection Act 1998.

All information that you share during the interview will be kept absolutely confidentially. The only exception when I would have to breach confidentiality would be if you report feeling unsafe, such as having thoughts to harm yourself or someone else. In that case I would need to share this information with Sarah Gustavus Jones, Under 5s Service Manager, so that together we offer you help and agree upon a safety plan with you.

What will happen to the results of the project?
The results will be used in published academic papers and in academic presentations. You can request to receive a summary of the results.

What are the possible benefits of taking part in this research?
There are no immediate benefits to you or your young child. However, by taking part you will increase our understanding of brief treatment for families presenting to an under 5s service. In particular, what happens when parents like yourself ask for help having encountered problems with their young child.

Are there any risks?
You may find that the interviews get you thinking about yourself and your young child in a way you may not have thought about before or for a long time. This may stir up some emotions or be unsettling. At the end of each interview I will offer you time, if you require it, to talk about how you are feeling.

Contact details
I am the main contact for this project. My contact details are:
Jane Lowe
Email: jlowe@tavi-port.nhs.uk
Tel: 020 8383 6126

You are welcome to contact The Tavistock and Portman NHS Foundation Trust if you have any concerns about this project. The contact details are:

Simon Carrington
Head of Academic Governance and Quality.
The Tavistock and Portman NHS Foundation Trust.
120 Belsize Lane. London. NW3 5BA
Tel: 020 7435 7111

Thank you for considering taking part in this project
and for taking the time to read this information.
If you agree to take part please complete the consent form.

Appendix 2 - Participant Consent Form

Participant Consent Form

Research Project:

An exploration of parents' reflective functioning and their view of themselves and their young child.

		Please initial
1.	I confirm that I have been provided with details of this research project (Participation Information Sheet dated 8th June 2018). I have had an opportunity to consider the information and ask questions.	
2.	I confirm that I understand that information I have routinely provided as part of being seen by the under 5s service, such as on forms or questionnaires and information such as age, gender, ethnicity will be analysed for the purposes of the research.	
3.	I confirm that I understand that the there are two interviews and these will be audio recorded and then transcribed and analysed for the purposes of this research. I understand that any extracts from what I have said in the interviews that are quoted within the research will be anonymized.	
4.	I understand I will be asked to complete an additional brief questionnaire before and after each interview.	
5.	I understand that any identifiable information linked to my participation in the research will be anonymized and held securely by the researcher.	
6.	I understand that information that I provide will be used in published academic papers and in academic presentations.	
7.	I confirm that I have read and understood that my participation in this research is voluntary and that I can withdraw my participation without giving a reason.	
8.	I understand that my participation or withdrawal from this research will not alter the service myself and my young child receive from the under 5s service.	
9.	I understand that I may contact the researcher, Jane Lowe on email: jlowe@tavi-port.nhs.uk or Tel: 020 8383 6126, if I require further information about the research.	
10.	I understand that should I have any concerns relating to the under 5s service I can contact: Sarah Gustavus Jones, Under 5s Service Manager. Consultant Child & Adolescent Psychotherapist. Child & Adolescent Mental Health Service. Parkside Clinic, 63-65 Lancaster Road. London. W11 1QG. Tel: 020 8383 6126.	
11.	I understand that should I have any concerns relating to this research I can contact: Simon Carrington. Head of Academic Governance and Quality.	

	The Tavistock and Portman NHS Foundation Trust. 120 Belsize Lane. London. NW3 5BA. Tel: 020 7435 7111	

Name of parent (BLOCK CAPITALS) ……

Signed ……

Date ……

Name of researcher (BLOCK CAPITALS) ……

Signed ……

Date ……

One copy to be given to the parent and one held by the researcher.

Thank you for agreeing to take part in this research project.

Appendix 3 - Semi-structured interview

Preliminary questions were asked about the parent's family such as: who lives in your family? How many children do you have? What are their ages? Wanting to know about other children, their ages, including those living outside the home, parents, other adults living in home. Also, about any atypical rearing situation (foster care) history of foster placements, who has been the primary caregiver for the infant. Any history of divorce or previous marriages, any step-children.

Question 1. Parent's view of the infant

1. I'd like to begin by getting a sense of the kind of person your infant is... so, could you get us started by choosing 3 adjectives that describe your infant. Now let's go back over each adjective.
   Does an incident or memory come to mind with respect to _____?
   Go through and get a specific memory for each adjective.
2. OK, now let's return to your infant...In an average week, what would you describe as his/her favourite things to do, his/her favourite times?
3. And the times or things he has most trouble with?
4. What do you like most about your infant?
5. What do you like least about your infant?

Question 2. Parent's view of the relationship

1. I'd like you to choose 3 adjectives that you feel reflect the relationship between you and (your infant).
   Now let's go back over each adjective.
   Does an incident or memory come to mind with respect to _____?
   Go through and get a specific memory for each adjective.
2. Describe a time in the last week when you and (your infant) really "clicked". (Probe if necessary: Can you tell me more about the incident? How did you feel? How do you think (your infant) felt?)
3. Now, describe a time in the last week when you and (your infant) really weren't "clicking". (Probe if necessary: Can you tell me more about the incident? How did you feel? How do you think (your infant) felt?)
4. How do you think your relationship with your infant is affecting his/her development or personality?

Question 3. Parent's affective experience of parenting

1. Can you describe yourself as a parent?
2. What gives you the most joy in being a parent?
3. What gives you the most pain or difficulty in being a parent?
4. When you worry about (your infant), what do you find yourself worrying most about?
5. How has having your infant changed you?
6. Tell me about a time in the last week or two when you felt really angry as a parent. (Probe, if necessary: Can you tell me a little bit more about the situation? How did you handle your angry feelings?)

6a. What kind of effect do these feelings have on your infant?

7. Tell me about a time in the last week or two when you felt really guilty as a parent. (Probe, if necessary: Can you tell me a little bit more about the situation? How did you handle your guilty feelings?)

7a. What kind of effect do these feelings have on your infant?

8. Tell me about a time in the last week or two when you felt you really needed someone to take care of you. (Probe, if necessary: Can you tell me a little bit more about the situation? How did you handle your needy feelings?)

8a. What kind of effect do these feelings have on (your infant?)

9. When your infant is upset, what does he/she do? How does that make you feel? What do you do?

10. Does (your infant) ever feel rejected?

Question 4. What is the problem

1. What difficulties and problems do you have at the moment, if you would describe them in your own words?
2. How do you regard what it is that led you to seek help from the under-fives service?
3. Is there something else you are struggling with at the moment?
4. In what way does this affect your daily life at the moment? Can you give me some examples? Summaries the main problem:
   Your daily life?
   Your relations to others?
   Your work or your education?
   Your feelings?

Question 5. How did the problems arise?

1. How have things become this way? How did the problem arise?
2. What are your thoughts about this?
3. How did the whole thing begin?
4. How do you regard this (problem) today?
5. Tell me about some (other) important experiences or events in your life that you associate with how these difficulties and problems began.
   These can be both current episodes, and episodes from your past or childhood.
   When did it take place?
   What happened then?
   How did it feel then?
   How did you react?
6. Can you go even further back in time? What are your thoughts about this?
7. How does it feel when you think about this?
8. Why do you believe that they [parents, siblings or other significant persons in an episode] acted as they did?
9. If the interviewee limits him/herself to one theme, repeat: "Any other important experiences and feelings?" As in go back to beginning of question 5.

Question 6. How can the problems be remedied?

1. What do you believe would help you best with the difficulties and problems you have at present?
   Can you give concrete examples?
   What are the obstacles?
   What would need to be different?
2. Something else that would be able to help you?
   In the treatment?
   What specially in the treatment?
   In what way can the treatment help you?
   Something else outside the treatment here?
3. What can you do yourself?
   What are your thoughts about this?
   If the parent limits themselves to one single theme, enquire further:

4. Are there other ways to remedy the problems?
5. Is there something that I have not asked you that you think I would need to know in order to better understand how you perceive your difficulties and problems?

Appendix 4 - NHS Ethics Approval

NHS
Health Research Authority

London - Queen Square Research Ethics Committee

HRA NRES Centre Manchester
Barlow House
3rd Floor
4 Minshull Street
Manchester
M1 3DZ

Please note: This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval

14 June 2018

Ms Jane Lowe
163 Colchester Road
London
E10 6HG

Dear Ms Lowe

Study title:	**An exploration of parents' reflective functioning and their view of themselves and their young child pre and post-treatment: a mixed method study.**
REC reference:	**18/LO/0795**
Protocol number:	**None**
IRAS project ID:	**242538**

Thank you for your letter of 01 May 2018, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Vice-Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact hra.studyregistration@nhs.net outlining the reasons for your request.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System, at www.hra.nhs.uk or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from the HRA. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites
NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Interview schedules or topic guides for participants [Pre-treatment]	3	10 April 2018
Interview schedules or topic guides for participants [Post-treatment]	3	10 April 2018
IRAS Application Form [IRAS_Form_08052018]		08 May 2018
Participant consent form [Consent Form]	6.0	08 June 2018
Participant information sheet (PIS) [Participant Information Sheet]	5.0	08 June 2018
Research protocol or project proposal [Protocol]	0.5	10 April 2018
Response to Request for Further Information [Response to REC Provisional Opinion]		08 June 2018
Summary CV for student [Jane Lowe]	1	10 April 2018
Summary CV for supervisor (student research) [Felicitas Rost]	1	25 March 2018
Summary, synopsis or diagram (flowchart) of protocol in non technical language [Study Gantt/Flow Chart]	0.5	10 April 2018
Validated questionnaire [Reflective Function Questionnaire RFQ 54]	1	10 April 2018

Statement of compliance
The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- x Notifying substantial amendments
- x Adding new sites and investigators
- x Notification of serious breaches of the protocol
- x Progress and safety reports
- x Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:
http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Training
We are pleased to welcome researchers and R&D staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

18/LO/0795	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project.

Yours sincerely

Katherine Ashley REC Manager on behalf of the Vice Chair, Ms Danielle Wilson

Email: nrescommittee.london-queensquare@nhs.net

Enclosures: "After ethical review – guidance for researchers"

Copy to: Dr Felicitas Rost

Ms Mabel Saili, NOCLOR

Appendix 5 - HRA and HCRW Ethics Approval

Ms Jane Lowe
163 Colchester Road
London
E10 6HG
06 July 2018

Email: hra.approval@nhs.net
Research-permissions@wales.nhs.uk

Dear Ms Lowe

HRA and Health and Care

Study title:	**An exploration of parents' reflective functioning and their view of themselves and their young child pre and posttreatment: a mixed method study.**
IRAS project ID:	**242538**
Protocol number:	**None**
REC reference:	**18/LO/0795**
Sponsor	**The Tavistock and Portman NHS Foundation Trust**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

How should I continue to work with participating NHS organisations in England and Wales? You should now provide a copy of this letter to all participating NHS organisations in England and Wales, as well as any documentation that has been updated as a result of the assessment.

Following the arranging of capacity and capability, participating NHS organisations should **formally confirm** their capacity and capability to undertake the study. How this will be confirmed is detailed in the "summary of assessment" section towards the end of this letter.

You should provide, if you have not already done so, detailed instructions to each organisation as to how you will notify them that research activities may commence at site following their confirmation of capacity and capability (e.g. provision by you of a 'green light' email, formal notification following a site initiation visit, activities may commence immediately following confirmation by participating organisation, etc.).

It is important that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details of the research management function for each organisation can be accessed here.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within the devolved administrations of Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) has been sent to the coordinating centre of each participating nation. You should work with the relevant national coordinating functions to ensure any nation specific checks are complete, and with each site so that they are able to give management permission for the study to begin.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your nonNHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?
The document "After Ethical Review – guidance for sponsors and investigators", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including: Registration of research

- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

I am a participating NHS organisation in England or Wales. What should I do once I receive this letter?
You should work with the applicant and sponsor to complete any outstanding arrangements so you are able to confirm capacity and capability in line with the information provided in this letter.

The sponsor contact for this application is as follows:

Name: Dr Felicitas Rost
Tel: 02089832234
Email: frost@tavi-port.nhs.uk

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **242538**. Please quote this on all correspondence.

Yours sincerely

Miss Lauren Allen
Senior Assessor
Email: hra.approval@nhs.net

Copy to: Dr Felicitas Rost
Ms Mabel Saili, NOCLOR

List of Documents
The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	*Version*	*Date*
HRA Schedule of Events	1.0	06 July 2018
HRA Statement of Activities	1.0	06 July 2018
Interview schedules or topic guides for participants [Pre-treatment]	3	10 April 2018
Interview schedules or topic guides for participants [Post-treatment]	3	10 April 2018
IRAS Application Form [IRAS_Form_08052018]		08 May 2018
Participant consent form [Consent Form]	6.0	08 June 2018
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Summary, synopsis or diagram (flowchart) of protocol in non technical language [Study Gantt/Flow Chart]	0.5	10 April 2018
Validated questionnaire [Reflective Function Questionnaire RFQ 54]	1	10 April 2018

Summary of assessment
The following information provides assurance to you, the sponsor and the NHS in England and Wales that the study, as assessed for HRA and HCRW Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England and Wales to assist in assessing, arranging and confirming capacity and capability.

HRA assessment criteria

Section	HRA Assessment Criteria	Compliant with Standards?	Comments
1.1	IRAS application completed correctly	Yes	The applicant confirmed that A4 and A64-1 have been completed incorrectly. The sponsor The Tavistock and Portman NHS Foundation Trust.
2.1	Participant information/consent documents and consent process	Yes	The Chief Investigator is a clinician at the site and has access to contact details to make the initial approach to potential participants.

3.1	Protocol assessment	Yes	No comments
4.1	Allocation of responsibilities and rights are agreed and documented	Yes	The Statement of Activities and Schedule of Events will act as the agreement between the sponsor and site.
4.2	Insurance/indemnity arrangements assessed	Yes	No comments.
4.3	Financial arrangements assessed	Yes	There is no external funding for the research. No funding will be provided to the site.
5.1	Compliance with the Data Protection Act and data security issues assessed	Yes	Participants' personal data will be accessed by the Chief Investigator only.
5.2	CTIMPS – Arrangements for compliance with the Clinical	Not Applicable	No comments
Section	**HRA Assessment Criteria**	**Compliant with Standards?**	**Comments**
	Trials Regulations assessed		
5.3	Compliance with any applicable laws or regulations	Yes	No comments
6.1	NHS Research Ethics Committee favourable opinion received for applicable studies	Yes	No comments
6.2	CTIMPS – Clinical Trials Authorisation (CTA) letter received	Not Applicable	No comments
6.3	Devices – MHRA notice of no objection received	Not Applicable	No comments
6.4	Other regulatory approvals and authorisations received	Not Applicable	No comments

Participating NHS Organisations in England and Wales

This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.
There is one participating site. All study activity will be conducted by the Chief Investigator who is a clinician at the site. The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England and Wales in order to put arrangements in place to deliver the study. The documents should be sent to both the local study team, where applicable, and the office providing the research management function at the participating organization.

Where applicable, the local LCRN contact should also be copied into this correspondence. If chief investigators, sponsors or principal investigators are asked to complete site level forms for participating NHS organisations in England and Wales which are not provided in IRAS, the HRA or HCRW websites, the chief investigator, sponsor or principal investigator should notify the HRA immediately at hra.approval@nhs.net or HCRW at Research-permissions@wales.nhs.uk. We will work with these organisations to achieve a consistent approach to information provision.

Principal Investigator Suitability

This confirms whether the sponsor position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and Wales, and the minimum expectations for education, training and experience that PIs should meet (where applicable).
The Chief Investigator will be responsible for the study activity at the site and is expected to act as Principal Investigator. GCP training is not a generic training expectation, in line with the HRA/HCRW/MHRA statement on training expectations.

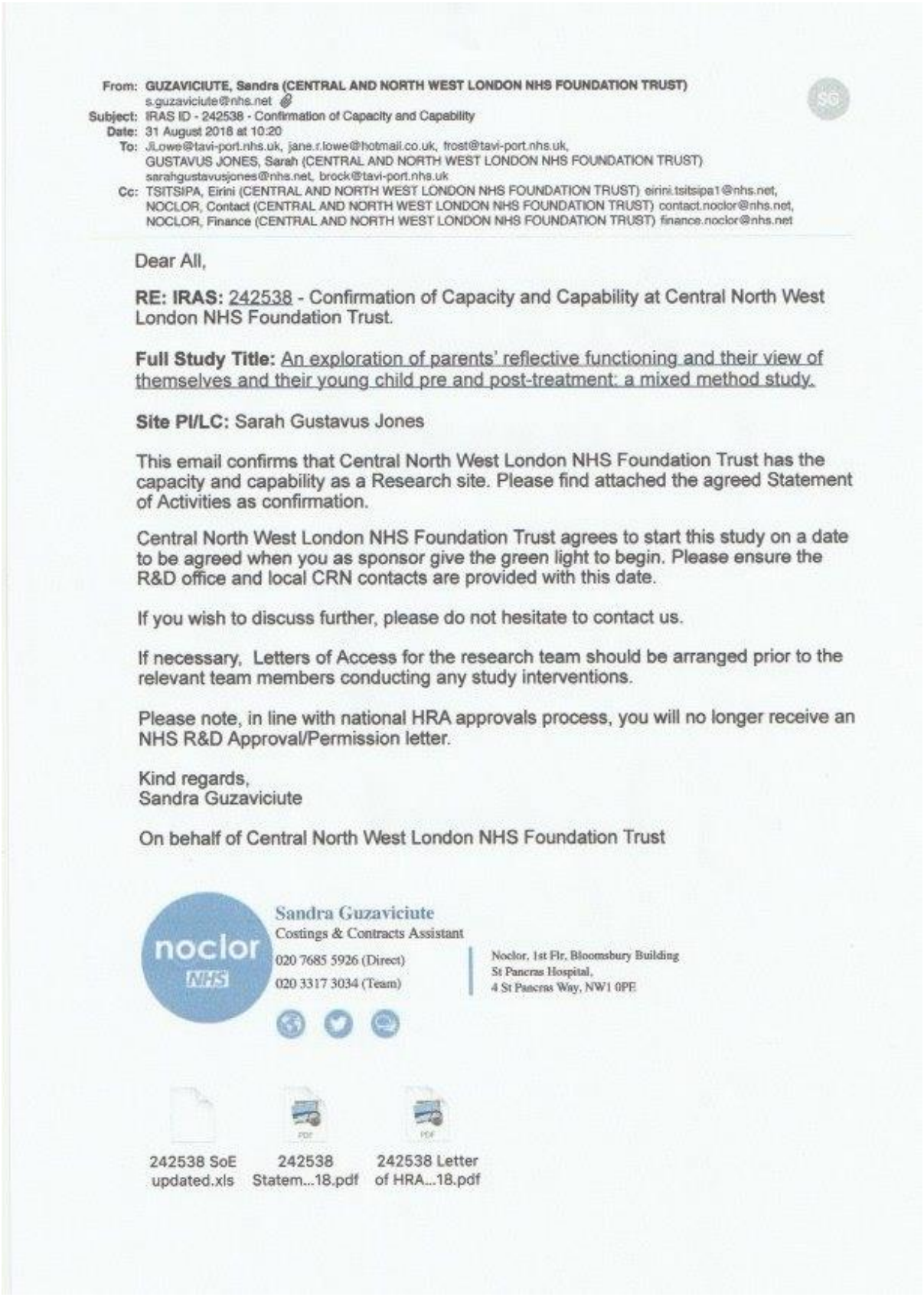
HR Good Practice Resource Pack Expectations

This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken
Access arrangements are not applicable as the study activity will be conducted by the Chief Investigator who is a clinician at the site.

Other Information to Aid Study Set-up

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales to aid study set-up.
The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

Appendix 6 - NOCLOR Ethics Approval



From: GUZAVICIUTE, Sandra (CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST)
s.guzaviciute@nhs.net
Subject: IRAS ID - 242538 - Confirmation of Capacity and Capability
Date: 31 August 2018 at 10:20
To: JLowe@tavi-port.nhs.uk, jane.r.lowe@hotmail.co.uk, frost@tavi-port.nhs.uk, GUSTAVUS JONES, Sarah (CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST) sarahgustavusjones@nhs.net, brock@tavi-port.nhs.uk
Cc: TSITSIPA, Eirini (CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST) eirini.tsitsipa1@nhs.net, NOCLOR, Contact (CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST) contact.noclor@nhs.net, NOCLOR, Finance (CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST) finance.noclor@nhs.net

Dear All,

RE: IRAS: 242538 - Confirmation of Capacity and Capability at Central North West London NHS Foundation Trust.

Full Study Title: An exploration of parents' reflective functioning and their view of themselves and their young child pre and post-treatment: a mixed method study.

Site PI/LC: Sarah Gustavus Jones

This email confirms that Central North West London NHS Foundation Trust has the capacity and capability as a Research site. Please find attached the agreed Statement of Activities as confirmation.

Central North West London NHS Foundation Trust agrees to start this study on a date to be agreed when you as sponsor give the green light to begin. Please ensure the R&D office and local CRN contacts are provided with this date.

If you wish to discuss further, please do not hesitate to contact us.

If necessary, Letters of Access for the research team should be arranged prior to the relevant team members conducting any study interventions.

Please note, in line with national HRA approvals process, you will no longer receive an NHS R&D Approval/Permission letter.

Kind regards,
Sandra Guzaviciute

On behalf of Central North West London NHS Foundation Trust

noclor NHS

Sandra Guzaviciute
Costings & Contracts Assistant
020 7685 5926 (Direct)
020 3317 3034 (Team)

Noclor, 1st Flr, Bloomsbury Building
St Pancras Hospital,
4 St Pancras Way, NW1 0PE

242538 SoE updated.xls
242538 Statem...18.pdf
242538 Letter of HRA...18.pdf

Appendix 7 - TREC Ethics Approval

The Tavistock and Portman NHS
NHS Foundation Trust

Quality Assurance & Enhancement
Directorate of Education & Training
Tavistock Centre
120 Belsize Lane
London
NW3 5BA

Tel: 020 8938 2699
https://tavistockandportman.nhs.uk/

23 November 2018
By Email

Dear Ms Jane Lowe

Project Title:	An exploration of parents' reflective functioning and their view of themselves and their young child.
Researcher:	Jane Lowe
Programme of Study	Professional Doctorate in Child and Adolescent Psychoanalytic Psychotherapy

I am writing to confirm that the application for the aforementioned NHS research study reference: 242538 (IRAS Project ID) has received TREC ethical approval and is sponsored by the Tavistock and Portman NHS Foundation Trust (the Trust).

The lapse date for ethical approval for this study is 28th September 2019 (4 year enrolment period for the programme). If you require ethical approval beyond this date you must submit satisfactory evidence from the NHS confirming that your study has current NHS R&D ethical approval and provide a reason why the Tavistock Research Ethics Committee (TREC) approval should be extended.

Please note as a condition of your sponsorship by the Trust your research must be conducted in accordance with NHS regulations and any requirements specified as part of your NHS R&D ethical approval. By acknowledging this letter you confirm that you will conduct your study in accordance with the consent given by the Tavistock Research Ethics Committee by emailing academicquality@tavi-port.nhs.uk.

Please ensure you retain this approval letter, as in the future you may be asked to provide proof of ethical approval.

With the Committee's best wishes for the success of this project.

Yours sincerely,

Paru Jeram
Quality Assurance Officer (Research Degrees and Research Ethics)
For and on behalf of the Chair of the Tavistock research Ethics Committee

T: 020 938 2699
E: academicquality@tavi-port.nhs.uk

cc. Course Lead, Supervisor

Appendix 8 - TREC Ethics Approval (Delayed)

From: Academic Quality
Sent: 23 November 2018 14:15
To: Jane Lowe
Cc: Felicitas Rost; Catrin Bradley; Academic Quality
Subject: FW: Notification to TREC

Dear Jane

Please accept my apologies for the delay in this confirmation email. Your approval letter is attached for your information. This means you can proceed with your research.

If you have any further questions or require any clarification do not hesitate to contact me.

May I take this opportunity of wishing you every success with your research.

Regards,

Paru
Mrs Paru Jeram
Quality Assurance Officer
(Research Degrees and Research Ethics)
Academic Governance and Quality Assurance (Room 259)
The Tavistock and Portman NHS Foundation Trust
120 Belsize Lane
London
NW3 5BA
Tel: +44 (0)20 8938 2699

-----Original Message-----
From: Jane Lowe
Sent: 22 November 2018 15:05
To: Academic Quality <academicquality@Tavi-Port.nhs.uk>
Subject: Notification to TREC
Importance: High

Dear Academic Quality,

I am left wondering if you are receiving these messages.

Please could I have an acknowledgement?

Kind regards,
Jane

From: Jane Lowe
Sent: 29 October 2018 12:43
To: Academic Quality <academicquality@Tavi-Port.nhs.uk>
Subject: Notification to TREC

Dear Academic Quality,

Please could you acknowledge receipt of my notification to you in July 2018?

Kind regards,

Jane

_____

From: Jane Lowe
Sent: 22 September 2018 11:20
To: Academic Quality
Subject: Notification to TREC

Dear Academic Quality,

Please could you acknowledge receipt of this notification?

Kind regards,

Jane

_____

From: Jane Lowe
Sent: 17 July 2018 17:04
To: Academic Quality
Subject: Notification to TREC

Dear Academic Quality,

I am notifying TREC that I have NREC approval to conduct my doctorate research as part of my professional doctorate in Child & Adolescent Psychoanalytic Psychotherapy.

I have attached all the documents that NREC and the HRA required.

Kind regards,

Jane Lowe