Major Research Project

What Goes Unheard When Struggling Mothers Speak: A Qualitative Analysis using the Adult Attachment Interview

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For my Mum and Dad

Acknowledgements

This piece of work is dedicated to my mum and dad, as without them I would not have been in such a privileged position to complete the work. For the immeasurable love and support they have given me throughout the years, I am eternally grateful. Dad, thank you for teaching me about learning and the importance of perseverance. Whenever I thought I couldn't push myself anymore, your pep talks always gave me the energy and motivation to continue on. Your steadiness and encouraging words telling me 'you can do this' sound in my ears whenever I find myself under pressure. Mum, thank you for being the most loving, nurturing and thoughtful mum a person could ever wish for. Your ability to mind read and know when I need you and what to do has meant that I never feel alone; we have a bond which cannot be explained in words.

Traditionally psychology and psychoanalysis have placed a great deal of weight on 'vertical' parent-child relationships and as such the importance of 'lateral' sibling relationships can get lost. I therefore wish to thank my brother as this lateral relationship has taught me so much and undoubtedly influenced my career. I am inclined to agree with him that perhaps we are indeed "the darker side of each other".

I wish to thank my darling Gus, for always taking an interest in my work, for listening to my frustrations and for containing my anxieties when I could not. The support of my friends has helped me in my journey; thank you Andrea for your continued support.

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1.0 ABSTRACT

Studies of attachment in the community suggest that most people have secure attachment styles, but as many as 40% may have an insecure attachment style (Bakermans-Kranenburg & van Ijzendoorn 2009). Frightening parental behaviour has been found to predict disorganised attachment in infants, which in turn is associated with clinical disturbance in adolescence (Van Ijzendoorn, Schuengel & Bakermans-Kranenburg, 1999). Insecure attachment has been found to be disproportionately more common in many psychiatric disorders than the general population: including substance misuse, eating disorders, and Personality Disorder (PD).

Transgenerational transmission of attachment has become widely researched over recent years and evidence has shown that a mother's attachment style can predict the attachment style of her infant (Ward, Ramsay, Turnbull, Steele, Steele, & Treasure, 2001). Research has found that a mothers' ability to mentalize about her own early attachment relationships has important implications in her transition to becoming a mother. Motherhood can be challenging for mothers who have good mental health, therefore women with poor mental health may find the transition to motherhood especially stressful.

The aim of the current study was to give voice to mothers who have been silenced in many ways, to learn from their struggles and to help services develop more effective ways to reach 'hard to reach' vulnerable mothers. The Adult Attachment Interview (AAI; George, Kaplan, & Main, 1984) was conducted with eight mothers who were attending a Mentalization-Based Treatment (MBT; Bateman & Fonagy, 2004) group designed for mothers who had caused harm to their children and had subsequently had them removed from their care. Thematic Analysis was used to analyse the AAI transcripts and five main themes emerged: 'Love and loss', 'Change and confusion', 'Families and normality', 'Safety and boundaries' and 'Strength and vulnerability'. The findings contribute to the field of maternal mental health research and clinical implications are discussed at an individual, organisational and societal level.

2.0 INTRODUCTION

2.1 Overview of Chapter

This chapter first introduces the researcher's epistemological stance, before considering their theoretical positioning and relevant literature. A discussion of epistemology from the outset enables the reader to understand the 'lens' through which the following literature is understood and indeed why and how the study was conducted. Relevant literature is discussed in relation to Attachment Theory, personality disorder, motherhood and transgenerational factors. The Adult Attachment Interview (AAI) is introduced and critiqued.

While the main body of this study is written in the third person, reflexive accounts and observations are written from a first person perspective. This is in order to help differentiate between academic theorising and personal reflexivity, while highlighting the complex interweave between the two.

2.2 Personal epistemological stance

Prior to commencing clinical training I had not encountered the word 'epistemology' before, therefore during induction when we were each asked to consider our "epistemological position" my anxiety started to build. I needed to remind myself that I deserved my place on clinical training and should not feel so easily de-skilled by the use of big scientific words. I had been working clinically for the past twelve years in various settings, many of which were highly emotive and challenging. I had worked with perpetrators of homicide, serial sex offenders, victims of childhood sexual abuse, in palliative care and in 'Personality Disorder' services; it was bizarre that I now felt unnerved by the word 'epistemology'.

After reading around the subject I came to understand the term in its most basic form to mean 'how do I know what I know?'. When attempting to write a concise answer to this question the term 'compassionate pragmatist' came to mind. By this I mean that

above all else, whatever setting I am working in and with whom, I always hold on to my belief that people are who they are for good reason (and are often trying their best). This perspective becomes clearer as I discuss issues of attachment, personality development and transgenerational patterns.

In keeping with my belief that we are all influenced by early experiences (even before we are born) I thought back to some of my early memories and can link these directly to how I try to make sense of the world around me. I had hearing difficulties as a child and would often miss what people were saying. My speech was delayed and I pronounced words incorrectly. I attended Speech and Language Therapy and have vivid memories of drawing snakes in order to help me with ‘s’ sounds. Fortunately, my hearing improved as I grew up and memories such as these faded into the distance. On reflection I suspect my difficulty hearing had more of an impact on my development than I first thought, particularly informing how I understood the world around me.

It is relevant that my dad was a scientist. He was (and still is, although now retired) a brilliant teacher who imparted knowledge as standard; a simple walk along the coast often involved being taught the Latin names of Heather and seaweed varieties. I have always enjoyed Science, which (traditionally) is all about developing hypotheses and manipulating variables in a methodical and controlled way in order to find evidence and infer Truths.

Another relevant memory I have from childhood involved me asking my dad how we each see the colour ‘green’, more specifically ‘how do I know that the green I see is the same as the one you see?’. I was fascinated by the idea that someone could potentially see (what I would call) the colour blue and call it green, and I would never know. I wish I could remember my dad’s response although I suspect he would’ve taken the opportunity to teach me about Cone and Rod cells. Even at this age, unbeknown to me, I was in fact questioning the existence of individual experiences and challenging social constructs.

Memories such as these, among countless others, lead me to now be able to describe myself as a ‘critical realist’. I need to know there are some Truths out there, for example the ocean is wet and gravity exists; however I believe there are degrees of truth and it is the ‘small t’ truths which interest me the most. It could even be said that a lot of my work is to help individuals understand their "Truths" as "truths".

2.3 Theoretical and research position

The current study was influenced predominantly by Attachment Theory and Social Constructionism. These theories were chosen for their clinical utility in attempting to understand concepts of human development, care giving/receiving behaviours, and ultimately, the unique individuality inherent in meaning-making processes. Attachment theory underpinned much of the researcher’s prior clinical work and research interests, while Constructionism was the guiding philosophy of the Clinical Psychology training programme which the researcher was undertaking.

2.4 Attachment Theory

The history of Attachment Theory has been described comprehensively, and often beautifully, by many academics, clinicians and researchers. In particular, Bretherton (1992) details the origins of the theory and Holmes (1993a) provides an informative biographical perspective. The writings of Bowlby, of which there are many, are both fascinating and inspiring. An attempt will now be made to give an overview of Attachment Theory with the aim being to help contextualize later discussions of how attachment influences personality development and disorder.

It was while studying undergraduate Psychology that the researcher took an external module in ‘Animal Behaviour’ and subsequently became fascinated by the complexity and perceived innateness of survival behaviours, particularly attachment behaviours. Watching video footage of the ethologist Konrad Lorenz walking around his garden with geese in tow was fascinating. The process of ‘imprinting’, whereby certain species of birds bond with the first moving object they see within hours of hatching, had been studied previously however Lorenz was the first to describe the process as the

development of an ‘instinctive emotional bond’ (Lorenz, 1979; Vicedo, 2009). It was Lorenz’ discovery of the principle of attachment which led onto further research of animal attachment behaviours.

The highly controversial and well known Harlow experiments (Harlow & Harlow, 1962) are an example of such influential research conducted throughout the 1960s (before the conception of ‘animal rights’). While, fortunately, advancements in ethical considerations have been made throughout the last fifty years, Harlow’s research may be viewed as ground breaking and, perhaps, even necessary. By using rhesus monkeys in their experiments Margaret and Harry Harlow were able to demonstrate the psychological and physiological distress caused by an absence of nurturance. For those who have viewed video footage of the experiments images of frightened baby monkeys clinging to a towel for comfort at the expense of food (provided by a metal frame) may well be ingrained into memory. The learning points were clear; the baby monkeys needed/preferred closeness and warmth over nourishment (even when the result was starvation and subsequent death). The experiments had other striking findings, particularly in relation to maternal behaviour. Once the emotionally deprived monkeys grew up and gave birth, they did not know how to care for their offspring. They became distressed by the presence of their baby, were physically violent towards them, and even killed them. Sadly, they did not know how to nurture their offspring. This gives rise to questions concerning the impact of early care receiving experiences on later (adult/parent) life, particularly whether maternal behaviour is innate or learned.

While animal attachment behaviours were being studied, so too were human infants. In the years post-World War II there was a recognition of the impact of the war on families and a subsequent influx of research into infant-mother relationships. Many of the influential studies conducted throughout the 1950s and 1960s remain central in our understanding of human behaviour, and indeed guide theory development and clinical interventions to this day. The collaborative efforts of John Bowlby and Mary Ainsworth gave birth to what is referred to today as ‘Attachment Theory’ (Ainsworth and Bowlby, 1991). Bowlby (1969) believed that every human being had an ‘attachment system’ which he described as being a type of homeostatic mechanism

for regulating anxiety and stress by seeking out an attachment figure for security and protection. The attachment system can be regarded as a biological and psychological system that regulates how we (a) seek care and give care to others and (b) how we regulate feelings of distress, especially at times of illness, vulnerability and loss. Attachment does not only affect children, it has been found that adults seek proximity to the attachment figure when stressed (Weiss, 1982) and in this respect attachment can be regarded as a cross-cultural and humanistic theory by which to understand the basis of all relationships.

An individual's early experiences of care giving lay down a blue print, literally as well as metaphorically, which sets them on a particular trajectory through life. There is a growing body of research which focuses on the neurological development of infants, namely that our early attachment experiences literally shape our brains (Glaser, 2000; Schore, 2005). The type and quality of neurological development manifests in attachment behaviours. Bowlby proposed the idea that insecurely attached children may develop certain types of behaviour (minimising and maximising) in order to try and achieve/maintain interaction with their primary attachment figure (thus seeking homeostasis). He believed that if the primary attachment figure (usually, but not exclusively, the mother) was absent, inconsistent in their approach or indeed a source of fear, the development of the attachment system would be impaired.

While Bowlby 'revolutionized our thinking about a child's tie to the mother' (Bretherton, 1992, p. 759) he did not achieve this alone. Bowlby's like-minded colleague, James Robertson, had joined him at the Tavistock Clinic in 1948 where he focussed on behavioural observations of young children in hospitals separated from their mothers. Robertson developed a theory of how children respond when an 'affectional bond' is broken, namely passing through three distinct stages: protest, despair, and denial/detachment (Robertson, 1953a). The similarities between Harlow's distressed monkeys and the children featured in Robertson's film entitled 'A two-year old goes to hospital' (Robertson, 1952) are striking.

Fortunately Bowlby's WHO Monograph published in 1951, highlighting the importance of attachment relationships, led to improvements in the care of young children in hospitals and residential institutions. Interestingly his Monograph was initially heavily criticised by academic psychologists (O'Connor & Franks, 1960) and rejected by the psychoanalytic establishment (Holmes, 1993, p. 5). The initial harsh response yet subsequent softening reminds one that there was a lack of any integrated biopsychosocial model at that time. It also highlights the extent to which thinking has since evolved.

Bowlby was a psychoanalyst who was influenced by the object relations school of thought, which argued that humans have an innate drive to relate to others. His work was influenced by that of Melanie Klein who believed the way adults relate to others is shaped by their family experiences during infancy (Klein, 1946). She posited that an infants' pattern of subjective experience form "internal objects" (e.g. an internalized image of one's mother) which often continue to exert a strong influence throughout adult life (Greenberg & Mitchell, 1983, p. 145). Bowlby (1982, 1988) preferred to call these representations of self and others that are constructed under the influence of the attachment system "internal working models (IWM)" (Liotti, 1999, p. 3). A growing body of research supports the view that an infant's early experiences of receiving care, can (and does) shape both adult and parenthood.

The well-known 'Strange Situation Experiment' (summarised in Table 1) was developed by Mary Ainsworth (Ainsworth & Bell, 1970) to test out Bowlby's theories about proximity seeking behaviours in infants. In contrast to Bowlby's belief that attachment was an 'all or nothing process' Ainsworth believed that attachment could exist in varying degrees.

Table 1 - *Stages of Ainsworth's Strange Situation Experiment*

Stage	Process
1	Mother, infant and stranger in the room together
2	Stranger leaves (mother and infant alone together)
3	Stranger re-enters room and joins mother and infant
4	Mother leaves the infant and stranger alone together
5	Mother returns and stranger leaves
6	Mother leaves (infant left completely alone)
7	Stranger returns
8	Mother returns and stranger leaves

Ainsworth found that children's attachment behaviours tended to fall within three distinct patterns; secure, avoidant and ambivalent. The securely attached children were distressed when their mother left them, but reattached with closeness when they returned. The children with an avoidant attachment style did not show signs of distress when they were left (either with the stranger or alone) and showed no interest when their mother returned. The ambivalent children showed intense distress when their mother left and on reuniting responded by approaching their mother yet resisting contact; they appeared unsure whether to approach or avoid. Ainsworth's work has been replicated across many countries and cultures.

In 1986 Main & Solomon proposed a further pattern of insecure attachment in children which was categorised as 'disorganised' (Main & Solomon, 1986). Children with a disorganised attachment style appeared to become frightened in the Strange Situation paradigm, and 'freeze' when reunited with their attachment figure. Frightening parental behaviour (including abuse) has been found to predict disorganised attachment in

infants, which in turn is associated with clinical disturbance in adolescence (Van Ijzendoorn, Schuengel & Bakermans-Kranenburg, 1999).

Bowlby hypothesised that attachment styles developed in infancy remain relatively stable throughout time. There is indeed evidence that attachment styles persist into adolescence and adulthood (Waters, Merrick, Treboux, Crowell & Albersheim, 2000, p. 681), and ultimately affect relationships with the next generation of infants.

2.4.1 Adult Attachment Interview

The Adult Attachment Interview (AAI; George, Kaplan, & Main, 1984) was developed in an attempt to translate Ainsworth's infant attachment patterns into corresponding adult patterns. George et al. (1984) devised an open-ended interview schedule which asks adults about their attachment relationships in childhood and the influence of these in their adult lives (Appendix 1). Interviews are audio recorded, transcribed and coded. Attention is paid to material purposely expressed by the individual, as well as to material which may be unintentionally communicated (such as incoherence and inconsistencies). The traditional Main & Goldwyn (M&G; 1994) method of coding has been refined and expanded over time (see Crittenden & Landini, 2011; Lyons Ruth, Yellin, Melnick, & Atwood, 2005; Ensink, Berthelot, Bernazanni, Normandin, & Fonagy, 2014).

The central feature of the AAI is that language and discourse style used reflects the state of mind with respect to attachment (Waters, Hamilton, & Weinfield, 2000, p. 680). Three distinct linguistic patterns of responding were initially identified: Autonomous-secure, preoccupied, and dismissing. George et al. (1984) found that *autonomous* (secure) adults tended to give clear and coherent accounts of their early attachment relationships, whereas *preoccupied* adults tended to focus mainly on conflicted and distressing relationships from their childhoods and displayed a degree of incoherence in their recall. Adults who showed a *dismissing* pattern of responding were characterized by their struggle to recall any/many attachment related memories, and the memories they did report tended to contradict their accounts of actual experience.

A key empirical question for the AAI was whether a mother's attachment style predicted her child's attachment pattern i.e. whether there was intergenerational transmission of attachment. There have been several studies that show how adult attachment affects infant attachment in the next generation (Crowell & Treboux, 1995). Concordance rates as high as 75% and 80% have been found in various studies where the AAI classification across three generations were analysed; correspondence between grandmothers and infants were mediated by mothers' classifications (Benoit & Parker, 1994; Ainsworth & Eichberg, 1991; Fonagy, Steele, & Steele, 1991; Main, Kaplan, & Cassidy, 1985; van IJzendoorn, 1992; Zeanah et al., 1993).

Table 2 shows how each of the AAI classifications mapped onto Ainsworth's infant attachment classifications (i.e. a dismissing parent correlated with an avoidant infant) (Main, Kaplan & Cassidy, 1985).

Table 2 - *Corresponding infant-adult attachment styles*

Adult Attachment Style	**Infant Attachment Style**
Secure-Autonomous	Secure
Insecure-Dismissing	Avoidant
Insecure-Preoccupied	Ambivalent

Bowlby had postulated that grief could affect attachment. Subsequently, Main & Hesse (1990) introduced the category of 'Unresolved' in order to denote those individuals whose attachment representations were affected by unresolved loss or trauma responses. These adults report attachment-related traumas of loss and/or abuse in childhood which still have an active impact on how they think about attachments. Cognitions and emotions related to the loss or trauma may be too painful to consciously process and become actively avoided; and thus remain unresolved. Failing to integrate loss or trauma with representations of the self and the world may

result in ‘intrusion and avoidance phenomena’ not unlike symptoms of PTSD (Pasco Fearon & Mansell, 2001, p.390).

Lyons-Ruth and colleagues proposed a further attachment classification known as ‘Hostile-Helpless’ (HH; Lyons-Ruth, Yellin & Melnick, 2005). This was in response to observing limitations of the Main & Goldwyn (1994) scoring system (which had been developed with low-risk samples) in that the classification codes were not adequately capturing the range of states of mind seen among high risk, clinical groups (p. 2). Lyons-Ruth et al. (2005) proposed an additional interview-wide coding system to classify HH parental states of mind. While it is possible to score ‘hostile’ and ‘helpless’ in their pure forms, they are ‘not necessarily expected to appear as such as they are related aspects of a single HH internal model of self-other relations’ (Lyons-Ruth, et al., 2005, p. 11). An HH state of mind describes the overall psychological organization of an adult who displays explicit contradictory and unintegrated emotional evaluations of a caregiver throughout the transcript, often showing an unexamined identification with that caregiver (Lyons-Ruth, et al., 2005, p. 11).

Studies of attachment in the community suggest that most people have secure attachment styles, but as many as 40% may have an insecure attachment style (Bakermans-Kranenburg & van Ijzendoorn, 2009, p. 243). Insecure attachment has been found to be disproportionately more common in many psychiatric disorders than the general population: including substance misuse, eating disorders, psychosis and Personality Disorder (PD). Retrospective and longitudinal studies suggest that early childhood adversity is a potent risk factor for the development of PD in adulthood (Modestin, et al., 1998; Johnson, et al., 1999). The mediating factor may be attachment security; childhood abuse and adversity causes insecurity of attachment which in turn affects the development of a functioning personality.

Before thinking more about personality development and ‘disorder’ it is important to critique the concept of the AAI as an adult attachment classification system. The AAI is the only interview based measure; but there are many self-report measures of

attachment in research and clinical use. These include Bartholomew & Horowitz's (1991) 'Attachment Interviews', the 'Current Relationship Interview' (CRI; Crowell, 1990), the 'Adult Attachment Q-set' (Kobak, 1989), and the 'Adult Attachment Styles' (AAS; Hazan & Shaver, 1987). The 'common theoretical ground' of all these measures have historically led to confusion and even discord (see Hazan & Shaver, 1994); possibly because they each appear to be measuring very different constructs. Crowell & Treboux (1995) wrote about the dearth of published research examining relations between the different measures, however Roisman, Holland, Fortuna, Fraley, Clausell, & Clarke (2007) have since published a comprehensive critique of attachment measures.

Despite these debates, there is general agreement that the AAI is a valid and reliable measure of adult attachments; and many would still say is the 'gold standard'. The AAI can offer relevant perspectives and shed light on an individuals' belief system and culturally held expectations pertaining to family life, and indeed parenting. Additionally, comprehensive analysis of the AAI provides valuable information about an individual's psychological defense profile, in particular the attachment strategies used (E.g. Idealisation, derogation, dismissal etc.) which constitute each of the patterns.

Furthermore, the AAI has demonstrated stability of classifications over time (Bakermans-Kranenburg & van IJzendoorn, 1993; Benoit & Parker, 1994) and demonstrated discriminant validity with respect to intelligence, memory, cognitive complexity, social desirability, and overall social adjustment (Bakermans-Kranenburg & van IJzendoorn, 1993; Sagi, van IJzendoorn, Scharf, Koren–Karie, Joels, & Mayseless, 1994).

2.5 Critique of Attachment Theory

Attachment Theory has made a significant contribution to the current understanding of child development, bonding processes, and relational patterns. Liotti (2009) stated that 'attachment theory and research have provided us with a powerful conceptual tool for understanding dissociative processes throughout personality development and in

adult life' (p. 759). It is important to acknowledge however that Attachment Theory does not claim to explain everything about human relating and in this respect should continue to be regarded as 'work in progress'.

The researcher's own experiences of applying Attachment Theory to clinical practice, combined with a review of literature by Rutter (1991) and Liotti (1999), who have written about the potential limitations of Attachment Theory, highlight several main criticisms of the theory which will now be discussed.

'Normal' Child Development

Attachment Theory was developed in the Western world within a middle-class profession and assumes the presence of a nuclear family structure; it can therefore be regarded as a culture-specific theory. The theory was not developed with issues of poverty, marginalisation, and educational attainment in mind. In addition to this, Attachment Theory is based within the context of 'normal' child development and does not take into account neurodevelopmental disorders, such as autism and intellectual disabilities (see Rutter, 1991). The majority of infants develop a secure attachment and because of this it has become viewed as 'normal'. It is highly unlikely however, that people would describe infants with an insecure attachment style as showing biologically abnormal development. From a biological perspective, natural selection will always favour a mixture of styles and thus 'insecure attachment cannot be equated with psychopathology or disorder' (Belsky & Nezworski, 1988, p. 28).

'Once insecure, always insecure'

Rutter (1991) described another flaw of Bowlby's initial theory concerning the 'sensitive period'. Bowlby had believed the first two years of a child's life to be the 'sensitive period' in which attachment security was achieved (or not). After this time, regardless of the quality of care received, it would not be possible for the infant to develop a secure attachment. Empirical evidence has since shown otherwise and the 'sensitive period' timeframe is probably much broader than the first two years and 'the effects not as fixed and irreversible as once thought' (Rutter, 1991, p. 129).

Type versus dimension

Just as the development of attachment security shows some flexibility, so too should the measures used to capture it. Infants vary in their degrees of attachment security and this is not always captured accurately on attachment measures such as the Strange Situation Experiment (which is based on a brief observation) or Attachment Q-Sort procedures (which are based on longer-term, more naturalistic observations, but still use categorical coding as opposed to dimensional scoring systems).

Measures which use categorical scoring systems are interesting when used with autistic children. Rogers, Ozonoff, & Maslin-Cole (1991) found that children with autism who showed severe relationship deficits did not score as insecure on the Strange Situation Experiment. In addition to relationship difficulties seen in children with neurodevelopmental disorders, proximity seeking behaviours observed in children raised in institutional care settings (with high turnover of carers) are not sufficiently (or accurately) captured on the current measures. There is therefore a need to develop more accurate, sensitive, and dimensional measures to further understand children's attachment security.

'Three's a crowd'

Rutter (1991, p. 126) stated Attachment Theory did not provide an adequate explanation of relationships beyond dyads; there is a lack of acknowledgement of the influence of wider social systems. Attachment Theory historically focussed on mothers, and while language has changed throughout the decades from 'mother' to 'primary care giver' to reflect changes in societal norms, it remains that fathers are often overlooked in child development research.

Bowlby's monotrophy concept (in which the infant develops a selective attachment to one figure) has been heavily criticized and evidence found to the contrary (Rutter, 1991). It has been found that infants can in fact develop selective attachments to small numbers of people who are closely involved in their care. This leads one to think

beyond mother and/or father, and consider the impact of siblings, peer groups, and wider support networks that can influence an infant's attachment.

'It's not what you say, but how you say it'

While there are indeed criticisms of Attachment Theory there appears to be a general consensus that the theory should be regarded as continually evolving, and attachment measures as works in progress. Many of the concerns related to Attachment Theory are more centred round how the theory is used, as opposed to the theory itself. An example of this is when attachment labels get applied to an individual instead of a particular relationship (Kobak, 1994, p. 42). This can indeed be seen in measures such as the AAI, which classify individuals as secure or insecure, rather than classifying the person's relationships with different people. Certainly simplistic use of the AAI whereby only basic attachment classifications are given is not helpful.

Attachment Theory can be used in other unhelpful ways, particularly when too much focus and responsibility is placed on the mother. Continuing to focus on dyadic relationships and assuming that secure is 'normal' and good, and insecure is therefore bad, can contribute to a mother-blaming society which is endemic in the mental health field.

In summary, the application of Attachment Theory to research and clinical practice requires careful consideration and skill. Furthermore, it is perhaps best to think of the attachment system as one bio-behavioural motivation system among others, including sexual, agonistic, and caregiving motivation systems. Attachment Theory can be both fascinating and clinically useful, however its use should not come at the exclusion of considering other motivational systems.

2.6 Clinical Utility of Attachment Classifications

There are times when it is helpful to classify patterns of behaviour; for the individual or system around them it can bring clarity, validation and a feeling of relief. For

professionals it can help to identify vulnerabilities and potential risks which may require resources and attention. A (crude) example might be if an infant were to be referred to services for behavioural problems, including challenging behaviour. In this instance, professionals would benefit from observing the infant with its caregiver and establishing the degree of attachment security. If attachment difficulties were identified various interventions may then be recommended, including practical and psychological support for the caregiver.

Another example of when attachment classifications can be helpful is when (medical) professionals are attempting to use differential diagnoses in identifying the aetiology of certain 'problems', such as hyperactivity or chronic gastrointestinal problems. Hyperactivity and the diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) is frequently given yet such presentations overlap with those seen in a child with insecure attachment (Crittenden & Kulbotten, 2007; Bergin & Bergin, 2009; Clarke, Ungerer, Chahoud, Johnson, & Stiefel, 2002). As many as 80% of children diagnosed with ADHD have attachment issues (Clarke et al., 2002; Moss & St-Laurent, 2001). Fortunately there is growing recognition of this and the NICE guidelines now recommend parent-training/educational programmes as first line interventions for parents of children presenting with ADHD (NICE CG72, 2008). Misdiagnosis can also occur when attachment difficulties are somatised and a child presents with frequent stomach aches, headaches and nausea (Massie & Szajnberg, 2006, p. 476). These children often present to GPs, are referred to gastro services, and miss more school than children with secure attachments. The anxiety experienced in childhood as a result of lacking a secure base may be difficult for children to express due to their stage of language development and emotional literacy. Their anxieties subsequently manifest in their body and thus somatization becomes 'an expression of distress' (Stuart & Noyes, 1999, p. 34).

Diagnostic classifications can be both helpful and hindering and the debate as to whether (medicalised) diagnostic systems should still be employed in modern healthcare systems rages on (Johnstone, 2000; Johnstone & Dallos, 2006; Bentall, 2006; DCP, 2013; Bond & Bruch, 1998; Glasser, 2003). Certainly a concern would be

that by labelling a child with an attachment 'disorder' (referred to as 'Reactive Attachment Disorder', RAD, in the DSM-5; American Psychiatric Association, 2013) it may negatively impact on their development, with them becoming viewed in a particular way by services and possibly becoming stuck in a 'damaged' or 'victim' position. Internet sites which make sweeping (and incorrect) statements such as 'RAD is incurable, but entirely preventable' are not helpful. This gives rise to the question whether or not attachment styles are indeed 'curable' and able to change over time.

There is growing research into how attachment styles can change over time; 'Insecurely attached' may no longer be a 'sticky label' which follows a child through school and beyond. There are numerous interventions aimed at improving attachment security (both in childhood and adulthood), including Mentalization-Based Therapy (MBT; Bateman & Fonagy, 2004), Video Interaction Guidance (VIG; Biemans, 1980) and Parent-Infant Psychotherapy (PIP; Barlow, Bennett, Midgley, Larkin, & Wei, 2015). Recent research has shown that specialised interventions aimed at improving mothers' mentalizing capacity can be effective in changing their psychological defensive structures and overall wellbeing, and their subsequent attachment behaviours (Williams & Adshead, under review). While Bowlby believed that attachment styles generally remain stable over time he hypothesized that change was possible through the influence of new emotional relationships (Bretherton, 1992, p. 771). Certainly the growing research into brain 'plasticity' is fascinating when considering the potential for new neural pathways to develop given safe, consistent and repeated opportunities to do so (Fonagy & Adshead, 2012; Bateman & Fonagy, 2013).

2.7 Personality Development and Disorder

2.7.1 Personality Development

Personality has been defined as 'a combination of characteristics or qualities that form an individual's distinctive character' (Soanes & Stevenson, 2003, p. 1065) and the APA (2016) define it as 'the individual differences in characteristic patterns of thinking, feeling and behaving'.

Since the late 19th century interest has grown in the area of 'personality' and the last hundred years has seen various models and taxonomies developed in the hope of understanding the concept of 'personality' better. Ideas have ranged from there existing over 4,000 personality types (Allport & Odbert, 1936) to as few as 3 types of personality (Eysenck, 1947). Currently one of the most popular theories is the 'Five Factor Model' (McRae & Costa, 1987), often referred to as 'The Big 5'. This theory proposed that personality is made up of five broad personality dimensions, namely: extroversion, agreeableness, contentiousness, neuroticism, and openness. However, while there appears to be a general consensus of the definition of 'personality' and various traits, there is less clarity about *how* personality develops.

The attachment system plays a 'key role in personality development because it is the first among the interpersonal motivational systems to become active in infancy' (Liotti, 1999, p. 761). We remain unclear however about how the attachment system relates to the Big 5 personality traits and 'temperament'. Research conducted by Vaughn, Stevenson-Hinde, Waters, Kotsaftis, Lefever, Shouldace, Trudel, & Belsky (1992) showed that dimensions of temperament (such as negative emotionality) were associated with insecure attachment, however there remains a dearth of research in this area.

The ongoing nature-nurture debate highlights the different schools of thought, where many believe temperament and personality are predetermined (to a degree) within an individual's genetic coding (Van Reekum, Conway, Gansler, White, & Bachman, 1993), and others believe personality development is more heavily influenced by environmental factors (Perry & Herman, 1993, p. 123). It seems unrealistic that either is solely responsible for the development of personality hence researchers ongoing work to investigate the impact ratio of nature:nurture. Interest into gene-environment interaction (GxE) studies has exponentially increased over recent years (Kendler, Aggen, Czajkowski, Roysamb, Tambs, Torgersen, et al., 2008) and has helped to shift thinking away from an 'either/or' approach. While epigenetics is still a relatively new area of study its potential to provide a biological understanding of how the environment

can influence gene expression, is steadily becoming realised (Caspi, Hariri, Holmes, Uher & Moffitt, 2010, p. 510).

When attempting to understand the balance of factors responsible for the development of personality, it is perhaps helpful to consider attachment security as a mediating factor. Barr, Newman, Shannon, Parker, Dvoskin, … & Higley (2004) established that quality of early care moderates the expression of genes related to stress reactivity and positive attachment relationships have been associated with reduced cortisol responses (Hertsgaard, Gunnar, Erickson, & Nachmias, 1995, p. 1101). Conversely, high stress and disorganised attachment relationships in early life have been found to alter cortisol production, affect noradrenalin, serotonin, and dopamine neurotransmitter systems and impair hippocampal function (Bennett, Lesch, Heils, Long, Lorenz, & Shoaf, 2002; Bremner & Narayan, 1998). Children who grow up with abusive attachment figures have a more developed primitive neurobiological system (allowing them to respond to threat quickly) and show less brain activity in the prefrontal cortex (the brain area responsible for more sophisticated and reflective function) (Ensink, Berthelot, Bernazzani, Normandin & Fonagy, 2014, p. 3). Neurobiological factors such as these will have an impact on personality development as they affect the development of cognition, emotion regulation and behaviour.

If a securely attached infant experiences trauma or abuse their attachment relationships may serve to protect them. If however the infant does not have access to sensitive and attuned care, in a safe and validating environment where they are able to communicate their experiences of distress, they may develop protective psychological strategies (such as dissociation). While this demonstrates children's resourcefulness, it may be that on entering adulthood the strategies become maladaptive (Ensink et al., 2014, p. 10).

Ryle (1997) writes comprehensively about the development of Borderline PD and proposed the 'Multiple Self States Model' (Ryle, 1997). In this model he suggested that experience of abusive and neglecting relationships in early life could result in an

internal psychic conflict where the child internalises harsh parental attitudes. Ryle describes how the child may adapt by repressing feared memories and dissociating from uncomfortable and upsetting emotional states. Without an opportunity to assimilate their confusing and often contradictory emotional states, they maintain a split which manifests as various Axis I disorders and 'personality pathology'.

2.7.2 Personality Disorder

Bowlby (1944) argued that insecure children were more likely to be antisocial and subsequent research has confirmed that children with an insecure attachment are more likely to display aggressive and antisocial personality traits (Lewis, Feiring, McGuffog, & Jaskir, 1984; Lyons-Ruth, Alpern, & Repacholi, 1993; van IJzendoorn, 1997). Studies of adult male offenders have found rates of insecure attachment to be as high as 95% (van IJzendoorn, Feldbrugge, Derks, de Ruiter, Verhagen, Philipse, van der Staak, & Riksen-Walraven, 1997). It can therefore be said that clinical populations have a much higher proportion of insecure classifications than the general population (Bakermans-Kranenburg & van IJzendoorn, 2009, p. 252).

When children with disturbed attachment histories grow up they often experience certain difficulties, particularly relationship problems. They may present to services with low mood, anxiety, difficulty regulating their emotions, substance misuse and other difficulties. Often this group of people become labelled as having a PD.

The DSM-IV defined PD as:

> *An enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment (APA, 2000, p. 685)*

The DSM-IV recognised ten types of PD, these include: Paranoid, Schizoid, Schizotypal, Anti-social, Borderline, Histrionic, Narcissistic, Avoidant, Dependent and Obsessive-compulsive. The long-awaited updated version of the DSM (DSM-5; APA, 2013) made amendments to the previous PD definition, stating that:

The essential features of a personality disorder are impairments in personality (self and interpersonal) functioning and the presence of pathological personality traits (APA, 2013, retrieved December 2015)

Prior to publication of the DSM-5, several proposals were made requesting that the system of diagnosing PD change from a categorical model to a more dimensional one (Horowitz, 2004). While the proposals received consideration, the APA Board of Trustees eventually decided to retain the DSM-IV categorical approach and the (above) ten types of PD classifications remain.

The researcher's experience of facilitating psychoeducational groups for individuals with a diagnosis of PD enabled her to witness some of the controversy surrounding the term. Phrases such as "How dare people say my personality is wrong" and "Who gets to decide what is 'normal' anyway?" were often voiced with high emotion by group members. It fits therefore that an information booklet prepared by the mental health charity 'MIND' stated 'Personality disorder is one of the most misunderstood and stigmatised diagnoses in mental health' (MIND, 2013, p. 2).

PD is often used as a pejorative label and 'equated with people who behave badly' (Adshead, 2001, p. 408). Focussing on negatively evaluated behaviour detracts attention from other ways of thinking about PD, such as disturbed attachment histories and subsequent 'psychological deficits' (Blackburn, 1988; Adshead & Jacobs, 2008, p. 167). It is therefore important that clinicians and researchers alike, remember that babies are not born with PD. External events shape adult personality and it is therefore

best to think of PD as an acquired, rather than innate, condition (Adshead, 2001, p. 410).

2.7.3 PD and Gender

There is a stark difference in rates of PD diagnoses between males and females in that males are more likely to be diagnosed with Antisocial PD when females tend to be diagnosed with Borderline PD (Skodol, 2003). Biological and psychological factors go some way towards explaining gender differences in prevalence rates of PD, however it is important that societal factors are considered particularly in terms of gender constructs and role identity development. It may be frightening for society to acknowledge that anger and a potential for violence can indeed exist in women; women who are 'meant' to be caring, sensitive and motherly. It seems therefore that while males with an insecure attachment history are more likely to enter into the forensic system (Dutton, 1995), females with insecure attachment tend to end up in the mental health system.

2.8 Motherhood, Maternal Ambivalence and Personality Disorder

'Even a Saint may feel like throwing her baby down the stairs' - Anon

Becoming a mother is, for many, a wonderful and rewarding rite of passage in which innate maternal instincts become activated. From an evolutionary perspective maternal bonds to offspring increase the chance of species survival. It is therefore vital that women bear children, and this evolutionary pressure has led to the development of a dominant social discourse (across cultures) that women 'have' and 'rear' babies.

What if the maternal instinct or drive to comfort and protect a vulnerable dependent baby is absent, or ambivalently present? Parker (2005) discusses the taboo of maternal ambivalence, and considers classic literature which details such 'opposing impulses towards merger and autonomy' (p. 38). There is a strong social narrative that

there is only one way to be a good mother and an assertion that ‘mother knows best’; but what if Mother does not know best? Attention should therefore be paid not only to child development, but ‘maternal development’ also.

It seems that becoming a mother is both simple and yet complex. The conflict evoked by motherhood can become unthinkable (Raphael-Leff, 1993, p. 10) and indeed many women may feel overwhelmed and experience negative feelings towards their child, and about becoming a mother. Motherhood can be challenging for mothers who have good mental health, therefore women with poor mental health may find the transition to motherhood especially stressful. It is well known that as many as 1:500 mothers become psychotic after the birth of a child (Sit, Rothschild, & Wisner, 2006, p. 353), however less attention has been paid to the mothers with PD. Mothers with PD may particularly struggle to care for their children because of a lack of a positive internal working model of what a nurturing and safe mother is, combined with their potential difficulties in regulating their emotions at times of vulnerability and distress. They may find themselves faced with a screaming baby and not know (intuitively) what to do with ‘it’ or themselves. Put simply, there is a big difference between carrying a child physically and carrying one psychologically (Raphael-Leff, 1993, p. 10).

Mothers with BPD may idealize the infant during pregnancy with an expectation that it will repair past negative experiences, however after birth ‘the baby is naturally unable to fulfil his mother’s needs’, instead reflecting back the mothers own childhood experiences of distress and fear (Apter-Danon & Candilis, 2005, p. 305). In this respect parents with BPD may represent ‘enormous public concern’ (Stepp, Whalen, Pilkonis, Hipwell, & Levine, 2011, p. 1), particularly given that studies of children from BPD parents show higher rates of social and emotional difficulties.

2.8.1 Social Care Involvement

Mothers for whom the transition to, and demands of, motherhood become too overwhelming undoubtedly require compassion and support, however unfortunately all too often become villainized. A blaming approach is seen in tabloid headlines such

as ‘Britain’s most reviled mother’ (Daily Mail, 2009) and ‘Faces of Evil Mother’ (The Sun, 2016) both of which refer to Tracey Connelly, the mother of baby Peter (‘Baby P’). Tracey Connelly was ‘caged in 2009’ (The Sun, 2016) for the systematic torture of her son and for failing to protect him from two men who abused him to such an extent that he died aged seventeen months. Stories later surfaced regarding Connelly’s troubled upbringing with one newspaper stating that ‘almost from birth she was exposed to every vice conceivable’ (Daily Mail, 2009).

While there are many lessons to be learned from tragedies of infanticide, not least the importance of clear communication and effective multi-agency working, it remains that sensationalist tabloid headlines and media attention serve to perpetuate a stigmatising social discourse around mothers who are ‘bad’ and ‘evil’. Emotions such as guilt, shame, and loss often get overlooked in cases of child abuse, with society (including professionals) instead succumbing to a culture of blame. While this may be understood in terms of people’s unconscious desire to locate ‘badness’ and ‘evil’ in others and thus exempt oneself, it remains that this group of mothers are in serious need of care and support.

2.8.2 Maternal Child Abuse

Mothers are implicated in different types of child maltreatment, most commonly infanticide, physical abuse, neglect, emotional abuse and (rarely) sexual abuse. In children under one year of age, mothers are the most likely perpetrator of abuse whereas over one year it is equally likely to be the mother or father (Porter & Gavin, 2010, p. 99). Mothers may perpetrate multiple types of abuse together, for example, neglect and emotional abuse go together; or like Tracey Connolly, they do nothing when their partners hurt their children. Finally, mothers are the people most likely to perpetrate abnormal illness behaviour by proxy, known as factitious illness by proxy or Munchhausen Syndrome by proxy (Adshead & Bluglass, 2005).

So why is it that some mothers go on to abuse their children? Although attachment security may be an important factor, it does not exclusively account for maternal child

abuse; there are mothers with secure attachment histories who harm their children, and mothers with insecure attachment histories who strive hard not to let history repeat itself. The notion of 'abused becoming an abuser' is largely unfounded (Widom, 1989) and, in fact, mothers who were themselves abused as children may try harder not to abuse their children. When considering the perpetration of child abuse, like any act of violence, a combination of factors should be considered, including attachment insecurity, personality disorder and mental illness.

Mothers who commit infanticide are often deemed to have severe mental illness; such as postnatal psychosis, but not all do. Substance misuse problems are often present as is the case for most offenders and social rule breakers. Most mothers who mistreat their children or fail to care for them are young mothers, who didn't plan the pregnancy, are single or in a violent relationship, are socially disadvantaged, or have babies that are vulnerable in some way, such as premature or handicapped babies. Teenage mothers are at high risk of child maltreatment; especially if they have had experiences of abuse, neglect and domestic violence (Adshead & Bluglass, 2005).

It has been postulated that caregiving behaviour is organized within a behavioural system that is independent from, but linked developmentally and behaviourally to attachment (George & Solomon, 1999). A child's attachment system and parent's caregiving system are separate however interact with each other. Just as the adaptive goal of the attachment system is to 'be protected', the goal of the caregiving system is to 'protect the child'. While the child's attachment system becomes activated at times of separation and threat, so too does the caregiving system become activated by the child's verbal and nonverbal signals of discomfort and distress. Once activated, the parent engages in behaviours such as retrieval, carrying, looking for the child, and (in humans) smiling to reassure the child. Once the child is safe, both the child's attachment system and the parent's caregiving system become deactivated.

Ainsworth et al. (1978) described sensitive mothers as those who are 'alert to perceive her baby's signals, interprets them accurately, and responds appropriately and

promptly' (p. 140). Of course even the most vigilant parents may not evaluate each and every situation correctly and Winnicot's concept of the 'good enough' mother (Winnicot, 1958) is helpful in this case. However, when a mother is unable to recognise her infant's distress signals, evaluate the situation and act accordingly, or indeed when a mother chooses to abdicate her protective role, damage to the child's attachment system ensues.

2.9 Transgenerational Factors

One of the most influential papers which impacted upon the researchers thinking and clinical practice is that of Selma Fraiberg's 'Ghosts in the Nursey' (Fraiberg, Adelson, & Shapiro, 1975). In this paper Fraiberg highlights the unconscious impact of an individual's past on their present. She writes 'They have been present at the christening for two or more generations…while no one has issued an invitation, the ghosts take up residence and conduct the rehearsal of the family tragedy from a tattered script' (Fraiberg et al., 1975, p. 165).

The researcher was fortunate enough to have been supervised by Peter Aylward, a psychoanalyst and author, while working within a high secure forensic psychiatric hospital. This is where she first learnt about the importance of sibling birth order and critical ages. In Chapter One of Aylward's book entitled 'Understanding Dunblane and Other Massacres' he describes the phenomenon of palindromes within 'the calendar of the mind' (Aylward, 2012, p. 2). He describes a critical date as a time when a significant event occurs in an individual's life that symmetrically represents an earlier critical event (or trauma), such as the arrival of a sibling. Aylward provides examples of how unconscious processes 'play back again' and refers to the critical dates of renowned people such as Adolf Hitler and Sigmund Freud (p. 2). This fascinating and abstract concept supports thinking around transgenerational transmission.

Transgenerational transmission of attachment has become widely researched over recent years with strong evidence being found to show that a mother's attachment style can predict the attachment style of her infant (Ward, Ramsay, Turnbull, Steele,

Steele, & Treasure, 2001). It is thought that transmission may occur via maternal mental processes and the way a mother thinks about her child. Elizabeth Meins and colleagues suggested that it is the mother's ability to think about the child's mind (her 'mind-mindedness') that helps a child make a secure attachment to her (Meins, Fernyhough, Johnson, & Lidstone, 2006). Recent research into Mentalization has found that a mothers' ability to mentalize about her own early attachment relationships has important implications in her transition to becoming a mother. It seems that mentalization may help mothers to 'screen and inhibit negative parenting behaviours that would otherwise undermine infant attachment security and organization' (Ensink, Normandin, Plamondon, Berthelot, & Fonagy, 2016, p. 9).

Interestingly, Main & Hesse (1990) found that 'an unresolved mourning process in the mother, during the first 2 years of the infant's life, is likely to be reflected in disorganization of the child's attachment behavior' (Liotti, 1999, p. 772). A more recent study found that mothers with 'unresolved trauma' who had insecure attachment styles were more likely to have infants with insecure attachment (Iyengar, Kim, Martinez, Fonagy, & Strathearn, 2014). Lyons–Ruth et al. (2005, p. 3) believed transmission was not simply a replication and that different etiological mechanisms may account for disorganisation in childhood and adulthood. They proposed that if an infant with a disorganised attachment style grew up without specific direct experience of loss or abuse their 'disorganised attachment strategies' would not be expected to persist into adulthood and termed this a 'transmission block' (Lyons-Ruth, et al., 2005, p. 3). Liotti (1999) concluded that trauma and dissociation are transmitted in some families from one generation to the next through the mediation of the motivational dynamics of the attachment system. The Allen Report (2011a) and the Marmot Review (2010) advocate that parents and key professionals need to have the understanding and knowledge of how to build social and emotional capability within children and therefore empower individuals to break inter-generational cycles of dysfunction and under-achievement.

It remains that the process of how stories are passed down through generations is fascinating. There are the explicit stories, perhaps refined or embellished through time,

however, there are stories which follow each of us in our day-to-day life and remain outside of our consciousness. Indeed a family may 'find themselves re-enacting a moment or a scene from another time with another set of characters' (Fraiberg et al., 1975, p. 165).

3.0 LITERATURE REVIEW

3.1 Overview of Chapter

This chapter outlines the systematic literature review process. The findings from relevant research studies are discussed and the rationale for the current study is introduced.

3.2 Literature Review Process

In order to identify previous research into the area of mothers with a diagnosis of PD who have completed an AAI, a comprehensive literature search of peer reviewed journals was conducted. A diagrammatical flowchart outlining the search strategy and exclusion process is included as Appendix 2.

In summary, three search engines were used, each selected based upon recommendation and previous positive experience of using them. The search engines were Web of Science, PsyARTICLES, and PubMed. Initially the search terms used were "adult attachment interview*" AND "personality disorder*" AND "mother*"; however this provided only 20 articles which felt inadequate for a comprehensive review. The search term "mother*" was subsequently removed and a total of 112 journal articles were found. Each of the titles were reviewed and duplicate articles removed from the process; this left a total of 81 articles remaining. Titles were then reviewed in relation to their relevance and articles clearly not in the selected field were excluded from the process; this left a total of 65 articles remaining. Abstracts of the 65 articles were reviewed and further exclusions made for reasons such as 'sample not include mothers and/or PD and/or AAI'. A total of 15 articles remained which were

each reviewed in full and are summarised and discussed below. A tabulated overview of the 15 articles is included as Appendix 3.

3.3 Evaluating the quality of research

Various factors need to be taken into account when deciding how 'good' a research article is (whether qualitative or quantitative). When reviewing the quantitative papers, the researcher paid particular attention to factors such as sample characteristics and size, choice of methodology, rigour of statistical analysis, as well as focussing on how the authors reported (significant) findings and made recommendations accordingly. Critiquing qualitative research requires a different focus and the researcher found it helpful to use the 'evolving guidelines' proposed by Elliott, Fischer, & Rennie (1999, p. 215). They explain that guidelines should evolve as 'explicit guidelines are fundamentally at odds with the spirit of qualitative research' (Elliott, et al, 1999, p. 225).

When reviewing qualitative research it is particularly important for the reader to 'bracket off' their knowledge of existing theory and their own values (Pope, Ziebland, Mays, 2000). The reader should look for 'trustworthiness' whereby the researcher/author makes clear their research orientation, shares reflexive accounts and is transparent about their internal processes, while continually grounding their work in clinical examples (Elliott, et al, 1999, p. 220). Wallace & Wray (2006) speak of underlying aims and agendas which authors may have and encourage readers to 'read between the lines' however 'good' qualitative research demands that such 'agendas' are made explicit (p. 221).

Overall, whether research be quantitative or qualitative in nature, there remain important factors which ensure good quality research. These include (but are not limited to): having respect for participants, using appropriate methods, making the purpose of the research explicit, contributing to the knowledge base, and writing in a clear and accessible manner.

3.4 Outcome of Literature Review

Of the 15 journal papers, four were qualitative in nature, ten were quantitative and one used a mixed methods design. It became apparent while reading the papers that certain themes dominated the literature, particularly pertaining to ways of expanding the AAI classification system, limitations of using the AAI with non-normative samples, the developmental pathways of adult personality (and personality dysfunction/psychopathology), and how attachment and subsequent psychopathology may be transmitted across generations. The papers were subsequently grouped according to topic (Table 3) and will now be discussed in detail.

Table 3 - *Literature review papers grouped by topic*

<table>
<tr><th rowspan="2">Theme of paper</th><th colspan="2">Type of paper</th></tr>
<tr><th>Quantitative</th><th>Qualitative</th></tr>
<tr><td>Expansion of AAI coding system (including validation of new coding systems)</td><td>4</td><td>0</td></tr>
<tr><td>Use of the AAI with non-normative samples</td><td>1</td><td>2</td></tr>
<tr><td rowspan="2">Impact of early (adverse) childhood experience and subsequent attachment disturbance on adult personality development and psychopathology</td><td>3</td><td>1</td></tr>
<tr><td colspan="2">1 paper was mixed methods</td></tr>
<tr><td>Transmission of attachment mother-infant</td><td>1</td><td>2</td></tr>
<tr><td>TOTAL</td><td colspan="2">15</td></tr>
</table>

3.5 Discussion of Literature Review

A study which spanned across the attachment literature was by Bakermans-Kranenburg & van Ijzendoorn (2009). In their seminal study they set out the Main & Goldwyn (M&G) coding method and reported on the distribution of AAI classifications

among clinical and non-clinical populations. They conducted a series of analyses on data obtained from over 200 attachment studies; more than 10,500 AAI classifications in total.

They first studied the AAIs of non-clinical mothers in order to establish a baseline. They predicted that secure-autonomous mothers would account for the majority of the sample, followed by dismissing, with preoccupied and unresolved accounting for a small proportion. In contrast to this, Bakermans-Kranenburg & van Ijzendoorn (2009) predicted that analysis of the clinical samples' AAI classifications would show a higher rate of insecure attachment with the secure-autonomous classification being underrepresented. Bakermans-Kranenburg & van Ijzendoorn (2009) had a further hypothesis based on the works of Dozier and colleagues (2008, 2009) whereby they expected to find differences between attachment style and clinical presentation. Dozier et al. (2009) had found internalizing disorders such as depression and Borderline PD (BPD) to be associated with preoccupied attachment, whereas externalizing disorders such as Antisocial Personality Disorder (ASPD) were more closely linked to dismissing styles of attachment.

Bakermans-Kranenburg & van Ijzendoorn (2009) conducted a comprehensive review of research literature in order to identify their samples. Issues related to classification method were addressed as well as consideration given to the potential overlap between studies. In addition to this the 'hotly debated topic' of the AAIs cross-cultural validity was discussed. Bakermans-Kranenburg & van Ijzendoorn (2009) highlighted concerns that secure attachment has come to be regarded as the norm, however respondents from low SES backgrounds, ethnic minorities and non-Western countries 'may not fit into the template of the normative attachment distribution derived from middle-class Caucasian-American samples' (p. 225).

Such discussion enhances the relevance of their study, which was further strengthened by the results they obtained. Bakermans-Kranenburg & van Ijzendoorn's (2009) hypothesis regarding the distribution of attachment status among non-clinical

mothers was supported; the majority (58%) of mothers were classified as secure-autonomous. Their prediction that dismissing and preoccupied attachment would rank in that order was also supported (23% and 19% respectively). Evidence was found in relation to their hypotheses regarding the clinical samples; the majority were dismissing (37%) and only 27% were classified as secure-autonomous. Further hypotheses related to the association between attachment style and clinical presentation was also confirmed in that a three-way distribution of individuals with BPD showed a significant overrepresentation of preoccupied attachment and those with antisocial disorders had higher rates of dismissing attachments.

One of the many strengths of the study was their critique of the recent AAI developments. Bakermans-Kranenburg & van Ijzendoorn (2009) referred to Crittenden's 'Dynamic Maturational Model' (DMM; Crittenden & Landini, 2011) approach to classifying AAIs and while they appeared to respect Crittenden's rationale for expanding the categories, they stated that without validation with larger samples the DMM is a 'genuine confetti of new labels in search for meaning' (p. 250). Similarly they appeared to appreciate Lyons-Ruth's attempts to validate an additional category (HH) however described it as 'value laden' (p. 250) which goes against Hesse's original Cannot Classify (CC) category (1999, 2008). Bakermans-Kranenburg & van Ijzendoorn did however praise the works of Fonagy and his team for their development of the Reflective Function (RF) concept, particularly for its use in measuring therapeutic progress (p. 251).

In terms of AAI developments, Bakermans-Kranenburg & van Ijzendoorn (2009) referred to the AAI continuous rating scales which were developed by Hesse (2008). They reported that the scales 'are conspicuously absent in most clinical attachment studies' which is unfortunate given that a continuous AAI classification system (as opposed to the current categorical one) would 'better reflect the clinical disorders than a single AAI category' (p. 251).

After reflecting on the limitations of their study, particularly the lack of control they achieved over co-morbidity and diagnostic uniformity, they made suggestions for future research. Bakermans-Kranenburg & van Ijzendoorn (2009) emphasized the importance of using the four-way classification system in future attachment studies (and no longer the three-way). This would enable conclusions to be made about the different roles of the U and CC categories. Also the continuous scales within the AAI require greater use and validation. Finally, they recommended that attachment research start to focus on the 'counterintuitive resilience' shown by many complex and at risk individuals (p. 253).

3.5.1 Expansion of AAI Scoring Methods

A quantitative study by Lyons-Ruth, Yellin & Melnick (2005) provided an overview of the M&G method and introduced a new interview-wide coding system for measuring Hostile/Helpless (HH) parental states of mind. In their review of the literature, Lyons-Ruth et al. (2005) reported an array of empirical research which found that the traditional M&G method of scoring AAIs was 'not yet adequately developed to capture the range of states of mind seen among clinical groups' (p. 2). The AAI had initially been developed for use with non-clinical populations and Lyons-Ruth et al. (2005) posited that the M&G scoring method was not sensitive enough to capture the high levels of attachment disorganisation often found in clinical samples. They stated 'one current frontier of attachment research lies in the extension of adult attachment constructs and assessment to at-risk or clinical populations' (p. 1).

Lyons-Ruth et al. (2005) suggested that the 'Unresolved' (U) classification in the M&G method of scoring was methodologically flawed if an individual did not have specific loss or abuse experiences. They reported that 'disorganized attachment behaviours and states of mind are likely to be related to a broader range of caregiving responses than abusive behaviours alone' (p. 6), meaning that an individual does not necessarily need to have experienced trauma, loss or abuse in order to develop a disorganized attachment; in fact they posited that a lack of protection from a caregiver (prior to age 6) can be more damaging to the attachment system than the degree of abuse experienced (p. 5).

In an attempt to measure 'atypical states of mind' associated with a lack of protection as opposed to experience of direct abuse, Lyons-Ruth et al. (2005) developed the Hostile/Helpless (HH) classification. Details of how to score for HH and indeed how to recognise HH presentations clinically are outlined in Lyons-Ruth et al. (2005) paper, however in sum, an HH state of mind:

> *Describes the overall psychological organization of an adult who displays explicit contradictory but unintegrated emotional evaluations of a central caregiver across the transcript, often including evidence of an unexamined identification with that caregiver (p. 7)*

Lyons-Ruth et al. (2005) conducted AAIs with 45 low income mothers and scored the transcripts using the M&G method, as well as the newly developed HH coding system. They found that 77% of the transcripts which were classified as 'U' were captured within the HH classification. While Lyons-Ruth et al. (2005) had initially expected the HH classification to 'elaborate current criteria' for the U and CC classification, they found that HH codes delineated additional trauma-related states of mind which manifest on the AAI (p. 16). They concluded that their newly developed HH classification was 'an important augmentation to the current system' for scoring AAIs (p. 16).

The construct validity of the HH category was later tested in a study by Frigerio, Costantino, Ceppi, & Barone (2013). Frigerio et al. (2013) recruited 102 women and divided them into three sub-groups; low risk, poverty sample, and maltreatment risk group. AAIs were administered and scored according to the M&G method and the HH coding system. Statistical analyses found the distribution of HH states of mind to be 'very low' in the low risk group, slightly higher in the poverty sample, and much higher among women who had maltreated their infants. Descriptively their results showed that the high risk group were more 'Hostile' and were more likely to maltreat their children. It was speculated that those who scored higher for 'Helpless' were less likely

to perpetuate the cycle of child maltreatment (Frigerio et al., 2013, p. 438). While the study provided support for the construct validity of the HH category, small sample sizes hindered its statistical power and findings were therefore regarded as 'exploratory' (p. 441).

Further research into developing and refining the methods used to score the AAI have been conducted. Of note, Crittenden & Newman (2010) describe the Dynamic-Maturational Model (DMM), which is a method of classifying AAIs, developed by Crittenden under the guidance of Ainsworth. Crittenden (1985a) added an additional category to Ainsworth's ABC model, called A/C, and continued to develop additional categories which formed the basis of the DMM for analysing attachment interviews. Fundamentally the DMM differs to the traditional M&G method due to the way it conceptualizes the effect that fear has on organization and memory, and the development of internal working models (IWMs). Crittenden claimed that by adding more categories it was possible to differentiate between 'meaningful subgroups within clinical populations' (Crittenden & Newman, 2010, p. 436) thus improving the accuracy and clinical utility of the AAI.

In their 2010 paper, Crittenden and Newman compare the DMM and M&G method of classifying AAIs. They studied a sample of 32 mothers who had a neuro-typical infant aged 3 years; 15 of the mothers had a diagnosis of BPD whereas the remaining 17 mothers had no mental health difficulties and served as a comparison group. AAIs were administered and coded using both the M&G and DMM methods. Crittenden & Newman (2010) hypothesized that the DMM method would differentiate between the two groups more clearly, and that recalled danger would predict the DMM classifications more accurately than the M&G classifications. Discriminant analysis supported their hypotheses and their findings added to 'the growing body of studies that challenge the validity of the ABC+D theory and call for an expansion of the conceptual framework' (Crittenden & Newman, 2010, p. 447).

The most striking aspect of the DMM was its strengths-based focus (as opposed to the deficit-based M&G method) where individual's behaviours are regarded as self-protective strategies which have aided survival. The way in which DMM classifications 'can be read like short life narratives' (p. 448) encourages a more holistic view of the individual and may serve to strengthen clinical utility of the AAI. Crittenden & Newman (2010) concluded that 'taking the strengths-based approach of treating behaviour as organized and meaningful, even if complex, has substantial mental health advantages' (p. 449). The way in which limitations of their study were made explicit, particularly the small sample size and lack of diversity within the sample, combined with their recommendations for future research made this a robust and important piece of research.

Research by Ensink, Berthelot, Bernazzani, Normandin, and Fonagy (2014) further developed the AAI scoring method. Seminal works of Fonagy (1994) found that mothers who experienced childhood abuse and neglect (CA&N) could adapt well to the transition to motherhood if they had high levels of RF; in this respect RF can be regarded as a mediator between mother's histories of CA&N and their ability to parent their children. Ensink et al. (2014) recognized the need to develop a system for scoring RF (specifically in relation to trauma) on the AAI. Previous research showed the RF of mothers with a history of CA&N may not be captured accurately by a single overall RF score (p. 4). Ensink et al. (2014) subsequently developed the Reflective Function-Trauma (RF-T) score alongside RF more generally (RF-G).

In their 2014 paper, Ensink et al. (2014) wished to find preliminary evidence for convergent and discriminant validity of the RF-T scale and hypothesized that pregnant women with CA&N histories would manifest particular difficulties in mentalizing in the area of trauma and abuse, compared to mentalizing about early attachment relationships more generally. They administered the Parental Bonding Instrument (PBI; Parker, Tupling & Brown, 1979), the Childhood Experience of Care and Abuse (CECA; Bifulco, Brown, & Harris, 1994) and the AAI to a sample of 100 pregnant women in the US. They first scored the AAI data using the M&G method before coding the AAIs for RF using Fonagy's RF manual (Fonagy, Target, Steele, & Steele, 1998).

A range of statistical analyses were applied and findings indicated that 'RF-T is indeed a valid construct which is able to be meaningfully differentiated from RF-G (p. 9).

3.5.2 Use of the AAI in non-normative samples

The literature discussed thus far has explored the need to refine and expand constructs within the AAI in order to improve its' accuracy and clinical utility with diverse populations. As previously mentioned, the AAI was initially validated in normative community samples before it became widely applied in clinical settings (Bakermans-Kranenburg & van Ijzendoorn, 2009). The following two qualitative papers reflect on researcher's experiences of using the AAI with non-normative samples.

Turton, McGauley, Marin-Avellan & Hughes (2001) described an array of challenges faced by the interviewer and coder alike when AAIs were conducted with particularly 'disordered populations'. After completing AAIs with 45 mentally disordered offenders detained in a high-security hospital, Turton et al. (2001) identified several areas which posed challenges. Firstly, Turton et al. (2001) found the extremes of the participant's experiences made it difficult to elicit a clear biography and identify key attachment figures. They discuss the difficulty posed by repeated use of derogatory language and comment upon how the M&G method might class such discourse style as 'dismissing', yet 'in some disturbed populations, self-derogating comments are common' (p. 289) and derogation of an attachment figure may be 'licensed' when descriptions of abuse and sadism are detailed (Turton et al., 2001, p. 288). Further problems arose when participants presented as psychotic, were heavily medicated, or appeared to have suffered 'cognitive damage' from long-term substance abuse; at these times participants did not seem to understand the questions that were asked of them and provided 'bizarre and clearly false thoughts' or spoke with extreme incoherence (p. 295).

Further challenges identified by Turton et al. (2001) related to context. Their participants had all been detained in secure settings for some time and had therefore

told their life stories several times previously; 'the power of the AAI to surprise the unconscious' was therefore diminished (Turton et al., 2001, p. 296). Further, because they were detained in secure settings, participants were inclined to censor material and attempt to present themselves in a positive way with interviewers, which may have skewed the results. Finally, issues related to controlling and contemptuous behaviour towards the interviewer were discussed and Turton et al. (2001) concluded that 'non-normative populations can present real challenges to attachment researchers using the AAI' (p. 300).

A further account of AAIs being used with non-normative samples was provided by Steele (2003) in which he reflected on his experiences of interviewing adult female survivors of chronic ritual abuse. Steele referred to Turton et al.'s (2001) paper by concurring that many 'unique speech acts occur in interviews from these samples' and he stated that AAI classifications 'require expansion and redefinition for individuals from prison and hospital samples' (Steele, 2003, p. 357). Not unlike Turton et al.'s (2001) findings, Steele (2003) referred to the multiple losses (and traumas) experienced by non-normative samples which can result in incoherent transcripts that often get classified as CC.

3.5.3 The role of attachment in personality development (and disorder)

A quantitative study by Patrick, Hobson, Castle, Howard & Maughan (1994) explored the mediating factors between childhood experience and adult personality development. Patrick et al. (1994) studied 24 women; 12 had a diagnosis of BPD and 12 were diagnosed with Dysthymia. They administered the AAI, PBI, and Beck Depression Inventory (BDI; Beck, Steer & Brown, 1996) and hypothesized that different clinical presentations would have different attachment representations. Their hypotheses were generally supported in that while there was no significant difference in secure attachment classifications between the two groups, there were significant differences in the prevalence of preoccupied, dismissing, and unresolved classifications between the two groups. Unfortunately the small sample size meant that the results could not be considered representative nor generalizable to broader populations, however Patrick et al. (1994) maintained their position that in order to

understand ‘pathogenesis’ of personality disorders (and other psychiatric conditions) ‘one needs to consider the nature and origins of the patients mental representations of early relationships with significant other people’ (p. 386).

Pianta, Egeland & Adam (1996) developed this idea further in their study of 110 first-time mothers from a high risk poverty sample. Pianta et al. (1996) used the Minnesota Multiphasic Personality Inventory-2 (MMPI-2; Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989) and the AAI to examine differences between the women’s self-reported symptoms according to their attachment style. Pianta et al. (1996) found support for their hypotheses; the differences in self-reported symptomatology between the dismissing and preoccupied attachment groups were significant. Those with a dismissing attachment status ‘complained less’, reported fewer somatic symptoms and expressed more hostility, whereas those with a preoccupied attachment ‘possibly exaggerated their distress, viewing themselves as in need of sympathy and attention’ (Pianta et al., 1996, p. 276 & 277). Interestingly they found that participants with a secure attachment also reported high levels of symptoms. Pianta et al. (1996) attempted to make sense of this in two ways. Firstly they wondered if the pregnant status of their participants was a confounding variable whereby expectant mothers might be more sensitive to recognizing symptoms. Secondly, they hypothesised that participants with secure attachments might have been more in-tune with their mind-body and thus able to evaluate symptoms more accurately. Pianta et al.’s (1996) reflections and re-hypothesising, combined with a good sample size, use of a control group and discussion of limitations related to self-report measures such as the MMPI-2, strengthened the quality of their study. Unfortunately the sample size did not allow for causal associations to be studied and therefore Pianta et al. (1996) concluded that their findings were ‘essentially descriptive’ (p. 279).

A recent study by Levy, Johnson, Clouthier, Scala & Temes (2015) reviewed literature focussed on the relationship between attachment and PD. Levy et al. (2015) proposed that Attachment Theory provides a ‘cogent, empirically based, clinically useful, and theoretically coherent model’ for understanding many aspects central to PD (p. 197). Empirical literature has shown the theoretical connection between attachment security

and personality pathology, however the relationship between attachment patterns and specific PDs are less clear (Levy, 2005, p. 197). Levy et al. (2015) therefore aimed to elaborate on Attachment Theory as a foundation for the etiology of PD.

In addition to providing an overview of Attachment Theory and its links to PD, Levy et al. (2015) reported findings from various neuroscience studies. In particular they discussed the implications of findings from child and adult studies which found individuals with an avoidant attachment may appear 'calm and indifferent' (p. 199) yet physiologically be attempting to (ineffectively) down-regulate their attachment systems (see Sroufe & Waters, 1977; Dozier & Kobak, 1992). Reference was made to Oxytocin studies (p. 200) whereby an unusual effect has been observed in individuals with BPD; Oxytocin has largely been found to increase trust and maternal behaviours, however administration of Oxytocin to those with BPD causes an increase in perceived levels of threat and distrust (Bartz et al., 2011).

Similar to Pianta et al. (1996) they comment on the difficulty of using self-report measures with PD samples and describe measures such as the AAI (which does not focus directly on content) as 'essential' in attempting to understand the relationship between attachment and psychopathology (p. 198). Levy et al. (2015) made further links to research by introducing Mentalization-Based Treatment (MBT), however highlight this as an example of the propensity for research to focus on BPD more so than other PD types. With this in mind it is important to note the work of Shu, Bureau, Easterbrooks, Zhao, & Lyons-Ruth (2012) and their review of literature on the developmental antecedents of ASPD. They reported studies which found insecurity of attachment to be significant indicators of later ASPD features, particularly if maternal withdrawal is present in the first 18 months of life (p. 64). They comment upon the generalizability of these findings across both ASPD and BPD; 'deviations in early attachment relationships may be a part of common environmental contribution to borderline and antisocial personality disorders' (p. 65). Studies such as this support Levy et al.'s (2015) suggestion that research has historically focussed heavily on BPD.

Adult sequelae are further discussed in the mixed methods study by Massie & Szajnberg (2006) whereby they describe the effects of child abuse on the emerging adult personalities of children who took part in the longitudinal Brody study (which began in 1963 and is detailed by Massie and Szajnberg, 2002).

In their beautifully written paper, Massie & Szajnberg (2003) introduce the Brody Study and summarize the initial findings that while 'quality of mothering' of the children affected their long-term emotional development, it was in fact the experience of trauma which had 'a stronger measureable effect on adult mental health' (Massie & Szajnberg, 2003, p. 473). Massie and Szajnberg (2003) were able to locate 76 of the original 96 participants, ten of whom reported experiencing childhood maltreatment. In addition to conducting AAIs with the ten participants, Massie & Szajnberg (2003) applied 4 further measures: the Global Assessment of Functioning (GAF; Endicott, Spitzer, Fleiss, & Cohen, 1976), psychiatric diagnoses according to the DSM-IV (APA, 1994), Erikson measures of psychosocial development (Hawley, 1980) and Vaillant's defensive functioning scale (Vaillant, 1994). Their findings were striking in that across all measures 'the mistreated children fared significantly worse than their non-abused counterparts' (Massie & Szajnberg, 2003, p. 474).

The paper had many strengths, in particular the language used was non-pathologizing and respectful of the children's need for 'armor' (p. 471). Massie & Szajnberg (2003) included a section on resilience and described the 'ways in which the mistreated children are doing well as adults' being 'remarkable' (p. 476). The title alone ('My Life is a Longing') acknowledged the sadness inherent in child abuse and the case examples provided were moving and helped to ground their research. An important and hope-instilling message included in their paper was that 'children's biological and psychological plasticity allows affectionate bonding to take place even in the face of mistreatment' (p. 488).

3.5.4 Transmission of attachment

Wendland, Brisson, Medeiros, Camon-Senechal, Aidane, David, … & Rabain (2014) reviewed the possible consequences of BPD for women transitioning to motherhood by reviewing maternal mental health literature and presenting a series of case studies. In support of Stern's (1995) description of the perinatal period being a time of considerable personal, marital, and social upheavals, Wendland et al. (2014) reported the majority of patients who attended an outpatient service only did so after the birth of their first child (p. 140). They discuss the transmission of attachment across generations by using case examples and one particularly moving quote illustrated the effect attachment insecurity can have across generations; 'it would have been too unfair for her daughter to have the love she was still waiting to receive from her parents' (p. 144). They concurred with the works of Barone, Fossati & Guiduci (2011) who described Attachment Theory as an 'almost indispensable way to approach people with BPD' (p. 142) as it helps to understand how attachment security may be transmitted across generations.

Research conducted by Macfie, Swan, Fitzpatrick, Watkins & Riva (2014) further helps to understand how attachment may be transmitted from one generation to the next. Macfie et al. (2014) referred to the work of Fonagy, Target & Gergely (2000), who describe BPD as a disorder of attachment, and cited various research literature which found children of mothers with BPD to be at an increased risk of developing the disorder. Macfie et al. (2014) hoped that by studying children of BPD mothers more could be understood about the precursors of the disorder. They studied 31 children whose mothers had BPD, and 31 children from normative comparisons. Macfie at al. (2014) conducted AAIs with the mothers, observed mother-child interactions and used story-stem exercises with the children to identify their attachment representations.

Statistical analysis of the data revealed that mothers with BPD showed significantly higher rates of preoccupied attachment than did the comparison group, and the narratives of BPD mothers' children correlated. These findings have been found in previous research (Bakermans-Kranenburgn &van Ijzendoorn, 2009) and are therefore perhaps not surprising. Most interesting however, were Macfie et al.'s (2014)

finding which showed that the mother's parenting style played a significant mediating role in the transmission of preoccupied attachment to the child (p. 9). Put simply, their research demonstrated that adult attachment style affects an individual's parenting ability, which in turn affects infant attachment status, thereby providing a framework by which to understand one pathway of intergenerational transmission of attachment security.

Building upon the previous Ensink et al. (2014) study which conducted AAIs with expectant mothers who had experienced CA&N, Berthelot, Ensink, Bernazzani, Normandin, Luyten & Fonagy (2015) used a 20-month follow-up design to assess the (now 17-month old) infants of the mothers. They used the Strange Situation to assess the infant's attachment, and hypothesised that infants of mothers who had low levels of mentalizing in relation to trauma would have insecure attachments. After detailed statistical analyses, Berthelot et al. (2015) provided 'the first evidence' of an association between (mothers') mentalization, specifically regarding trauma, and infant attachment disorganization (p. 208). They reported that 83% of infants whose mothers had experienced CA&N had an insecure attachment and that mother's mentalization mediated the transmission of attachment. Their findings support previous studies which found mothers with high levels of mentalizing had securely attached infants whereas mothers with low levels of mentalizing had insecure infants (Fonagy, Steele, Steele, Higgit & Target, 1994). Findings such as these are fascinating in that they show how infants may develop the same insecure attachment as their parent, even though they have not been directly exposed to abusive experiences like their parent had been.

Berthelot et al. (2015) grounded their paper in the works of Fraiberg, Adelson & Shapiro (1975) who acknowledged the challenge faced by parents with a history of CA&N in 'psychologically freeing' themselves from the trauma (p. 202). However whereas Fraiberg et al. (1975) were describing how past trauma is present in the nursery as a kind of 'ghost' in the relationship between mother and child, Berthelot and colleagues suggest that it is in fact an 'absence' (of mentalisation) which mediates the transmission of attachment from mother to infant. There is not a direct link between

maternal exposure to trauma and security of infant attachment; rather, the infant's security depends on how the mother processes and is able to reflect upon her experience of trauma. Berthelot et al. (2015) thus emphasize the important role MBT therapies have in current clinical practice and recommend particular attention is paid to improving RF related to trauma (p. 209).

3.6 Summary of Literature

The systematic literature review highlighted several areas relevant to the current study. Firstly it became clear that the AAI is regarded as 'the gold standard for assessing attachment representations' (Hesse, 2008, p. 552) and has been developed considerably over recent years. The works of Crittenden, Lyons-Ruth and Fonagy are central in understanding such developments. While they each made different modifications to the AAI coding system, their motivations were the same in that they believed the M&G method alone was not able to accurately capture the complex attachment patterns observed in clinical populations.

Secondly, the literature review highlighted the impact that an insecure attachment in infancy can have on adult personality development and mental health. The rates of insecure attachment found in non-normative samples, particularly in forensic settings, was striking. A trajectory for PD was alluded to and the concepts of Mentalization and Reflective Functioning appear to be central in understanding clinical presentations such as BPD.

Finally, pathways of how attachment security may be transmitted from one generation to the next was discussed. In particular, factors such as parenting ability and reflective functioning have been found to be significant mediators in the transmission of insecure attachment.

3.7 Rationale for Study

The AAI has many strengths, not least its ability to provide valuable information pertaining to an individual's attachment history and style, as well as offering a profile

of an individual's attachment strategies. It is important to bear in mind however that the AAI was developed with normative samples within a westernised culture. The literature reviewed thus far suggests there is a need to expand the AAI scoring system in order to improve its accuracy and clinical utility with 'non-normative' populations. A key part of this task will involve finding meaning within transcripts which are not currently captured by the use of (reductionistic) categories. While the addition of further categories to the AAI scoring protocol may be welcomed by some in the hope of solving this problem, the use of categories alone can be wholly unhelpful when trying to understand an individual's difficulties. An example is when an individual is rated as 'insecure-preoccupied' with no further details provided; such information is close to meaningless as without detail and context there is no value in the label.

The researcher of the current study does not intend to expand upon or develop new categories per se, but instead attempt to 'read between the lines' and give voice to the latent content that may be going unheard within the AAIs of 'non-normative' and marginalized mothers.

The aim of the current study is therefore to give voice to mothers who have been silenced in many ways, to learn from their struggles and to help services develop more effective ways to reach 'hard to reach' vulnerable mothers.

4.0 METHOD

4.1 Overview of Chapter

This chapter introduces qualitative methodological approaches to research, paying particular attention to Thematic Analysis. The design of the current study is outlined and attention paid to ethical considerations.

4.2 Design

4.2.1 Recruitment of Participants

A purposive sampling approach was used and participants were recruited from a Psychotherapy and Complex Needs Service that was part of an NHS Foundation Trust. The service offered individual and group-based treatments for individuals presenting with chronic and complex relationship difficulties; many of whom were diagnosed with PD. One of the group treatments was an MBT (Bateman & Fonagy, 2004) group designed for mothers who had caused harm to their children and had subsequently had them removed from their care.

The researcher conducted a service evaluation of the MBT group in 2014-15 in which she collected and analysed a selection of psychometric data pertaining to the group member's profiles and their progress in the group. The evaluation has been submitted for publication and was presented at the International Association for Forensic Psychotherapy (IAFP) annual conference in Belgium in April 2016. In summary, the evaluation highlighted a positive change in the mother's overall wellbeing (based on the CORE-OM; Evans, Connell, Barkham, Margison, McGrath, Mellor-Clark, & Audin, 2002) and indicated the beginnings of change in their use of psychological defences; becoming less immature and more mature after one year of treatment (as measured using the DSQ; Andrews, Singh & Bond, 1993).

In addition to administering the CORE-OM, DSQ, International Personality Disorder Examination (IPDE; Loranger, Janca, & Sartorius, 1997), and Parenting Stress Index (PSI; Abidin, 2012), the MBT group members were invited to complete an AAI. At the time of the service evaluation, eight group members had completed an AAI (conducted by the researcher and scored by Dr Gwen Adshead using the M&G method). The small number of AAIs, combined with limited resources meant that no further analysis of the AAI data was conducted at that time. This study analyses the eight AAIs and demographic information for the participants is included in Table 4.

Table 4 - *Participant Demographics*

Pseudonym		Age	Ethnicity	No. of child-ren	No. children removed	Children fostered/ adopted	Reason for removal	AAI Classification
1	Hannah	42	White British	5	4	Adopted	Failure to protect	Insecure – preoccupied
2	Lesley	50	White Irish	4	4 (but later returned to her)	Foster care	Failure to protect	Insecure – preoccupied
3	Georgina	20	White British	4	3	Adopted	Failure to protect	Insecure – dismissing
4	Rosa	35	White British	2	2 (but later returned)	Special guardianship provided by her family	Neglect	Insecure – preoccupied
5	Emma	24	White British	2	2 (but later returned)	Foster care	Neglect	Insecure – preoccupied
6	Debbie	29	White British	5	4	Adopted	Failure to protect	Insecure – preoccupied
7	Felicity	43	White British	7	2	Adoption	Failure to protect	Insecure – preoccupied
8	Amy	37	White British	7	7	Adopted	Failure to protect	U/CC

4.2.2 Consideration of Inclusion and Exclusion Criteria

Participants were screened for suitability and the inclusion/exclusion criteria is included in Table 5.

Table 5 - *Overview of Inclusion and Exclusion Criteria*

Inclusion Criteria	Exclusion Criteria
Participants were mothers	Serious mental disorder, including active psychosis (which may compromise capacity to consent)
Were/had been members of the MBT group	Serious substance misuse (which may compromise capacity to consent)

Experienced personality dysfunction that would meet criteria for a diagnosable PD	
Experienced Social Care involvement in relation to their parenting	
Had their child/ren removed from their care	

4.3 Data Collection

4.3.1 Interview Design

The history, aims and validity of the AAI has been detailed in Chapter 2 therefore attention will now be paid to the content and structure of the interview. While the full AAI interview schedule (George, Kaplan, & Main, 1984) has been included as Appendix 1, an overview is provided (below) for ease of reference.

The AAI consists of twenty main questions which require the interviewee to recall memories from their childhood, reflect upon their present lives, and consider their wishes for their own children's futures. While there are twenty main questions various sub-questions and prompts can be used (as appropriate) throughout the interview, and the process usually takes approximately one hour.

The interview starts by asking orientation style questions in order to 'warm up' the interviewee and collect basic demographic information. The interviewee is asked to describe their childhood relationships with each of their parents and state who they felt closest to, and why. Interviewees are then asked to recall what happened to them when they were a child and had been upset, hurt, or poorly. The interview then asks about experiences of rejection, threat and loss. Interviewees are encouraged to think about how their childhood experiences have affected their adult personalities and to reflect upon why their parents may have behaved as they did, and how their relationships with their parents have changed over time. Towards the end of the interview, future-orientated questions are asked, in particular, how they manage when they are separated from their children and what their wishes are for them in 20 years' time.

4.3.2 Interview Process

Upon joining the MBT group, new members were invited to meet with the researcher to complete the AAI. It was explained that this was standard practice and offered to all new group members. They were informed that they did not have to accept the invitation and their care would not be affected in any way.

On arriving for their appointment, the participants were greeted by the researcher and taken to a private consulting room. The researcher explained the nature of the interview and the participants each signed a consent form allowing their interview to be recorded for transcription and research purposes (Appendix 4). Participants were made aware they could choose to stop the interview at any time and withdraw their consent should they so wish.

The researcher started the recorder and asked each of the questions in line with AAI protocol. The researcher had been trained to conduct the AAIs by her supervisor (GA) who had explained the importance of saying little and using prompts sparingly; this was to enable the participants to structure their responses and allow their sentences to come to a natural close.

Participants were given time to de-brief at the end of the interview which allowed the researcher to assess their emotional state and ensure that they were grounded back in the present before the end of the appointment.

4.4 Ethical Considerations

The AAI data had been collected as part of standard practice within the service and each participant had signed a consent form giving permission for their anonymised data to be used for service evaluation, teaching/training, and research purposes. It was therefore deemed not necessary to apply for ethical approval via the Integrated Research Application System (IRAS); a system used to apply for permission and

approval for health research in the UK. In order to be sure, the researcher contacted IRAS to confirm this (Appendix 5). The researcher informed the University of Hertfordshire (UH) about the proposed study and detailed how she intended to use the AAI data. Their response indicated that UH ethical approval was not needed as the data was secondary and had already been collected (Appendix 6). UH recommended the researcher log her proposed study with the NHS Trusts' Research and Development (R&D) department, which she subsequently did (Appendix 7). In order to confirm that she had completed all necessary steps the researcher met with her supervisory team who confirmed she had done all that was needed (Appendix 8).

4.5 Data Analysis

4.5.1 Qualitative approach

The term 'qualitative' literally refers to quality (and qualities) as opposed to quantity. Qualitative research is often referred to as being 'naturalistic, emergent, interpretive, phenomenological, hermeneutic, critical, or ideological' (Bailey, 1997, p. 19). In this respect qualitative research is able to focus on abstract concepts which may otherwise be difficult to measure; which is particularly important given that some aspects of human experience cannot be understood through reductionistic measures (Mishler, 1990, p. 420). Qualitative research uses inductive data analysis, in that it allows information and meaning to emerge, as opposed to fitting data into predetermined frameworks. Lewis (2015) described qualitative research as the most appropriate method to use when seeking to understand the context of a problem or when working with a 'priority population' (p. 474).

There are several criticisms of qualitative research, particularly its lack of any statistical power and its subjective nature. Until recent years qualitative methods were generally viewed as 'an exploratory approach to inquiry that required further validation by quantitative methods' (Leininger, 1992, p. 378) and in this respect validity of qualitative research has been a highly controversial issue (Bailey, 1997; Mishler, 1990).

Fortunately researchers have not been deterred by criticisms of the approach and recent years have seen an increase in qualitative research criteria being published (Silverman, 1993; Cresswell, 1998; Elliott, et al, 1999) in the hope of formalising (and therefore allaying fears round subjectivity) qualitative research standards. The researcher found the standards proposed by Elliot et al. (1999) (discussed in Chapter 2) to be particularly helpful and was guided by these throughout the research process.

4.5.2 Consideration of Qualitative Methodologies

The researcher wished to qualitatively analyse AAI transcripts. This was in response to clinical experiences whereby the researcher had conducted AAIs and observed that after they had been scored, a classification was assigned and the transcripts filed away. Having administered the AAIs the researcher had become acutely aware of how much rich and meaningful information had been shared by the individuals and it felt a great shame (and unethical) to disregard information which may not 'fit' into the predetermined scoring categories. In this respect the researcher became interested in the information that was not being coded for; that which was going unheard.

Content Analysis (CA; Berelson, 1952.) was briefly considered, however the researcher was quickly deterred by its quantitative nature. Historically, CA comes from a quantitative tradition within the humanities and social sciences where emphasis is placed upon establishing categories, counting the number of instances in which they appear and determining frequencies. Silverman (1993, p. 123) highlighted the issue of decontextualization and described CA as 'trite'. The researcher felt this approach to analysis may be too reductionist and would not help in her quest to develop a deeper understanding of the individuals' AAIs.

Due to her interest in 'meaning-making' the researcher considered using Interpretative Phenomenological Analysis (IPA; Smith, 1996) to analyse the data. IPA aims to explore in detail how an individual makes sense of their 'personal and social world' (Smith & Osborn, 2003, p. 51) and attempts to gain an 'insider's perspective' (Conrad, 1987, p. 34). After consultation with an experienced IPA researcher it became

apparent that the method would not be suitable due to the predetermined structure of the interviews. IPA would require the researcher to devise a new interview schedule specifically for the purpose of the study. While the interpretative and analytical aspects of IPA appealed to the researcher, she remained determined to attend to the AAI data and thus decided against using IPA.

Interestingly the researcher found she had gone full circle by returning to the initial idea she had had upon entering her clinical training; the most helpful way forward would be to use Thematic Analysis (TA; Braun & Clarke, 2006). TA was a method familiar to the researcher and fitted with the researchers' critical realist position in that it is a 'method which works both to reflect reality, and to unpick or unravel the surface of reality' (Braun & Clarke, 2006, p. 9).

4.5.3 Thematic Analysis

TA is a method of identifying, analysing and reporting themes or patterns of meaning within data and is one of the most common forms of data analysis in qualitative research (Guest, 2012). TA has many strengths, not least its ability to help organise rich data sets and allow themes to emerge (Saldana, 2009). TA places value on the meaning of data (both semantic and latent) as opposed to simply measuring frequency. The method has been described as forming 'the implicit basis of much other qualitative work' (Harper & Thompson, 2012, p. 210) and demands that the researcher take into account their own epistemological position. The flexibility provided by a TA approach, combined with the emphasis it places on reflexivity appealed to the researcher and she felt confident that potential unheard voices within the AAIs may come to the fore. The researcher was aware however that voices or themes do not reside in the transcripts and thus do not simply (passively) emerge; even a 'giving voice' approach involves the researcher selecting and editing material upon their own judgement (Fine, 2002) hence the importance of making explicit ones epistemology and reflective processes.

According to Braun and Clarke (2006, p. 16) there are six main phases of conducting a Thematic Analysis (Table 6).

Table 6 - *Stages of conducting a Thematic Analysis*

Stage	Action	Method
Stage 1	Become familiar with the data	Transcribe interviews, read and re-read
Stage 2	Generate initial codes	Notice re-occurring patterns in the material and start to organise into 'codes'
Stage 3	Search for themes	Analyse preliminary codes and consider over-arching themes
Stage 4	Review themes	Re-work potential themes (revise/expand) in order to find support/refute proposed theory
Stage 5	Define and name themes	Identify a theme's 'essence' and consider it within the 'bigger picture'
Stage 6	Produce a report	Discuss the contribution of themes to the research question

In depth instructions about how to conduct a 'good' thematic analysis can be found in Braun & Clarke's (2006) paper in which they describe several 'pitfalls' to be mindful of. The first of these is failing to actually analyse the data, instead simply reporting and paraphrasing themes. Secondly, they describe a common problem where the research questions being asked become the themes identified in the analysis; ironically indicating that no analysis has taken place. Finally, they describe 'too much overlap between themes' where the themes identified are not coherent or consistent, nor capture the majority of the data (p. 25). They maintain however that TA is a 'flexible approach which can be used within a range of epistemologies' and as long as research questions guide the process and transparency and reflexivity are maintained throughout, TA can be a useful and sophisticated approach with many advantages (p. 4).

4.5.4 Analysis of data using Thematic Analysis

In order to prepare the data the researcher anonymised each transcript and changed any potentially identifying details. The researcher then numbered all of the sentences/excerpts as this would assist with the identification of themes and later retrieval of verbatim quotes. The researcher read each of the transcripts several times and made manual notes on the scripts (a section of an analysed script is included as Appendix 9).

In her notes the researcher paid attention to latent content and made tentative interpretations in addition to attending to the explicit spoken words. For example, assume that a participant said: 'we had a family dog… no actually it was a cat… well really it was my dad's and not the family's… in fact I think it belonged to my mum'. In this instance the researcher would not only develop codes based on the explicit content (such as 'animal reference', 'reference to family' etc.) but would also interpret the latent material and develop codes for, perhaps, 'confusion' and 'ownership/belonging'. Thus TA was used in a flexible and interpretive way.

Each transcript contained approximately 300 individual excerpts which each linked to a number of sub-themes. The researcher therefore felt it important to develop a robust process by which to collate the information. When previously using Thematic Analysis methodology the researcher had hand-drawn diagrams connecting and interlinking sub-themes/themes, however the sheer volume of data in this instance led the researcher to develop an electronic spreadsheet. The researcher generated sub-themes inductively and after analysing six of the eight transcripts had recorded 520 sub-themes. It therefore felt an appropriate stage to pause and group together/refine the sub-themes before continuing with the final two transcripts. This decision was not only based upon the volume of sub-themes identified, but the researcher had noticed a significant amount of repetition starting to occur. 'Data saturation' such as this is reached when new information is able to be captured within sub-themes/themes already identified (Mason, 2010). Sub-themes were linked and merged until approximately 35 remained. At this point the remaining two transcripts were analysed deductively, thus enabling the researcher to test the inclusiveness of the identified

themes (i.e. if excerpts from transcripts 7 and 8 did not 'fit' into any of the identified themes, it would indicate either the themes were not robust enough, or that data saturation had yet to occur).

The researcher refined sub-themes further and carefully considered the names of themes before sharing the analysed transcripts with her supervisor. This triangulation helped to ensure good quality research as each of the themes and sub-themes were discussed and agreed upon.

4.6 Reflexivity

It is important in qualitative research to try and put aside personal values and beliefs so to minimise bias. While this process of 'bracketing' is crucial, Ahern (1999, p. 407) emphasised that to be totally objective 'is not humanly possible' (Crotty, 1996; Schutz, 1994).

In order to try and bracket her own values and assumptions, the researcher made use of a reflective journal throughout the research process (Aherne, 1999). The researcher used the journal to consider her motivations for conducting the research (i.e. why was she so interested in the field of attachment and parenting?) and to note her personal reflections on the material being discussed; particularly the impact such material had on her thinking and wellbeing (a selection of journal excerpts are included as Appendix 10).

5.0 RESULTS

5.1 Overview of the chapter

This chapter reports the results of the Thematic Analysis and is organised via theme. Each of the five superordinate themes are comprised of several sub-themes and Table

7 provides an overview. Each of the themes described here are illustrated via use of verbatim quotes and explored in detail in Chapter 6.

Table 7 - *Overview of themes*

Superordinate themes	Sub-themes
1. Love and loss	• Sudden death • Distance and spatial accounts of relationships • The loss of being mum • The absence of something • Belonging and attachment • Love and it's different forms • Rejection • 'Sweeping things under the carpet' • Hostility to parents and carers
2. Change and confusion	• 'I just didn't know what was happening' • Change and instability • Gaps in memory: dissociation and trauma • 'Years and years and years'
3. Families and normality	• Family structures • Parents and carers • Siblings • Role reversals • Forgiveness and resentment
4. Safety and boundaries	• 'I didn't know there was any rules when I was little' • Memories of abuse and maltreatment • Failure to protect • Splitting as a defence: 'The goody and the baddy' • Deception
5. Strength and vulnerability	• Protection and caring • Passivity and self-esteem • Choice and control • Unheard voices • Survival • Doing better: thinking about the next generation

5.2 Love and Loss

Sub-themes of love, loss and inherent rejection were present in each of the eight transcripts. While the AAI asks direct questions pertaining to experiences of loss, participants were found to spontaneously and repeatedly speak about loss throughout their interviews; before the concept had been introduced by the researcher. Loss came in many shapes and forms, including death, the loss of a relationship, the loss of closeness (psychological and physical), and participant's loss of role identity (as that of a mother). Love was spoken about in contrasting ways; namely the lack of it and the importance of having love in their lives. Related to both love and loss were the repeated experiences of feeling rejected; participants frequently described feeling dismissed, unsupported and not understood by their caregivers.

5.2.1 Sudden death

Loss came in different forms, ranging from permanent and sudden losses (such as death) which were often unresolved, through to more abstract losses; the life that could've been. Many of the participants had experienced the sudden death of a family member which they had either not been informed of, or had not been allowed to attend the funeral. It was striking that four of the participants used the phrase 'world was turned upside-down' when speaking of these sudden losses. Participants were often told of family deaths in ways which did not acknowledge the potential impact it may have on them and as such they did not know how to process the information:

"Madness… crazy really to know that we only had a few words to each other and then he's dead… I think it was quick but I… I hope he wasn't in pain and all that… I dunno they just said he was dead" (Hannah, p. 16 & 17)

None of the participants had experienced being told about the death of a loved one in a sensitive and thoughtful way, nor had they had the opportunity to speak openly about the impact of such losses on them. As such the participant's memories of the losses appeared traumatic in nature as they lacked any sense of closure or understanding of what had really happened to the person:

"Me dad said to me 'oh, your aunty Rachel's dead' and that was it… he made me dinner and I went to bed like normal and that… I didn't really know what had happened. That was it" (Hannah, p. 31)

"It came out of nowhere, he wasn't ill or anything" (Georgina, p. 31)

5.2.2 Distance and spatial accounts of relationships

The experience of losing connections and relationships with important people who had not died but instead were no longer around, was shared by each of the eight participants. The distance created either by geography or significant age gaps were frequently referred to and appeared to present a barrier to maintaining connected relationships. Participants often spoke about their sibings having their 'own lives' and felt separate from these:

"I've not had contact with [brother] for many years, he's got his own life. He doesn't know what I get up to and I don't know about him, that's just the way it is isn't it, he's a grown up" (Hannah, p. 3)

There was a general acceptance among participants that as they reached adulthood their relationships with their siblings changed and they were less involved in each other's lives:

"I'll phone [sister] occasionally but it always seems like she just doesn't …she's not interested in the same things so we haven't got much to talk about. She's into fashion and all that and I… I've got other stuff to worry about" (Emma, p. 4 & 5)

In response to the AAI question about memories of separation, participants spoke of being sent away to army boot camps, summer camps, and to live with other family

members. However, psychological separations were present in their narratives also whereby participants frequently described feeling emotionally distant from their parents, or as though they were kept at a distance from their parent/s:

"[mum] was always distracted by something else so I was sort of… I always felt like she was there and along her list of things, I was sort of there… there was always that sort of distance and I couldn't quite get close enough to have a relationship with her because she would put a lot of other stuff in the way… It was always 'shut up', 'go away', 'be quiet', 'go to your bedroom'… she didn't wanna talk to me, she just watched TV" (Emma, p. 15)

5.2.3 The loss of being mum

All of the participants had experienced having their children removed from their care and while some had their children returned to them, many of the children had been permanently adopted. Participants spoke about their loss of opportunity to get to know their children and feared their children would not remember them:

"I didn't get a lot of time with them … my first child was taken at 13 months, Kim it was only 2 weeks and Bobby was taken at birth… There's no photos of him so I don't remember what he even looked like and he don't know me" (Georgina, p. 27)

Debbie spoke in a matter of fact way which seemed to defend against her feelings of sadness at having her daughter taken away from her. It was perhaps her way of softening the loss in some way:

"I don't see [daughter] at all, but I didn't have that bond with her anyway, she was taken from birth. At the end of the day what can you do, you got to just get on with it haven't you" (Debbie, p. 61)

Another participant spoke about her sadness when her children were placed into foster care and while she tried to remain positive about the new opportunities her children now had, her sadness at being separated from them was clear:

"I hate it, I absolutely hate it… they've been gone for a year now and now I see them once a month… I get to speak to them every Sunday and I hate being away from them, I absolutely hate it… they've changed so much I don't know the things they like anymore, their personalities have changed. I know that sounds really horrible, I feel really horrible for saying it, but them being in foster care, they have got so many more opportunities that they are doing and I feel ashamed that I haven't been able to give them opportunities myself… but all the new things they are doing… " (Felicity, p. 26)

There were mixed feelings about loss and some participants seemed to connect to the loss more than others. It seemed important for Debbie to suppress her sadness in order to cope, just as Felicity needed to believe that her children were 'better off' without her. Reframing loss in positive ways was also seen when Lesley described experiencing early menopause:

"It's because I knew he was my last baby, I knew I wasn't going to have another baby and it gave me the opportunity to treasure all those memories, all those little things that I didn't have time because with the others I had three under 5's, so you do treasure them, but it's so intense, you know, the landmarks are coming in fast and furious, first day at school, first walk, first word… it is in some ways too much to have three children under 5, whereas with Jonny it was… I knew I was never going to have another baby… I could savour it, like having a box of chocolates, you know, there's been the bad times as well but it's a unique opportunity" (Lesley, p. 61)

5.2.4 The absence of something

Throughout each of the eight transcripts the participants spoke about a void where they felt as though something had been missing from their lives:

"I don't remember sitting and cuddling and… I don't remember ever having birthday parties… we never went anywhere. Boring was just the word of my childhood really in that there was nothing in it" (Emma, p. 8 & 9)

The presence of meaningful relationships, feeling connected to and wanted by a parent were also often lacking:

"I wanted a bit more out of her, like I knew there was something, lack of her inside … when I was younger I knew I was missing something but I couldn't quite understand what the hell it was at that age" (Hannah, p. 9)

Missing out on opportunities and positive childhood experiences were reported by each of the participants and in this respect, a mourning for the 'life that could've been' was very present:

"I wish that I was never born with those people, I wish I was born with a different mum and dad" (Amy, p. 4)

"[dad] should've got custody of me not her, I would've had a better life" (Rosa, p. 19)

5.2.5 Belonging and attachment

A common sub-theme was a sense of belonging. The participant's described their need to feel they belonged somewhere, however often reported feeling confused

about where they belonged or lacked any sense of belonging altogether. This was seen when they spoke about the concept of 'home':

"I wasn't really wanted, you know, It was like implanting a stranger in someone's home, that's what I was, that's how I felt, it never felt like my home ever because the first time I tried to run away I was about 10 and it was only when I ran off to Nottingham which was the closest city and then I realised that there was nothing I could do, I couldn't go anywhere… there was no one to go to, so I was trapped and it was just… that was when I decided that I would have to wait until I was older, old enough to run away" (Lesley, p. 30 & 31)

"I never felt like I belonged at home, never felt it. I was treated totally different, I could be a kid at my auntie's but I couldn't be a kid at home, I had to be quiet and that's not good for a kid" (Rosa, p. 21)

The range of loss experienced by the participant's impacted upon their adult lives with the most painful experiences of loss involving a deep sense of love for the person.

5.2.6 Love and its different forms

The concept of love was frequently referred to by participants as they considered the different ways to show 'love'. The majority of the participants described their parent/s being emotionally unavailable yet attending to their basic needs such as food and shelter; they felt this was their parent's way of showing love:

"My mum was there for us and loved us and all that but on the emotional side, she wasn't there for our emotional needs and nor was my dad. She was always there to make sure we were bathed, you know, clean clothes, food in our bellies, she would starve for us my mum would" (Hannah, p. 10)

Other ways of showing love were thought to be ‘control’ and experiences of domestic abuse in the participant’s adult relationships were common:

“All the domestic violence I’ve been through, I thought that was love. He said he cared and that’s why he did it but I don’t know… he’d say sorry and things would be fine again, all back to normal” (Hannah, p. 26)

Less frequently described were more affectionate and tactile relationships where love was present. The occasions when affectionate relationships were referred to were both rare and moving:

“I used to sit on me grandads knee and play with him and kiss him and hug him and he used to always tell me he loved me” (Hannah, p. 22)

Often these accounts involved a member of their extended family who served as a protective figure, for example a grandfather or uncle. Their descriptions were akin to idealised images of ‘knights in shining armour’ who appeared at their time of need to try and rescue them:

“He started hitting me because I had been sick because I had been made to eat something I didn’t like and that was one of the few times anyone in the family ever stood in and my grandad kind of went ‘that’s bang out of order’ but my dad just buggered off to the pub” (Lesley, p. 29)

“I would go off on my own, there was no one I could trust to turn to it was like I was bullied all the way through primary school and I was frightened all the way through primary school but there was no one I could do anything with because Bruce had died by this point. I was probably about 8 or 9. He was, I loved him to bits, he was the only person who ever gave me affection. When he was ill, he had had a stroke

and I used to go up to the hospital to visit him and it was just… he was already gone, there was no Bruce left. I didn't know it until later on but he had actually argued with my dad on a number of occasions and my dad had beaten him up because he was sticking up for me" (Lesley, p. 37 & 38)

By all accounts the protective figures had tried to provide nurturance and keep them safe from danger (the danger often being their own parents):

"Uncle Bob always took notice, always, and I was so close to him, it was like he was my dad, it was like he give me the love what I was lacking" (Hannah, p. 29)

Experiences of unconditional and enduring love was reported by only three of the participants. In these accounts qualities such as 'non-judgemental', 'interested' and 'protection' were valued:

"I know that [mum] loved us and she still does… I don't think that she's ever stopped loving us, I think she loved us from the day when we were born" (Hannah, p. 7)

"[husband] took me as I was, he knew what I was like as a person, he knew that I'd been through a lot of domestic violence and he knew I done therapy and he could see a change in me… its like he didn't judge me because of my past… he didn't judge me as that person like social services did" (Hannah, p. 39)

Positive experiences of feeling loved, both in their child and adulthoods, was rare and indeed longed for. When asked about their wishes for their own children's futures, many of the participants wished for their children to have 'love' in their lives:

"A decent job and to know that he is loved by me, emotionally 100%... always put your children first, not a man, and always protect them… be there emotionally as well as love them, be there 100%" (Hannah, p. 42)

5.2.7 Rejection

A dominant narrative for the participants was one of seeking love from a parent and being met with rejection. Almost all the participants reported feeling unwanted as children and reflected on the impact this had on their adult lives:

"[mum] was talking to me, saying that she never wanted me in the first place and said I was a fucking pain, sit there and watch TV, I wasn't allowed to play with toys much because of the noise, she's still the same now with the grandkids… I never got love and never got hugs, never, now that is what I struggle with… I show it in other ways, I can't physically do it because I wasn't shown it so I how am I supposed to do it" (Rosa, p. 22)

Participants described feeling unwanted as children and as if they had been a hindrance to those caring for them:

"Thinking about it as a grown up I didn't really know [dad] that well because he was hardly ever there, but I suppose he was quite similar to my mum in a sense… like on the weekends dad would have to look after us and he'd go and dump us at his parents' house and go and play golf or he would go and play cricket and we would have to just sit on the side, or he would go fishing and then we would just sit on the side. Mum saw us as a burden really… I think we stopped her from having a life that she wanted to have and I think we just got in the way" (Emma, p. 16 & 17)

Participants described their childhood desire to feel loved by their parents and their subsequent confusion and despair when they did not receive it:

"I tried so hard when I was young to get her attention and to get her love and I think I reached a point where I just thought actually this is never going to happen. I just felt very unwanted, there was no… I never had the feeling of being wanted by either of my parents, you know, they shouldn't have had me" (Lesley, p. 44)

In addition to feeling unwanted several of the participants reported feeling blamed by their parents for family disputes, marital discord, and on occasion, for simply existing:

"She used to say 'after I had you I put on loads of weight so it's your fault I'm fat' and I would think, charming. I've had five children and I'm still a size 10 so I know that's rubbish what she's saying. She just likes to blame me for things" (Felicity, p. 18)

One participant spoke with resignation when she explained that her mum had persuaded the rest of her family that she was to blame for the breakdown of her parent's marriage:

"They all hated me thinking I had broken her marriage up… and it's never been the same, they don't ask about me, I don't visit them, I'm the black sheep" (Rosa, p. 7)

Feeling in the way, rejected, and ostracised by family members had caused many of the participants to feel abandoned as children and as if they had to fend for themselves:

"When I was 7 my dad got a job and a neighbour had a backdoor key so we would, James and I, would let ourselves in and stay at home together until whoever it was came home" (Lesley, p. 43)

5.2.8 Sweeping things under the carpet

For those whose parents were present, a sub-theme of critical and dismissing parenting emerged. Interestingly, three of the participants used the phrase 'sweep things under the carpet' when describing their mothers:

"She liked to believe what she thinks and sweep everything under the carpet… she never believed me or whatever I said" (Debbie, p. 12)

"[mum] don't know how to handle that side when you get upset, she would brush it under the carpet and say 'oh pull yourself together'" (Hannah, p. 8)

A further sense of rejection came from feeling excluded from dyadic family relationships, often involving two parents or a sibling and parent:

"I'm the black sheep really, they are more there for each other because they are real siblings, I am only a half, and two's company three's a crowd and that's just how I feel" (Rosa, p. 7)

"[dad] would come back and have his dinner then it was mum and his time wasn't it. Me brothers and me would go upstairs and be quiet, not go to bed, but not downstairs" (Debbie, p. 24)

5.2.9 Hostility to parents and carers

Over half the participants expressed hostility towards a parent and in this respect, the parents were the ones who became rejected:

"I just really didn't like [mum], I thought me and my dad would be better off without her… I'd make me dad cups of tea and wouldn't make me mum one" (Felicity, p. 8)

"[mum] gripped me up and I beat her, one punch and clean out, so… it wouldn't bother me in the slightest because she's my mum, she's like anybody really" (Debbie, p. 45)

5.3 Change and confusion

Many of the participants described feeling confused in their childhoods. They reported lots of changes with little understanding of the reasons why things happened as they did:

"Deluded house what I was brought up in… I was so confused, I just didn't know what the hell was going on" (Hannah, p. 13)

5.3.1 'I just didn't know what was happening'

The majority of participants described a sense of confusion which they experienced as children. Seven of the participants repeatedly used the word 'weird' to describe experiences which had not made sense to them, and other words such as 'bizarre', 'mad' and 'strange' were used as punctuation. There was confusion regarding who people were and what their intentions were, along with a sense of not knowing how to think or behave:

"She started an affair with a guy who later became my step-dad when I was about 9 and I didn't really click, I think I was a bit dim actually and we even went on holiday

with them and it never occurred to me they were having an affair, but she told me one thing… I remember her telling me never say anything to your dad about it so we'd go on these holidays and I didn't really know what to think" (Lesley, p. 9)

"I met [dad] when I was 14 on a bus quite strangely" … "It was weird because my little brother, who I didn't know was my little brother at the time, he was calling him dad and I was getting really upset because I was thinking 'I don't understand', and I have just seen like I've got this dad and this kid calling him dad and it was all very emotional" (Emma, p. 5).

5.3.2 Change and stability

Two of the participants' fathers had been in the army and they each described their childhoods as regimented whereby routines were followed such as set meal times and they visited grandparents the same day each week. On the whole however, participants experienced a lot of change and instability in their upbringings:

"I was back and forth like a yo-yo, one minute I was living with my mum, then I fell out with my mum so I came back to live with my dad, I fell out with them lot down there and then come back up so I had 2 homes, I was back and forth like a yo-yo" (Debbie, p. 58)

"I just had friends who I knew for a few years and then moved on again… it wasn't nice but you just have to get on with it … we moved around a lot" (Georgina, p. 28)

Participants often had not understood the reasons why their living situations or family membership had changed. Some participants reported a type of catalyst or trigger in bringing about change:

"The catalyst came to me when I was about 12 or 13 and I was at high school and I had never really had many close friends anyway because you couldn't bring anyone to your home because my dad could kick off so you never had visitors or anything like that and I was talking to some girls and they were saying about their fathers and I had been to one of the girls' houses so I suddenly had burst of what a normal family was like and none of them believed me, they thought I was making it up and it was… it took… I say it was the catalyst because I suddenly realised that what I was experiencing wasn't right" (Lesley, p. 21)

The catalyst for change or understanding the reason why things had changed was not always clear however and this added to the participant's sense of confusion:

"It was like a switch had flipped, he didn't really want to be with me, avoided me, started making more and more excuses… I didn't get it really, he was just distant" (Lesley, p. 51)

Changes within relationships were frequently referred to, particularly mood fluctuations and unpredictable responses of parents:

"It depended on how much… depending on his hangover for starters, depended on his mood… the worst ones was the ones completely out of the blue because I might not even have done anything and it just be 'coz he used to" (Lesley, p. 23 & 24)

"When I went home after school it came to the point where we were too scared to ask for a loaf of bread for how much [mum] would kick off. Sometimes she was fine, but then there were the other times" (Rosa, p. 16)

While change in the participant's childhoods was often reported in a negative way due to the lack of clarity and understanding, participants reported some changes in their

adult lives in positive ways; particularly in relation to personal development and progress:

"I never used to until I started therapy, I used to go and beat people up and then I got warned that one more time and I would go to jail and so I stopped and I just used to punch the hell out of doors and things like that, but I don't even do that now, I cry" (Rosa, p. 28)

5.3.3 Gaps in memory: dissociation, trauma and amnesia

While the AAI encourages memory recall, many of the participants referred to memory changes over time, with some memories being lost or 'wiped out':

"I don't know what went on after that, then all I knew was basically I spoke to my mum and dad on the phone, I don't know about what, and then I think my brother died, then I came home so I don't remember every little detail and feelings and stuff, one minute I was there, one minute I wasn't" (Debbie, p. 38)

Some memories were difficult for participants to recall and suggested there was an unconscious need for them to 'forget' details, particularly those related to painful memories:

"I don't have much memory because, I think… I don't know… I think I just sort of wiped my memory a little bit" (Emma, p. 7)

Participants displayed memory disturbances when recalling childhood traumas, but also as adults when their children were removed into care. At these times participants appeared to either remember the minutia of the event, or alternatively block out memories related to the time when their children were removed:

"I had two boys… I think they were about 2 and 3 maybe when they went I think… I don't really… because back then I wasn't a good mum and I don't really remember stuff really so…" (Emma, p. 21)

5.3.4 'Years and years and years'

Perhaps as a response to the changeable nature of memory, there seemed to be a common theme among all of the participants which was one of needing to be certain about timescales and chronology. While describing their childhoods, many of the participants paid a great amount of attention to exact timings and ages:

"For years and years and years… when I was 16 … not long ago my dad died and then about 3 months afterwards, 4 months after, my grampie died…about 3 years ago now… when I was 12 erm… dad and mum was going to court from when I was 10 to get access… dad kept threatening mum all the time" (Hannah, p. 33)

While the participant's attempts to be exact about timescales may have been related to anxiety and a desire to answer questions 'correctly' and thoroughly, there was a sense that the amount of detail provided was an attempt to make sense of their confusion, organise their memories and fill in the gaps in their narratives.

5.4 Families and normality

Participants frequently referred to a concept of 'normal' when considering their own and other people's families. In Western culture 'normal' was once considered to be a '2.4 family' with two heterosexual parents and (2.4) biological children making up the nuclear family unit. Over time however western family structures have changed to include step-parents and step/half siblings, same sex parents, single-parent families, and adoptive parents/siblings all being considered 'normal'; or at least, not unusual. Indeed some may say that non-nuclear families are the new norm in Western culture. Social discourses surrounding 'normal' families dominated the participant's accounts

and appeared to provide them with a baseline by which to measure the extent that their own family deviated from the norm.

5.4.1 Family structures

Seven of the participants described complicated family compositions often involving the arrival of step/half siblings, step parents, and extended family (such as aunts and grandparents) taking on the parental role. One participant described a traditional (perhaps idealised) family Christmas where all the family congregated at her grandparents' house each year, however she later described being sexually abused by her brother and having a child by him; thus even the most 'normal' sounding family lives appeared to contain a degree of disturbance.

Finding out that a parent was not their biological parent was not uncommon among the participants:

"We called him dad from such an early age I just presumed that he was my dad, but I think about the age of 8 or 9 they told me that he wasn't my dad and that I had another dad somewhere out there" (Emma, p. 1)

Similarly unusual living arrangements were commonplace among the participants:

"My dad, my mum and my step-dad all live together in the same house… it works for them so it's up to them isn't it, I find it a bit peculiar" (Debbie, p. 6)

In contrast to the chaotic family experiences the participants reported, many of them shared that their wish had been to start their own family where they could be in charge of the membership; their hope being to create a 'normal' family:

"That is why I had my daughter, to get out" (Rosa, p. 15)

"I married him so my boy had a dad. He adopted him so it's written down and my boy can say he's got a dad now. All boys should have dads… obviously I love him to bits, but I don't take him to football and stuff, his dad does that" (Amy, p. 13)

5.4.2 Parents and carers

Participants often spoke about 'sides' and 'size' of their families, as well as commenting on their family's functioning:

"I've got a big awkward family" (Emma, p. 7)

A widely held view among the participants was that parents should want the 'best' for their children and should keep them safe. Two of the participants reported feeling loved and protected by their fathers, and one participant aspired to be like her mother. Overall however there were many negative experiences of being parented whereby participants had not felt loved, nurtured, nor kept safe as children. Subsequently this shaped the participant's views about parent roles and appeared to affect their own parenting style:

"She's her and I'm me… I do my parenting almost on the complete opposite of my mum's 'coz I'm not like her… I don't wanna be" (Emma, p. 24)

"I want to be better than them [parents] that's why I… really, just never be like them. Always put your kids first… keep 'em safe that's it really" (Rosa, p. 29)

Parental roles were not always held by the parents. Grandparents were frequently described as taking on a parental role, providing food, affection and instilling boundaries:

"I was close to nanny, I used to go and stay there at weekends" (Rosa, p. 6)

"I was really close to my nan and grandad… My nan always loved us and looked after us with food and things, but my grandad was a bit more affectionate towards us kids… he would say 'OK you can have one biscuit' and I used to have only one because that was all we was allowed to have" (Hannah, p. 21 & 22)

"If I needed help I would go to grandad because he knew everything" (Emma, p. 17)

In addition to the important role often played by grandparents, many of the participants had experienced parent-like involvement (such as the provision of care, decision making and setting boundaries) from systems such as school, police and Social Care; in this respect there was a sub-theme of 'institution as parent':

"I had to be supervised and all sorts… the foster carer has to take Tamara out on school runs in the morning and I get really really annoyed by it… but it's what's been imposed by Social Services" (Georgina, p. 36 & 37)

"His developing and interacting and everything else is down to them [Social Services], him learning, his learning difficulties is nothing to do with me, it's them, they have to sort it not me. I lost that right they took it from me so they can sort him out now" (Debbie, p. 63)

5.4.3 Siblings

Siblings were frequently referred to outside of the AAI questions pertaining to family structure. A pattern emerged whereby siblings (whether full/half/step) were viewed as either friend or foe; providing care and protection that was otherwise lacking or being the favoured 'blue eyed' competitor:

"I was very protective of [brother]… we were very very close, if someone hurt him I would hurt them… One time my brother was crying and I said what's wrong, and he told me this kid was being mean to him at school and I said well I ain't letting that happen you know… I used to look through the railing to try and scare the boy 'coz you don't want your little brother being scared" (Lesley, p. 6 & 7)

"Even though I didn't have the best childhood, I did have my sister and she sort of knew how to look after me" (Emma, p. 16)

"When I heard her crying I knew the cry, I had been through it and I just needed it to stop because that was my sister, so I saved her really, it don't feel that way but I did… I made their dinner and looked after them more than mum did, she was drinking and it was me that was there for them, not her" (Rosa, p. 30)

Feeling like a disappointment to parents and regarded as the 'black sheep' was not uncommon and many of the participants described feeling that their sibling was favoured and given preferential treatment.

"[mum] let my brother get away with murder, definitely favoured my brother… like my brother… he would always blackmail me into doing his job and my job and she would always know when I done the job that he was supposed to do, because he would just like shuffle papers on the table whereas I would dust, polish and hoover, do it all properly and he didn't, so she'd always know that it was me that had done it and not

him, but she wouldn't say anything, she'd just leave it. I didn't trust her at all, I don't know I just didn't like her, she wasn't fair." (Felicity, p. 6 & 7)

"I had a very big sense of rejection, not necessarily from my mum but she would tell me that my real dad didn't want me because I was a girl, and obviously I come from a lot of brothers so she was always telling me that, so my sister at that age was what I used to call the 'golden child' and she still sort of is… she can't do any wrong, no one sees any fault in her. I can see lots of fault in her, but no one will ever see that, whereas everyone can see the fault in me and a lot of the family see me that way, even though I've grown up and changed… a lot of people still look at me that way." (Emma, p. 15)

5.4.4 Role reversals

Role definitions such as parent, sibling and child were not straightforward, and often role reversals were present in the participant's narratives. In particular, half of the participant's gave accounts of 'growing up quickly' and having to be responsible for others, often taking care of their younger siblings:

"[mum] used to go to work full time and I would be there to bring up her two kids that she had… I brought up my sisters to stop them going in care" (Rosa, p. 14)

Participants described times when their parents had been unable to parent them and had taken the role of child. Some participants described feeling as if they had become a parent to their own parent. One participant described her mother regressing and being cared for by her grandparents; the participant reflected on how she had felt "lost" not knowing which 'role' to be in; parent or child:

"*My mum regressed a little bit I think… she went back to being a child rather than a parent and she started to rely on her mum and dad for everything… she lost her*

house and she's now living with her mum and dad, she's got no money so she has regressed very much… she is like a child again" (Emma, p. 19)

"I didn't really feel close to [dad] but it was more like going out with a pissed up friend to be honest because that was what he used to do, get pissed and eat curry… it was very weird, it was really really weird and I never kind of felt really comfortable with it… and my mum… it makes me feel a bit uneasy because I'm not used to having a relationship with this person… this person isn't really… this is my birth mother, not really had anything to do with her, don't know much about her life, not really interested and it's been mutual… the only time she ever bothers with me is if some crisis comes into her life." (Lesley, p. 32 & 33)

In addition to care giving, protection roles inherent in parenting were frequently held by the participants as children. Three of the participants described times when they had been children and had needed to protect one of their parents from the other:

"[dad] tried raping my mum one night, in the bedroom, he locked her in and I hear my mum crying, and I tried to get in the bedroom to try and help her, and I was only about 5 or 6" (Hannah, p. 11)

Traditional parent-child, care-giver and care-receiver roles had been skewed for many of the participants and some of the participants reflected on how this had affected them as parents, in particular they commented on current role reversal processes they noticed with their own children:

"I feel [my son] has had to take on too much of the male role over the last couple of years which, you know, does worry me because I wasn't well enough to be able to… I am a lot better than I was… at one time I wouldn't go out in public at all… I'm a lot better now but I've got a long way to go. Sometimes I feel like a complete failure as a parent, I've got a daughter with mental health issues, I've got a child who is

suspected of being on the autistic spectrum… I have got Elsa who is a monster child… " (Lesley, p. 59)

5.4.5 Forgiveness and resentment

Several of the participants introduced the concept of forgiveness in relation to feeling let down by parents. Three participants appeared to have made sense of, and forgiven, their parent's behaviours:

"[mum] had to work long hours so she could pay the rent… pay for things that I wanted so I know she worked hard even if she wasn't always around" (Georgina, p. 6)

"[dad] hasn't been around for me but she didn't let him so it's not his fault and when he could be around he was" (Rosa, p. 19)

One participant was able to make some sense of her mother's behaviour, however in her mind she had equated forgiveness with exemption and thus felt conflicted:

"My mum just had a pretty shit life with her mum so I can kind of see… I can kind of understand but I just don't think it is an excuse enough for the cruelty or the emotional neglect" (Lesley, p. 46)

Others felt wholly unable to forgive their parents for their upbringing and appeared rigid in their reasoning:

"I just can't get on with her, I can't, you can't forget unless you forgive now I can't forgive, I can't forgive [mum] for what she done to me… what she put me through, too much to forgive… I won't forgive her because you should keep your kids safe… I

just feel that our relationship is complicated, no matter what I try I just can't, I just can't, the scars are there and they aint gonna go away" (Rosa, p. 13)

5.5 Safety and boundaries

All eight participants reported feeling unsafe throughout their childhoods. For many this was as a result of suffering direct abuse; and not feeling protected from the abuse. Violation of their personal boundaries was common and many reported not understanding what boundaries were. With abuse and a lack of protection came a difficulty to trust those who were in a caregiving role and deception was a sub-theme which all participants related to.

5.5.1 'I didn't know there was any rules when I was little'

Participants had experienced multiple boundary violations where they recalled boundaries being pushed, crossed and not upheld. While some boundary violations were considered to be less serious, for example a parent saying one thing yet enforcing something different, the result was that participants reported having felt unsure of what was acceptable and accepted behaviour:

"We always got grounded and an hour later we were allowed out… it depends if we were naughty and got caught for it, that's basically it isn't it… you'd get grounded and that didn't last very long because mum couldn't stand the sight of us. We would moan and everything else and then we would get on her nerves so she would have to let us out" (Debbie, p. 45 & 46)

"I say 'dad give us a tenner' he says 'right' and gives it to me, he's not the kind of boundaried person that tells you off, he's not like that, he's not strict, he's not strict at all" (Debbie, p. 26)

Two participants reported feeling as though they had never had any boundaries set by their parents and said they had not understood about rules:

"I didn't really follow the rules I suppose but I didn't know there was any rules when I was little" (Lesley, p. 10)

While boundaries generally remained unfamiliar and unclear for the participants as children, some clarity was gained over time whereby participants described learning how to behave around their parents for fear of punishment:

"I learnt after a while that you don't try and talk to mum when the TV was on and you don't mess around when dad was home" (Emma, p. 15)

Two of the participants described the lack of boundaries causing them to become fearful as children, the other six participants described pushing boundaries to try to see what they could "get away with". Some described pushing boundaries to such an extent that they became unmanageable to look after:

"I went into care because my mum and dad couldn't look after me, because I was a wild child… I got suspended and beat up a girl you know, I just laughed it off so you know my feelings probably just came out in a different way. I got suspended and beaten up… beaten up this girl and then I had a go at a teacher and threw my bag at him, so I was really destructive… really destructive" (Debbie, p. 19 & 20)

Participants reflected on the impact that boundaries (both lack and violation of) have had on their adult lives:

"I'm quite into my own physical space because of that, I don't like people encroaching on my area, it's just bizarre as far as I am concerned, it's alien, I think that is a better word" (Lesley, p. 35)

In particular the participants reflected upon their ability as a parent to enforce boundaries with their own children:

"I guess I have been a bit lenient. I don't want to hurt them, don't want them to hate me, don't want to upset them because of all the emotions of when I was younger, it does affect me a bit, I should've been tougher with them because they are little brats but how can I when I don't want them to feel like that" (Rosa, p. 29)

"It's really hard because I love them all to bits and I would never give up on my children but there have been times when I have really wanted to kick Elsa out, she's the 16 year old… she smashes up the house, you know, done some horrendous stuff, but I… I find it virtually impossible to do… I can't tell her off" (Lesley, p. 60)

5.5.2 Memories of abuse and maltreatment

Multiple serious boundary violations were reported by seven of the participants and often involved intra-familial violence and abuse; and in the case of two participants, incest.

"I got abused by my brother didn't I… my mum didn't believe me… she beat me. I told this friend, the friend told the school, the school told the police, the police informed my mum and then I had to do this video thing in a little room to say what happened… mum didn't believe me and when I got home she hit me, she hit me in the back house where the two dogs were" (Debbie, p. 18)

Many of the participants grew up in violent homes where they were subjected to and/or witnessed domestic violence:

"I remember mum and dad used to have severe fights" (Amy, p. 2)

"I used to go between the sofa and the chair in the living room and put the chair over myself, so I could block out the noise what was going on in the background between my mum and him and in the end it was that draining that I actually fell asleep… that chair, it was my shield, my protection. I hated him, didn't understand why he was being so nasty towards my mum and myself, scared me he used to, with his voice, and I see him beat up my brother at times as well… on a regular basis and my brother used to… he had a bedroom door but it was slats and he used to kick it all in… my dad would beat him up and many times my mum would try and stop him but she got the same, I think it was quite abusive " (Hannah, p. 12)

Often the abuse was from a young age and six of the participants recalled being physically assaulted by one of their parents when they were very young:

"I know I got battered when I was a baby and when I was 3½ I was sexually raped, I remember everything about it" (Amy, p. 1)

"My first memory was fear, my dad was an alcoholic and quite violent, and one of my first memories of my father is I was in my cot so I was probably about 2, maybe a little bit older, erm… and I needed a wee so I decided to climb out of my cot to go to the toilet and he caught me out of my cot so he beat me" (Lesley, p. 3)

As a result, many of the participants described feeling afraid of their parent/s and permanently "on tenterhooks":

"I was equally scared of mum and dad, I didn't feel safe" (Amy, p. 4)

"I was terrified of [dad] so you keep your mouth shut when you are frightened…it was the only way to vaguely stay safe. I remember being at nursery or pre-school or whatever you call it and then I would walk myself home and he'd be there, then erm… and then while he [dad] had his sleep I would have to lie on the bed next to him and theoretically have a sleep but I wasn't allowed to move… he was very aggressive and very grumpy because he'd been drinking" (Lesley, p. 18 & 19)

The amount of detail which some of the participants could recall about being assaulted as a child, was striking. Interestingly, participants frequently referred to their father's hands, describing their size, feel and strength:

"He was a big strong man doing that to a little child. He used to hit me a lot around the head with his hand, he had big hands… literally raised his hand and slapped me… he would just get bored or his hands would start hurting so he'd stop" (Lesley, p. 25)

As well as bare hands, participants often reported their parents using "weapons" such as belts and straps to assault them with:

"He would always smack my sister with the wooden ruler across the back, but when I got told off I always got smacked with the metal ruler" (Emma, p. 11)

"We got hit by spoons and all sorts" (Debbie, p. 12)

When describing the violence they experienced in their families while growing up, several of the participants tried to make sense of their parent's aggression; often detailing generations of family violence:

"My mum's mum was violent as was her older brother and my dad's dad went to jail for committing incest" (Lesley, p. 46)

While physical abuse was frequently reported, sexual abuse was not uncommon; also perpetrated by a family member:

"It was just pure abuse, same as my mum, it was physical, sexual abuse too he was horrible, I try not to remember about him… horrible, there is nothing else to say about him he was horrible, erm, horrible, poison… sick human being, seeing all that stuff on TV, I have to turn it over because it brings it all back, it's horrible" (Rosa, p. 18)

Other types of abuse, such as emotional abuse were rife throughout the participant's narratives and frequent accounts of being teased and humiliated by a parent were concerning and felt sadistic in nature:

"My dad would always cut off any black nasty gristley bits… always came to my plate I was made to eat stuff that I really didn't like. One time I won a goldfish from a fair and I was ever so pleased because it was the first pet I had, [dad] was pissed and knocked it over and killed the goldfish, erm… and as a joke he put the goldfish in a slice of bread and offered it to me" (Lesley, p. 28)

"[dad] used to tease us with them… he used to put a sweet in his mouth, he says 'if you want this you have got to get it out of my mouth'… he used to do spiteful things" (Hannah, p. 13)

5.5.3 Failure to protect

Participants frequently described feeling unprotected as children and it was not unusual for harm to be caused by those who they were seeking protection from; their parents:

"They used to go out I used to get babysat by the one that was in with my step-dad, with the nastiness, so it was just horrible… [mum] was an alcoholic and going to work full time and bringing men back to the house and all pissed up and that, that's just putting us at risk again… I would hear things that kids shouldn't hear" (Rosa, p. 15)

"Me dad come round and started on me in the street… mum was at the window and she couldn't even be bothered to come round and help me to get him off me" (Hannah, p. 14)

Transgenerational patterns of parenting were alluded to whereby some of the participants made links between their experiences of being parented and their experiences of parenting their own children, particularly their difficulty in protecting their children from abuse:

"My mum failed to protect us… I failed to protect my kids, I couldn't give my kids… or meet their emotional needs because mine wasn't met when I was a child, failed to protect through domestic violence, my mum failed to protect through domestic violence and brushing things under the carpet" (Hannah, p. 28)

5.5.4 Splitting as a defence: 'The goody and the baddy'

A culmination of dissociation and 'cutting off', as well as a pervasive sense of emptiness, appeared to manifest in despair. Participants described having resigned themselves to their adverse situations as children because they had felt unable to change their situation:

"I would just take myself off to bed, there was nowhere else for me to go, I wasn't going to get any family support… I just always felt on tenterhooks 'coz you know you can make yourself very small trying not to be noticed and I would just try to stay out of his way completely" (Lesley, p. 27)

Seven of the participants described the emotional pain associated with the lack of protection and safety they experienced in childhood and reflected upon their need to protect themselves psychologically by emotionally cutting off. This was observed via splits in their narratives, often regarding things as 'good or bad' or 'black or white':

"Mum was strict and dad was soft… you got the goody and the baddy, my mum was the baddy… there's always a goody and a baddy to some extent" (Debbie, p. 28)

"My parenting is the complete opposite… It's like the sublime to the ridiculous, like there was no middle path… I didn't really know how to parent so I kind of let my kids do stuff that I probably shouldn't have done" (Lesley, p. 50)

5.5.5 Deception

Deception was a sub-theme introduced by most of the participants and many had experienced having lies told about them:

"My sister was spreading rumours round that I beat up my kids and stuff and that's why they got took from social, but it wasn't that at all… my sister's a nasty piece of work" (Hannah, p. 37)

Participants frequently reported family members being deceitful and breaking their confidence:

"I don't want to talk to my mum about things that are on my mind… I need to talk to someone about it but I can't trust her. Like with my surgery, I told [mum] not to say anything to my sister and she went and told her straight away… she knew straight away, and when the boys got taken into foster care I actually didn't say anything to anyone until the week before they were taken, and when I eventually told my parents I told them not to say anything and my dad didn't say anything, but my mum went and told my sister and my sister told her friends, and told her boss… I don't trust my mum" (Felicity, p. 25)

Participants often reported being privy to family lies and described the moral conflict this caused for them:

"[dad] ripped my aunty Rachel off …he said he wanted to buy a car for us as a family so he can take us all down the seaside, and my aunty Rachel gave him the money and he never bought a car, I don't know what the hell he did with the money" (Hannah, p. 31)

"I went downstairs once and saw [dad] with another lady on top of a pool table, kissing her and stuff… [sister] tried to shove me out the way and I said 'why is daddy kissing that lady?' and I don't even know what the answer was but when I got home I told my mum, I said to my mum 'I saw daddy at work kissing a lady on a table' and my mum was like, 'oh yeah most likely his friend' and she tried to brush it under the carpet because she didn't want to come out and say, but I knew, I knew something wasn't right… he had loads of affairs there with women" (Lesley, p. 21)

Witnessing infidelity among their parents had not been an unusual experience and half of the participants had caught their parents having extra-marital affairs; and subsequently been encouraged to collude in the secret:

"My mum had half of where we used to live, half the men in the village, they used to come back with her for it yeah, and I caught mum and told dad… she used to bribe me, give me money for the shop to stop me saying anything, yeah so basically, she didn't keep her knickers on… my brother caught her as well up against the kitchen sink… basically my mum was a whore, do you know what I mean" (Debbie, p. 16)

The participants reported that the result of such deception meant that they found it difficult to trust their parents or families, and were generally untrusting of most people:

"I didn't trust either of them so I had no more belief in one more than the other and I knew they were both capable of lying" (Lesley, p. 33)

In contrast to the deception which many of the participants had grown up round, as adults they appeared to privilege truth and felt it important that their truth be known by others, especially their own children:

"I will always make sure my children can tell me anything and I won't say anything to anyone about it, if they tell me something in confidence I will not break that confidentiality, I will keep it confidential… I won't lie to them, I will be honest with them 100%, if they ask me a question, I will tell them the truth… yep, I will not hide anything from my kids… if they ask me a question I will answer it honestly" (Felicity, p. 20)

"When [children] are older I'll explain my side because there's always two sides to every story" (Debbie, p. 61)

5.6 Strength and vulnerability

The participant's narratives were saturated with reports of feeling vulnerable, rejected, abused and victimised, however alternative stories related to protective figures in their

lives were occasionally present. A beautiful (and symbolic) illustration of this was captured by Hannah's account of colouring in dragons and angels; while colouring the 'dangerous' dragon her (protective) uncle drew a fence round it:

"At infant school I was in a competition and they gave us like… posters or pictures, I picked out this dragon and… if our posters got picked we win a prize… so I coloured it all in and my uncle Bob come round… he come round and he always took notice, always, I was so close to him, it was like he was my dad, it was like he give me the love what I was lacking with my father and he said 'what are you doing there Hannah?'… and he helped me… he sat there for ages helping me… put all this fire coming out of his mouth and a gate fence thing round the dragon, it was amazing, we both done it together and I won, I won I did… and when I see my uncle I told him and he was jumping for joy, he picked me up and hugged me" (Hannah, p. 29)

5.6.1 Protection and caring

Almost all of the participants described at least one protective figure in their lives; for two participants it was their dad, for others their grandads and uncles, and one participant described the role that the church played in their childhood:

"[step-dad] was an absolutely lovely man… him and grandad were the two people that I absolutely… just really genuinely nice people" (Lesley, p. 13)

In addition to 'safe' people, almost all of the participants referred to feeling safe when they were around animals, particularly dogs:

"It felt like being with [grandad] and [dog] was the only safe place I ever had" (Lesley, p. 39)

"We used to go up the shops together, go out and have fun with the dogs" (Felicity, p. 22)

"I remember the dog specifically because I loved the dog" (Georgina, p. 7)

The presence of animals in the participant's childhoods appeared to encourage a shift from being in need of rescue to taking on a 'rescuer' role of those more vulnerable than themselves:

"I always took stray dogs home… If I ever won the lottery I'd buy a big rescue place and take all the animals that need it and look after them" (Rosa, p. 42)

The various helpful aspects of having animals around appeared to continue into the participant's adult lives and many spoke in detail about their love for their animals, particularly their ability to trust them:

"It takes a long time for me to trust someone, animals I trust them straight away" (Rosa, p. 42)

5.6.2 Passivity and self esteem

In the absence of protective figures, many of the participants had felt vulnerable as children and described feeling helpless and overwhelmed:

"The beatings were still going on for me and I just thought, you know what it doesn't matter what I do he's going to hit me anyway" (Lesley, p. 21)

"I felt very sad, very very sad, I felt bloody drained… I just couldn't cope, couldn't cope anymore" (Hannah, p. 36)

The participants reflected upon the impact their vulnerability in childhood had on their adult development, often feeling powerless, miserable and lonely:

"I was so miserable being married to him… I was so unhappy, he was completely in control and in charge of everything… Sometimes I feel quite sad because it's… I kind of almost accept that I am going to be on my own for the rest of my life… that's not always nice but I can't trust myself to pick a man and I just can't do that, I just can't do that anymore, yes it hurts sometimes when I see friends with their partners, but… I've been lonely all my life and it just feels like I am always going to be lonely" (Lesley, p. 53)

Feeling vulnerable as children and as adults appeared to affect the participant's identities as parents; often the participants spoke about their sense of powerlessness and as if they had "no rights" anymore:

"They could be in hospital or anything and I just don't know… there's nothing I can do about it" (Georgina, p. 39)

"I lost my rights a long time ago, yeah I give birth to them but judge said that's it, he's being adopted you lost all your rights" (Debbie, p. 63)

5.6.3 Choice and control

Almost all of the participants reported feeling controlled and trapped as children. Half of the participants had attempted to run away from home as a means of escaping such control:

"I never had any freedom to talk, to do anything you know, I couldn't have friends round, I couldn't choose to do things that I wanted to do… you know even down to food… I didn't feel like there was any freedom… it was like being stuck in prison" (Lesley, p. 48)

One participant had her first child aged 13 years, and others described wishing to start their own family in order to 'escape' their current one. The term 'escape' was used by six of the participants and was achieved in a variety of ways:

"That was an escape place I went to for a week during the summer holidays and it was wonderful because whenever I could get away I was just happy as Larry" (Lesley, p. 29)

Their wish to escape was often in response to feeling controlled and half of the participants described their fathers being powerful and controlling figures who would "issue orders":

"[dad] used to have a main chair, a comfortable chair by the windows so he could see everything that was going on out in the neighbourhood and he used to have these bags of sweets down the side of his chair… and he used to tease us with them… he used to do spiteful things… he used to count the sweets before leaving the room and if there was a sweet missing, oh my, you wouldn't dare touch his sweets…he would be like a volcano going off in the house if anyone touched his sweets (Hannah, p. 13)

Being dependent on those who had (and often misused) power felt unfair and a sense of injustice was very present in the participant's narratives:

"Just because I was slightly late home from school… he went absolutely ballistic and it was just whack whack whack whack" (Lesley, p. 24)

5.6.4 Unheard voices

Participants reported a lack of communication among their families often resulting in uncertainty (not knowing a family member had died) and fear (worried they were bleeding to death when they started to menstruate). One participant reflected on the lack of opportunities she had to communicate with others:

"I found it frightening, I'd always lived in quite isolated places for a lot of my life. I didn't come into contact with people, you know, it was only when I moved here that I started socialising a bit" (Lesley, p. 56)

Over half of the participants reported feeling silenced as children and said that even when they did manage to speak up for themselves, they often were not believed:

"I went to the police and they sent me home, I told them what was going on and they sent me home and said if it carries on to phone 999, and it did carry on and so I called them. When they picked me up they still didn't believe me… no one was listening to me, no one was hearing, my voice wasn't heard, my voice wasn't being heard…" (Amy, p. 20)

Other participants also spoke about not feeling listened to and said that their voices (or any sort of noise) were often not tolerated or welcomed, and two of the participants said they had grown up being told that 'children should be seen and not heard':

"I just had to sit and be quiet, I weren't allowed to call or make a noise. I just remember always sitting on the sofa crying, I do remember that because my mum

was so mean, she didn't like me to make a noise, I just had to sit there… I was scared to even cough" (Rosa, p. 10)

"I remember the TV always being on in my house and the TV was like the main feature so there wasn't ever a lot of attention from my mum because the TV was on, the TV sort of trumped me and my sister… we didn't get a lot of attention, [mum] was always like 'TVs on' and if we tried talking to her the TV would go up, like if the adverts come on I would think that's my chance to talk to mum and then she would change the channel" (Emma, p. 7)

As children the participants did not feel that their voices were important or welcomed and communication in general was not clear. In contrast to silence, shouting was commonplace and participants reported being shouted at a lot when they were children:

"My mum was always shouting, she still shouts now to tell us to shut up and we're loud anyway our family, very loud so… she shouts now still" (Debbie, p. 46)

Participants reflected on the effect such communication in their childhoods had on their adult style of communication:

"[Mum] would just shout and that was enough to do the job, so she would just shout. It definitely had an impact on how I bought up my children because I would shout at them, but then I realised, right shouting at them doesn't work because they ignore me so… they found it motivating or scary when I said it calm, and said stuff to them really calmly, that would frighten them more. So yeah I would get upset, but it's done… but everyone would end up shouting at each other all the time so… everyone would fall apart constantly with everyone shouting at each other all the time" (Felicity, p. 19)

While some of the participants acknowledged that as adults they shout a lot in order to get themselves heard, others described a type of default position whereby they become passive and silent when with other people; still finding it difficult to make themselves heard:

"I am trying to think this, 'coz you might be able to help me out with the word, 'coz sometimes what goes on in my brain I can't seem to vocalise it if that makes sense, erm… " (Lesley, p. 7)

"I don't like talking on the phone, it's horrible, I don't mind texting, hiding behind a text" (Rosa, p. 8)

It seemed the communication style the participants had become familiar with as children appeared to impact on them as adults in a variety of ways:

"I never got love and never got hugs, never, now that is what I struggle with, I show it in other ways" (Rosa, p. 22)

"As with everything, 'be quiet, be quiet, be quiet', it was always 'TVs on, be quiet'… I was always told to be quiet so I think that is why I'm quiet now (Emma, p. 10)

5.6.5 Survival

Many of the participants spoke about having to grow up quickly; walking themselves to nursery, taking two busses to school, looking after siblings, even becoming a mother at 14 years old. The majority of participants maintained hope throughout adversity; hope that things would change and be better. The amount and extent of abuse, rejection and fear experienced by the participants as children is difficult to comprehend, thus their surviving into adulthood indicates a degree of strength and

resilience. Survival was not easy however and one participant described attempting suicide as a teenager:

"If I'd been bought up decent with boundaries and guidance and love and respect and the right way in life, yeah, I could've given that to my kids but I couldn't, I was self-harming and I was on intensive care for 2 weeks on life support cos of what I done to myself (Amy, p. 20)

Participants described how as adults they had tried to "move on" from their difficult childhoods and many felt they had generally managed to "stay strong". The majority of participants however said that becoming a mother had proved more challenging for them than they had expected, and upon reflection understood this to be because they had (re)connected with feelings of vulnerability; feelings they had worked so hard to "block out" or forget:

"I have suffered with post-natal depression with all of my children… I have always been overwhelmed by them, this wonderful object that was mine, and just so precious… always just overwhelmed by love for them… but actually I've made so many cock ups because of it" (Lesley, p. 50)

5.6.6 Doing better: thinking about the next generation

All eight participants reported their wish for their children to have 'better' lives than they did and described their attempts to become 'better' parents:

"I had a break from having relationships with men and I think it has done me the world of good, having a relationship on my own and knowing what I need or not need, and how much I can take and how much I can't take on" (Hannah, p. 40)

Their motivations were shown in different ways, one of which was to remove their child from an abusive situation. Lesley spoke movingly about not wanting history to repeat itself:

"He would be violent towards the kids, he was aggressive towards me, he hurt the kids if I wouldn't sleep with him… erm, he killed… I used to breed chickens and one day he killed my favourite chicken because I pissed him off, you know he just hurt all of us. He cut Elsa's hair one day when I went out to meet a friend for coffee… she had lovely long blonde hair and [husband] cut it all off and so I was completely trapped… so that was when I thought this can't go on and I moved to the refuge here" (Lesley, p. 50)

Lesley spoke at length about wanting a better future for her children and felt strongly that a good education was an important part of this:

"My children have seen me struggle to get a university degree… I only did it to prove to them the importance of education" (Lesley, p. 68)

Other qualities which were valued by the participants and linked to their idea of a 'better life' included the ability to be assertive and set boundaries. Some of the participants felt they had developed their ability to stand up for themselves and spoke passionately about what they will and will not accept in their adult lives and relationships:

"I don't think he's grasped the fact that I'm an adult now and he can't just muscle his way in… I'm taking control here, I'm an adult now, I don't have to put up with anything really so I can just say 'no, it's my life, you're not wrecking it'" (Georgina, p. 35)

Finally, the participant's strength and resilience was demonstrated in their perseverance and determination to make positive changes in their lives in order to become better mums; as one participant so eloquently concluded her interview:

"I had to work hard and get my boys back, and I did" (Emma, p. 20)

6.0 DISCUSSION

6.1 Chapter overview

This chapter discusses the findings of the current study and makes links to the literature previously reviewed (in Chapter 2). To further understand the themes which emerged and ground the findings in psychological theory, additional research literature is drawn upon. The unique aspects of the current study are discussed, and strengths and limitations explored. Clinical implications are considered and recommendations for future research made.

6.2 Findings of the current study: an overview

When considering the findings of the current study it is important to hold in mind the context surrounding the participants. Bowlby hypothesised that if the primary attachment figure was absent, inconsistent or frightening, the child's attachment system would be impaired, and the internal working model of attachment would be insecure, rather than secure. Each of the eight participants had been classified as having an insecure attachment style (six preoccupied, one dismissing, and one unresolved). The participants' AAI classifications were consistent with the meta-analytic study of data from 10,000 Adult Attachment Interviews (Bakermans-Kranenburg & van Ijzendoorn, 2009), which found that people with clinical disorders had higher rates of insecure (particularly preoccupied) attachment than non-clinical samples.

Furthermore, participants described high levels of childhood abuse and neglect. Childhood maltreatment in particular predicts disorganised attachment (Bakermans

Kranenburg and van Ijzendoorn, 2009, p. 250) and it may be that the clinical difficulties that the participants had were related to disorganised attachment systems. Disorganisation of attachment is associated with clinical severity (Bakermans Kranenburg and van Ijzendoorn 2009, p. 252) and dissociation phenomena.

Disorganisation of mind with respect to attachment may be relevant to the diagnosis of personality disorder that was found in all the study participants; mainly Borderline Personality Disorder (BPD). This diagnosis is likely to be related to their experience of early childhood adversity since it is known that childhood abuse and neglect significantly increases the risk of being diagnosed with a personality disorder (Johnson et al., 1999). People with BPD frequently report experiences of loss, rejection, (multiple) traumas and unstable family backgrounds; and this may explain why high levels of insecure attachment are reported in people with BPD. Patrick et al. (1994) report that a group of women with BPD were all categorised as insecure pre-occupied on the AAI; and a related study of women with PD at the Cassell hospital also found high levels of attachment insecurity (Chiesa & Fonagy, 2004).

The key findings of the study were that all eight participants described multiple losses which began in their early childhood. Each participant had experienced (at least one form of) abuse in their childhood and the abuse had always been from a parent (and in one instance, a sibling also). As such there was a high level of unresolved grief and trauma expressed by the participants. In addition to this, the participants described feeling trapped and helpless; unable to take action or make choices that might protect them against danger or loss. The participants reported numerous ways they felt their adverse childhood experiences had impacted on them as adults, particularly their ability to be a mother. All participants made links between their mother's behaviour and their own behaviour as a mother, and both shame and sadness were expressed upon their realisation that a cycle of abuse had been repeated.

6.2.1 Understanding love, loss and rejection

Given the level of adversity suffered by the participants, both in childhood and adulthood, it was perhaps not surprising that the theme of loss emerged so clearly from the material. What was striking were the varying degrees of loss, and the severity also. Participants often introduced the concept of loss before being asked direct questions pertaining to it, as if it was at the forefront of the their minds.

Loss came in many shapes and forms; sometimes suddenly with no warning, and no opportunity to grieve. Half the participants described not being informed about the death of a loved one or were not permitted to attend the funeral. Each of the participants had experienced having their children removed from their care and when detailing this experience, used language indicative of shock and powerlessness. Both of these types of losses appeared unresolved in that they were still active in the participant's minds. The lack of resolution seemed to be related to a lack of understanding of how the loss had come about. All eight participants stated that they had not understood the reasons why their children were removed, and all felt the removal had been unnecessary.

Mourning the loss of a loved one, especially when the 'lost' person had been an abuser, appeared to complicate the participant's mourning process. When trying to understand the way that such losses may (or not) be processed it is helpful to refer to the work of Bowlby and Colin Murray Parkes. Bowlby's research on infant attachment helped inform models of grief and bereavement, which were later spearheaded by Murray Parkes. The Parkes/Bowlby model of bereavement (1970) detailed stages of adult grief and found adults respond to loss similarly to a child whose parent has disappeared out of sight (and protest accordingly). Bowlby and Murray Parkes described atypical or 'disordered mourning' whereby an individual may experience prolonged symptoms of depression and anxiety, become 'overly preoccupied' with thoughts of the missing person, and be unable to understand or accept the loss (Bowlby, 1980, p. 21). Recent years have seen individuals presenting with atypical mourning receive a diagnosis of Post-Traumatic Stress Disorder (PTSD); although this diagnostic label only came into use in the 1980's. Other terms have since been used

by researchers, including ‘complicated’ or ‘unresolved grief’. Research shows an association between unresolved mourning and preoccupied attachment (Bakermans-Kranenburg & van Ijzendoorn, 2009, p. 246), thus considering that six of the participants had been classified as insecure-preoccupied, the high level of unresolved grief reported by participants may not be surprising.

Research focussed on the concept of unresolved grief has tended to involve cases where the death of a loved one has occurred. The participants of this study however had not lost their children through death; their children were living elsewhere and being cared for by another. The concept of ‘ambiguous loss’ proposed by Boss (1999) is therefore particularly relevant as she states that ‘with no official verification of death, no possibility of closure, and no rituals for support, there is no resolution of grief’ (Boss, 1999, p. 118). Betz & Thorgren (2006) considered having a child taken into care as an ‘ambiguous loss’ and indeed a recent study of non-clinical mothers who had experienced having their children removed from their care, reported high levels of ambiguous loss (Memarnia, 2015). Memarnia (2015) reported that the mothers ‘felt their grief and their loss was not considered to be legitimate’ and thus the term ‘disenfranchised grief’ may be used (p. 65). Similar to Boss’ (1999) concept of ambiguous loss, disenfranchised grief has been found to occur when a loss is not acknowledged or socially validated (Doka, 2002).

Related to the theme of loss, was the theme of love, and the experience of giving and being loved as children. Participants referred to love in a variety of ways, and described different ways in which love was expressed in their childhoods. For example, practical aspects of love were compared with emotional expressions of love; many participants detailed being fed and washed yet feeling devoid of any emotional connection with a parent. The occasions when affection and ‘emotional love’ were experienced, albeit rare, were highly valued by the participants and such loving figures often came to be idealised.

Frequent references to the participant's basic needs being met (i.e. washed and fed) may be considered in relation to an early model developed by Maslow in the 1940's. Maslow's original five stage hierarchy of needs model (1943) organised human needs into five distinct categories: biological/physiological needs (e.g. food, drink, shelter), safety needs (e.g. order, stability, freedom from fear), love and belonging (e.g. friendship, affection and love), esteem needs (e.g. mastery, independence, respect from others), and self-actualization (e.g. self-fulfilment and achieving personal growth). The premise of Maslow's hierarchy is that once basic needs are met, the individual is able to climb up the hierarchy towards self-actualization. All of the participants reported having their basic needs met, however their higher level needs, such as love, affection and respect were rarely fulfilled. It is thought that the presence of threat (real or imagined) impedes the process and therefore it may be that the participant's attachment figures were only able to function at/provide basic level care due to their own experiences of both external and internal threat in their environments (E.g. violence and psychological distress).

Just as 'love' and 'loss' emerged in varying forms, so too did a pervasive sense of rejection. All of the participants reported feeling rejected, both as children and as adults. Many participants described feeling like a hindrance to carers during their childhood, and parental abandonment was frequently described.

Rejection was not always overt, and sometimes occurred unpredictably with other family members such as siblings. Some participants described a pervasive and chronic form of rejection in which they felt excluded from sibling relationships, and from their parent's marital dyad, and they also felt scapegoated by entire family systems and sub-systems. Only two participants felt able to forgive this rejection by their parents; the rest described high levels of hostility towards their parents and a reciprocal wish to reject them.

In attempting to understand the process of reciprocal rejection that was present in the participant's accounts, a Cognitive Analytic Therapy (CAT; Ryle, 1997) model may be

considered. The NICE guidelines recommend CAT as an effective therapy (CG78, 2009, p. 30) for people with a PD diagnosis as there is a recognition that such clients tend to get trapped in unhealthy patterns of relating to others (Ryle, 1997a). A central tenet of CAT is the concept of 'reciprocal roles' (Ryle & Kerr, 2002, p. 65) whereby a relational pattern develops which positions an individual in a particular role. Roles are considered to be split between two poles; in this instance 'rejecting' and 'rejected'. Reciprocal roles are maintained by a network of relational process which serve to keep the individual in the designated (and often familiar) pole position. When an individual attempts to move out of the position, they gravitate towards the opposite pole. This may be understood in terms of the participant's frequent experiences of feeling rejected as children; they may have internalised the rejection and taken up the position of 'rejected'. Although perhaps a familiar position it is far from desirable, therefore attempts are made to vacate the position and switch poles; thus placing the person who was 'rejecting' into the 'rejected' role, as they take up the position of 'rejecting'.

6.2.2 The complexity of families and family relationships

Many of the participants reported that as children they had felt that they did not belong anywhere. A lack of sense of belonging combined with changing family memberships appeared to create a desire in the participants to start their own families; in which they were in control of membership.

The AAI specifically asks about parental relationships, but the participants' accounts often went beyond the remit of the AAI questions. For most participants, other family members also played complex and often confusing roles in their lives. For example, participants frequently described being parented by extended family members, school and care staff, and by their grandparents. Grandparents in particular were observed to play an important and protective role, providing love and stability which was otherwise lacking in the participant's lives.

This finding supports one of the criticisms of Attachment Theory in that it has been considered to be a westernised theory based on a nuclear family structure (Rutter,

1991). Basant & Treasaden (2003) argued that ‘anthropology has shown that it is normal for childcare to be shared by a stable group of adults, of which maternal care is an important but not exclusive part’ (in Holmes, 2006, p. 46). This may bring to mind the African proverb ‘It takes a village to raise a child’.

The boundaries of family membership appeared changeable and were experienced by many as chaotic and confusing. A reversal of roles was frequently described whereby the participants were required to take on the role of parent; a process which Bowlby associated with disturbed attachment and referred to as ‘parentification’ (Bowlby,1979, p. 126).

Most of the participants were not raised by their biological parents; but by their mother and a series of step fathers. Six of the eight participants experienced the absence of a father figure in their childhood. Although some participants had welcomed a step-parent into their life, many described a complex and difficult relationship with step parents. Many of the step-fathers already had children and as a result, it was not unusual for step or half siblings to join families. These siblings tended to fall into one of two categories; viewed as either a carer or competition.

When attempting to understand sibling relationships it is interesting to consider animal behaviour research. Hamilton’s concept of inclusive fitness (Hamilton, 1964) can be seen in Vampire Bats who demonstrate a phenomenon known as a ‘shared stomach’; after feeding they return to their nest and regurgitate a ‘share’ of the blood for their weaker siblings (Wilkinson, 1984, p. 181). While appearing altruistic, Vampire bats have been referred to as a ‘siblicidal species’ (Leippert, Goymann, & Hofer, 2000, p. 535) as when critical resources are scarce they kill off their weaker siblings. Increased ‘siblicidal’ behaviour has been associated with the phenomenon of ‘parental optimism’ in which parents produce too many offspring to be able to provide for (Mock & Forbes, 1995, p. 130). Although perhaps unusual examples, the contrasting behaviours beautifully parallel those reported by the participants of the study. While none of the participants experienced attempts made on their lives, the incestuous sexual abuse

by a brother which was reported by one of the participants most certainly threatened her (psychological) survival and subsequent ability to thrive.

Almost all of the participants had experienced serious boundary violations as children, in the form of abuse, usually enacted by family members. Participants also described neglect in the form of a lack of any sort of behavioural boundaries. All but one participant reported physical, sexual and emotional abuse by carers in a trusted position. Physical abuse included significant acts of violence; sexual abuse included incest by fathers and a brother. Participants gave detailed accounts of emotional abuse, mainly inflicted by mothers and step/fathers. The abuse described often had a sadistic quality which suggested a high degree of humiliation in their experience.

Participants described how their experience of abuse and other boundary transgressions had impacted on their adult development. It is therefore not surprising that many reported finding it difficult to parent their own children in a safe, containing and boundaried way. Most of the participants had felt unprotected by, and afraid of, their parents, and upon becoming parents themselves had each had their children removed from their care for the same reason; neglect and failure to protect. Despite the participants wanting to parent their children differently, a transgenerational cycle of abuse had continued.

Research by Lyons-Ruth et al. (2003) which introduces the concept of Hostile-Helplessness (HH) is helpful when trying to make sense of the cycle of abuse. Lyons-Ruth et al. (2003, p. 348) found that mothers who had been maltreated as infants scored higher on the HH scale and those who scored high for ‘Hostile’ were more likely to maltreat their children. In support of this finding, Frigerio et al. (2013, p. 438) found that mothers who scored as ‘Helpless’ were less likely to repeat the cycle of child abuse. Although it was beyond the remit of the current study to measure the participant’s HH states of mind, given their struggles to protect their children (thus perpetuating a cycle of abuse) it may be hypothesised that the participants would score high for hostility.

Participants described witnessing deception among their parents and as children had been privy to secrets. It was not surprising that themes round communication and confusion surfaced. Participants reported frequently feeling powerless, helpless and trapped, not just as children, but as adults in relationships with romantic partners and with social services. Theories pertaining to developmental trauma may help to understand the participant's sense of helplessness in adulthood. Van der Kolk (2005) reports that 'normal' childhood development may become delayed or 'stuck' if a traumatic event occurs in a child's formative years which remains unresolved. In this respect the participant's unresolved distress keeps them at a younger developmental stage. The phenomenon of 'learned helplessness' (Seligman, 1972) may help to understand the participant's continued sense of powerlessness as adults; even when escape is possible, they have been 'conditioned' to believe that change is not possible and thus remain feeling powerless.

6.2.3 The effects of trauma: confusion and dissociation

Many participants referred to their lack of memory and sense of confusion around their childhood recollections. Confusion has been a theme previously reported in AAI research and thought to be related to the presence of parental conflict (Dallos & Smart, 2011, p. 535). It may also be that confusion and memory disturbance are a defensive exclusion and disavowal as set out in the AAI whereby dissociation is regarded as a sequel to early disorganised attachment in childhood (George & West, 2003). Liotti (1999) writes that 'disorganised attachment may be the earliest instance of dissociative mental processes in personality development' (p. 756).

Dissociation in children has been found to occur as a response to repeated feelings of terror; and has been described as 'a last resort defensive strategy' (Dixon, 1998, p. 417). Berthelot et al. (2012) report that children in attachment relationships with abusive parents frequently resort to dissociation. During frightening and stressful situations the child disengages from the outside world and instead turns their attention to internal stimuli (Tronnick & Weinberg, 1997); an attempt to find 'escape when there is no escape' (Putnam, 1997, p. 68 & 147). Infants who dissociate may be observed

staring with a glazed look, have a slumped posture, and may show self-soothing behaviours; all of which are reminiscent of the baby monkeys in Harlow's experiments.

Dissociation has an evolutionary function to 'foster survival by the risky posture of feigning death, to allow healing of wounds and restitution of depleted resources by immobility' (Powles, 1992, p. 213) and in humans, individuals who have repeatedly experienced hopeless and stressful situations become 'inhibited, and strives to avoid attention in order to become unseen' (Schore, 1999, p. 204).

Repeated dissociation has been found to result in long-term alterations in brain functioning (Chambers et al., 1999) and Alan Schore has written comprehensively about the impact of early trauma on the developing (right) brain. In particular, the direct connection between traumatic attachment and inefficient right brain regulatory functions (Schore, 2001, 2002, 2005).

While dissociation was not directly observed during the interviews, it may be reflected in the loss of memory and sense of confusion; plus the frequent use of 'mad' language such as "weird", "mad", "crazy" and "strange". In addition to this, two of the participants frequently referred to their father's hands which according to the AAI rating scale is 'prima facie' evidence of dissociation; the mind focusing on details to reduce arousal and distress.

The theme of 'splitting' (in an attempt to obtain psychological safety) is relevant to this discussion. Splitting is a defence against intolerable stress; and is manifested as conscious black and white thinking. It can be linked to object relations theory whereby as children the participants had experienced high levels of threat and unpredictability. They lacked a 'psychic organiser' (Bowlby, 1951, p. 53) and instead learnt to manage such challenges at a young age by developing psychological strategies, such as dissociation (Schore, 2002), to help separate (and cut off) the difficult mental conflicts they were faced with (i.e. wishing for closeness from a fearful figure).

6.2.4 Resilience and survival

Despite their many moving accounts of loss, rejection, abuse and confusion, participants also described an overarching sense of resilience and strength. Massie & Szajnberg (2003, p. 476) comment how 'remarkable' resilience is in individuals who have been mistreated as children and their idea that children develop 'armour' was observed in the participant's narratives. The presence of a single protective figure in the participant's life appeared key to a more positive experience, as described by Emmy Werner in her forty year longitudinal study of vulnerable children in Hawaii (Werner, Bierman & French, 1971).

The Kauai studies (Werner et al., 1971) showed that one third of the 'high risk' children who had been born into poverty and experienced high levels of adversity (and thus had 'all odds against them'), 'grew into competent young adults who loved well, worked well, played well and expected well' (Werner, 1992, p. 262). This 'resilient' group of children had been observed to behave differently to their low risk counterparts throughout their development. As babies, the resilient group of children had been reported to sleep and eat well, causing minimal distress to their caregiver. As toddlers, the resilient children demonstrated more advanced communication and self-help skills than their low risk counterparts. Werner explained the differences between the groups of children being (at least partly) due to the resilient children having established a close bond with at least one caretaker; frequently a substitute caretaker such as a grandparent or an older sibling.

What was intriguing was that an attachment to an animal also appeared helpful in the participant's survival; perhaps by allowing the participants to shift from a position of being in need of rescue, to one of rescuing. While this was perhaps an unexpected finding, the healing and protective qualities of animals is not new. From the 1700's there was the belief that animals 'would enhance the humanity of the emotionally ill', providing 'innocent pleasure' and helping children to 'learn self-control by having dependent upon them creatures weaker than themselves' (Beck & Katcher, 1996, p.132). Indeed Florence Nightingale promoted the presence of animals in hospitals

and it is now not uncommon to be greeted by ‘PAT dogs’ (Pets As Therapy) when visiting hospitals, care homes and schools. There is a growing body of research which links the presence of animals to improved mental health and functioning (see Brodie & Biley, 1998) and the participant’s accounts of animals (particularly dogs) playing an important role in their childhood supports this.

Ungar (2004) described resilience from a constructionist perspective to be a phenomenological concept that is ‘the outcome of negotiations between individuals and their environments to maintain a self-definition as healthy’ (p. 81). In contrast to a constructionist stance, neuroscientists have demonstrated that environmental conditions can shape neural pathway development and thus the concept of neural plasticity is central in understanding the neurogenesis of resilience. In particular, research has shown that hippocampal activation has been found to be a protective factor in managing trauma, and reduced hippocampal activity has been linked to higher prevalence of PTSD (Benoit & Anderson, 2012).

There are many studies which focus on the process of overcoming adversity. O'Leary and Ickovics (1995) describe a continuum of human responses to adversity, including: succumbing to adversity, surviving with diminished quality of life, resiliency (returning to baseline quality of life), and thriving. The participants of the current study appeared to move between surviving (with diminished quality of life), resiliency and thriving. The latter demonstrated via their engagement with therapy and their self-proclaimed wish to make a better life for them and their children.

Various religions describe the transformative power of suffering and the positive psychology movement describes a process of ‘post-traumatic growth’. Post-traumatic growth is not thought to occur as a direct result of trauma, instead the amount of growth is determined by how an individual copes in the aftermath of trauma (Tedeshi & Calhoun, 2004) thus the participant’s engagement in therapy and their active attempts to ‘win back’ their children may help them to achieve such growth.

6.2.5 Transgenerational effects

This study found evidence consistent with Bowlby's hypothesis that the attachment security developed in infancy remain relatively stable throughout time and influenced care giving capacity in adulthood. The Lyons-Ruth group suggests that disorganised states of mind are related to hostile-helpless states of mind which make disorganised attachment in offspring more likely. Indeed, all of participants believed their adverse childhood experiences with caregivers had negatively impacted on their adult selves, in particular their ability to care for their children. Having lacked a secure base from which to explore the world, they had struggled to provide one for their own children. A difficulty in their current lives was now having to watch their children be parented by others, or in some cases observe their own children's psychological suffering.

The findings of the current study show support for research into transgenerational transmission of attachment. Participant's had described growing up in chaotic and uncontaining environments where their parents showed a high degree of emotional instability, and many reported a mother or father who was dependent on alcohol (and in one case 'Crack'). As adults, the participants had each been classified as having an insecure attachment style and had struggled with the transition to motherhood; the task of caring for (and protecting) their vulnerable baby had been too overwhelming for them. The participant's children had become victims of physical abuse and neglect, and many had witnessed domestic violence. Male partners of the participant's tended to be the ones that had caused physical harm to the children and the participants had 'swept it under the carpet' by either turning a blind eye or justifying their partner's actions. Subsequently the participant's children had been removed into foster care, and others were adopted. Those participants who had their children returned to them described their children having significant behavioural difficulties.

Macfie et al. (2014) found mothers with BPD with an insecure attachment style had children with a correlating (insecure) attachment style. Berthelot et al. (2015) reported similar findings in relation to a mother's lack of mentalizing having an effect on the attachment style of her child. Although data on the attachment security of the participants' children was not available, the participants frequently described their

children having behavioural and mental health difficulties. Younger children tended to have been diagnosed with ADHD and Autism, whereas the teenage children were reported to engage in substance misuse and self-harming behaviours. It is not uncommon for ADHD presentations and autistic behaviours to be misdiagnosed and instead indicate attachment disorganisation. Substance misuse and self-harming behaviours are often viewed as ways of coping with intolerable, changeable and extreme emotions; helping to either numb the emotional pain or 'release' and communicate their distress to others. This may however reflect the fact that the participants had not known how to be an emotionally available parent to their children; and preferred to see the children as having problems, rather than admitting to the shame of being an unemotional carer like their own parents. Alternatively, both factors may be operating; the mothers' difficulty to care for their children may have increased the chance that the children developed mental health problems; which then made them more difficult to care for.

Initially it had been thought that transmission of attachment across generations was simply a replication of the mother's attachment style. Although studies of securely attached mothers appeared to support this replication theory, van Ijzendoorn's (1995) meta-analysis of 661 dyads found that concordance rates of attachment between mother and infant dropped from 75% (in securely attachment mothers) to 63 % when mothers had an insecure attachment. This indicated that the transmission of attachment from one generation to the next was not a simple replication of the mother's attachment pattern, thus the 'transmission gap' remained.

Slade and colleagues (2005) helped to close the 'gap' by promoting research into the area of mentalization; they hypothesised that the mother's ability to mentalize would directly impact upon the infant's attachment style. In Fonagy's (1994) studies of mothers who had experienced childhood abuse and neglect, he found their reflective functioning, and thus their ability to mentalise their child, had a mediating effect on the transmission of attachment from mother to infant. Studies by Meins, Ferryhough, Fradley, & Tuckey (2001) and Oppenheim & Koren-Karie (2002) also found that high levels of mentalization of the child by the mother were associated with the infant's

development of a secure attachment. The participants of the current study had attended an MBT group therapy programme and had thus been identified as having difficulty mentalising their children; empirically measured by the removal of their children.

It seems therefore that in addition to attachment theory, BPD research, and various therapeutic models such as CAT, Mentalization theory may help to understand the findings of the current study. Mentalization refers to the capacity to think about oneself and others as psychological beings and has been found to facilitate sensitive parenting and mediate the transmission of attachment (Slade et al., 2005). The findings showed that almost all the participants reported lacking a consistent and safe caregiver who was able to hold them in mind and reflect back their distress to them, therefore they grew up not understanding their distress, nor were they able to tolerate it in their own children. The theme of protection is relevant in this respect as the development of the capacity to mentalize requires an adult to take an interest in the internal world of the child and thus treat them as someone with a mind. Accounts of Uncle Bob helping to draw dragons and building things with grandad in his workshop become not only moving, but vital in making sense of the participant's ability to mentalize.

6.3 Clinical implications of the findings

The findings of this study have clinical implications at various levels; at an individual, organisational and societal level. Such implications will now be discussed.

6.3.1 Individual level

The researcher observed that the participants tended to experience the interview process in a cathartic way; and many expressed their gratitude to the researcher for allowing them to tell their stories without judgement or interruption. It seems therefore that having come from a background where their voices were not welcomed, nor respected, having an opportunity to speak candidly and be heard was an incredibly powerful and validating experience for the participants. While the findings of the current study cannot help to turn back time and change the participant's journeys of

motherhood, the participant's generosity in sharing their stories and giving voice to their struggles may indeed help to bring about change for other vulnerable mothers, perhaps their 'younger selves'.

6.3.2 Organisational level

From an organisational perspective, the findings of the current study are particularly relevant when considering assessment processes, treatment interventions and further maternal/infant mental health and attachment related research. In addition to this, organisational structures require consideration given that there remains a split in the NHS between child services and adult services. While a number of NHS Trusts are restructuring their care pathways in order to become more holistic 'family' services, it is essential that joined up and systemic ways of working happen in practice and not just in name.

6.3.2.1 Prevention, assessment and early intervention

In an ideal world, pregnancies would be planned and expectant mothers (and fathers) would be psychologically prepared for the challenge inherent in transitioning to parenthood. This is an unrealistic and tall order however and therefore attention is now paid to how and when is best to intervene.

The government document entitled '1001 Critical Days' (DoH, 2013) describes the need to intervene early in order to improve outcomes for children and families. A 'critical window of opportunity' is referred to (p. 5) in which it is thought that positive changes are most likely to be effective between conception and the age of 2 years. One may argue however that the time preceding conception is 'critical' also, particularly given the research on unplanned pregnancies increasing risk of child maltreatment (Hillis, Anda, Felitti & Marchbanks, 2001). There is evidence that young women leaving care and women exposed to childhood adversity are much more likely to have high risk unplanned pregnancies than women without such adversity (Hillis, Anda, Dube, Felitti, Marchbanks & Marks, 2004). There is therefore a need to reduce

mindless pregnancies, especially when there is a phantasy that the baby will repair past damaged relationships (Knight, Chase & Aggleton, 2006, p. 400).

There are already a number of initiatives which attempt to provide information and support to hopeful and expectant mothers; family planning clinics, internet forums and National Childbirth Trust (NCT) groups to name but a few. These are all helpful in providing information to those women wishing to start a family and expecting their first baby, however it is important to consider the mothers who do not engage with or utilise such resources. In reality, mothers who attend their antenatal clinic appointments, have a supportive family and group of friends around them and who engage with NCT programmes are the mothers who are (at least trying to be) prepared, informed and supported in their journeys into motherhood. It is the women who do not attend these appointments and who do not engage with potentially supportive networks that requires serious thought.

It seems necessary therefore to target educational and supportive interventions at first time, vulnerable expectant mums, especially if they have a history of abuse and unresolved trauma and loss; and reaching 'hard to reach' mothers will pose a challenge to this task. It is known that early intervention is best and brings about the most change, therefore the question which remains, and is perhaps more difficult to answer, is *how*.

First, potential 'high risk' and vulnerable mother's need to be identified and appointments with GPS, midwives and health visitors may provide this opportunity. An antenatal questionnaire which screens for insecure attachment style and a history of childhood adversity and trauma may help to identify 'at risk' mums. One such screening tool currently being used in New York is the Adverse Childhood Experience Questionnaire (ACE; Murphy, Steele, Dube, Bate, Bonuck, Meissner, Goldman & Steele, 2013). The ACE includes ten categories of abuse, neglect and household dysfunction and has been found to show good internal consistency (Cronbach of 0.88). Murphy et al. (2013) found that among a sample of 75 mothers 84% of the clinical

sample (n=41) compared to 27% in the community sample (n=34) had experienced four or more ACEs. The level of emotional support received by the mothers, as well as their attachment style (using the AAI, M&G method) was measured and it was found that as the number of ACEs and the lack of support increased, so too did the probability of the mothers AAI's being rated as U/CC. Murphy et al. (2013) recommend their ACE questionnaire be used in paediatric services to help with early identification and treatment for vulnerable mothers, thus 'reducing the intergenerational transmission of risk associated with problematic parenting' (p. 224).

A similar screening tool was developed by the researcher and supervisor of the current study and presented at the 6th International Attachment Conference in Italy, in 2013. The Pavia Index of Parenting Problems (PIPP; Williams, King, Tagg & Adshead, 2013) is a 20-item clinician completed checklist which measures levels of adversity experienced in childhood and adulthood. The structure of the PIPP is based on the Historical Clinical Risk management assessment (HCR-20; Webster, 1997) and consists of two sections; *historical* (10 items) and *current* (10 items). Information is gathered via self-report, file review and empirical data and adverse events are scored as either present ('1') or absent ('0'). Scores for each of the sub-scales are totalled to provide an overall score out of 20. Historic items include: inconsistent parenting, contact with CAMHS, Children's Social Services involvement, parents with substance misuse problems, parents with mental health difficulties, poor school attendance, left home before age of 16yrs, left school before leaving age (16yrs), childhood sexual abuse (CSA), and inadequate housing. Current items include: Children's Social Services involvement, contact with police, inadequate housing, contact with CAMHS, inconsistent parenting, reliant on benefits, substance misuse issues, mental health difficulties, domestic violence, and debt.

Preliminary findings from the PIPP have shown a correlation between historic and current scores; which support findings from the ACE Studies (Murphy et al., 2013) by highlighting that multiple exposures to childhood adversity correlates to the level of adversity experienced in adulthood. Murphy et al. (2013) understood the correlation to be related to the adult having 'not (yet) achieved a coherent state of mind tantamount

to coming to terms with one's childhood history of adversity, which may in turn affect parenting the next generation' (p. 225). Indeed this was observed in the current study in the level of unresolved trauma and loss reported by the participants.

The use of screening tools, such as the ACE and the PIPP, at initial appointments with healthcare professionals may help to identify expectant mothers who may be at a greater risk of struggling with the transition to motherhood. The question which remains is therefore how to intervene.

6.3.2.2 Effective interventions

NICE guidelines for managing difficult behaviour in children (NICE CG77, 2013) recommend parent training programmes such as the 'Triple P: Positive Parenting Program ®' (Sanders, Markie-Dadds & Tully, 2000) and 'Incredible Years' (IY; Webster-Stratton, Kolpacoff & Hollinsworth, 1988). Triple P has been described as 'one of the most effective evidence-based parenting programs in the world' (retrieved from www.triplep.net/glo-en/home, 2016) and provides parents with strategies and skills to help them manage their children's behaviour and develop healthy relationships. Similarly, IY interventions have been referred to as 'the most evaluated group intervention program for parenting skills, with evidence showing a range of positive short and long term effects' (retrieved from www.clinpsy.org.uk/wiki/article/incredible-years-webster-stratton-parenting-programme, 2016). There are countless other parent training programmes; the 'Strengthening Families Programme' (SFP; Kumpfer, Molgaard & Spoth, 1996), '1-2-3-Magic Parenting' (Phelan, 2003) and 'Systematic Training for Effective Parenting' (STEP; Dinkmeyer, McKay & Dinkmeyer, 1997) to name but a few. While helpful, they all focus on practical aspects of parenting, such as setting boundaries, using praise appropriately, and learning how to discourage undesirable behaviours. It may be said however, that parenting interventions such as these are not intervening early enough and their sole focus on psychoeducation and practical skills does not effect change and understanding at a deeper level, especially when complex interpersonal histories and family dynamics are present.

Given the volume of research (including the findings from the current study) which link unresolved trauma to impairments in reflective functioning and mentalisation, and thus negatively impact on a mother's ability to care for their infant, it would seem logical for interventions to be aimed at helping to 'resolve' trauma and help mothers develop their reflective functioning capacity.

Various MBT-based interventions have been introduced into mental health services; indeed the participants of the current study were recruited from an MBT-based group which had been developed for mothers who had had their children removed from their care.

Baby World (Parkinson, 2012) and Minding the Baby (Slade, Sadler, De Dios-Kenn, Webb, Currier-Ezepchick & Mayes, 2005) are two examples of attachment based interventions which use mentalisation theory to help mothers develop their mind-mindedness (a capacity to hold the infant in mind and acknowledge that the infant has a mind of its own). These groups have been found to have a positive effect on the mother's mentalising ability and mothers make significantly more appropriate mind-minded comments than those in the control group (Parkinson, 2012).

Bieman's work using video footage with mothers in the 1980s led to the development of a number of video interaction therapies which aim to improve mother's reflective functioning and help mother-infant bonding (Beebe, 2003). These interventions use video footage of interactions between mother and infant which are reviewed with the mother to help her understand more about her baby's communication and her behavioural responses. Research has found video interventions to be effective in reducing children's emotional and behavioural difficulties, as well as bringing about positive changes in parenting style and improving relationships between parent and child (Whalley & Williams, 2015). In an NSPCC study, parents reported that they had 'struggled to access appropriate support and found it frustrating that things had to be so bad before hearing about this programme' (Whalley & Williams, 2015, p. 6) which

supports the researcher's concern that effective interventions are not happening early enough.

The interventions described thus far focus predominantly on mothers (and sometimes fathers), however the findings of the current study show the important role played by extended family members such as grandparents. It may therefore be sensible to harness this potential resource and consider ways of involving them in prevention and intervention programmes, as well as ensuring that they too receive support and advice.

In addition to considering initiatives aimed at prevention and early intervention, attention needs to be paid to the parents who have not managed to care for their children and who have lost their parental rights. Thus support for parents in the 'aftermath' of child removal is important also; particularly given the research showing high rates of repeat pregnancies among this group. Broadhurst & Mason (2013) found that although post-adoption support is meant to be offered under the Adoption and Children's Act (2002), this rarely happens and they recommend a 'proactive and multiagency approach to enable the cycle of repeat pregnancies and removals to be broken' (Broadhurst & Mason, 2013, p. 298).

A Cochrane review (Barlow, Smailagic, Huband, Roloff & Bennett, 2012) concluded that there is:

> *Considerable potential for interventions aimed at promoting the psychosocial wellbeing of parents to reduce the disruption to the child's emotional, educational and social adjustment, and thereby to promote the mental health of future generations (p. 4)*

The interventions discussed thus far provide examples and suggestions for direct interventions which have such potential, however there is a need for more indirect intervention also.

Ensuring that attachment theory and mentalisation-based practices are included in the teaching curriculums for psychology, social work and other healthcare professionals is essential. The more able professionals are to think about problems existing within a relational framework influenced by transgenerational factors, the more likely such problems will be understood and dealt with in a holistic, effective, and non-blaming way. In practice, professionals should be supported to think from an attachment and systemic perspective whereby 'problems' are not located solely in the child, nor the parent. Clinical Psychologists are ideally placed to assist with such trainings and supervision, as well as being able to provide consultation and teaching regarding psychological theories of child development and parental mental health.

6.3.3 Societal level

At present mothers who cause harm to their children are vilified by the media and condemned by society. While child abuse is not acceptable in any form, regardless of class, culture and status, a degree of understanding is required. As one of the participants put it so eloquently "I can kind of understand, but I just don't think it is an excuse".

Changing the way that motherhood is either idealised or denigrated in the media is essential; it is not helpful for mothers to be presented as either saintly or evil. The works of Estella Welldon, particularly her book 'Mother, Madonna, Whore' (Weldon, 1988), are helpful when considering the concept of 'ordinary maternal failure'.

Marginalised groups who are unable to be tolerated by society (and thus positioned as 'evil others') experience serious and enduring stigma which undoubtedly impacts upon their mental health (Williams, Moore, Adshead, McDowell, & Tapp, 2011). The effects of such social stigma are vast and have been described as a second illness (Wahl, 1999). There is thus a need to establish more balanced media coverage which conveys compassion and a willingness to help. Mothers who are struggling with their

maternal role require support and simply removing children does not solve the problem.

Social Services have undergone significant transformations in light of the Munro Report (2011) whereby the needs for early intervention and better multi-agency working were identified. The Hertfordshire Family Safeguarding Project is an example of the current drive to try and keep high risk families together by conducting targeted assessments and interventions (delivered by MDT professionals).

6.4 Conclusion

The findings of the current study support previous research which links unresolved trauma and loss to difficulties with reflective functioning and thus impaired parenting ability. There are a variety of interventions aimed at improving parent's ability to mentalise their child, as well as practical parenting support groups. Identifying potential high risk parents is essential and suggestions for screening have been made. It is also believed that more indirect interventions are required, whereby professionals from all disciplines are trained in and supported to practice from an attachment and systemic perspective thus providing holistic, effective and non-blaming services. It is hoped that reporting good quality research will help change media narratives about mothers who are either perfect or wicked.

Clinical Psychologists are ideally placed to provide both direct and indirect interventions due to their training and expertise in various models and research. Furthermore, psychologists are able to provide training, supervision and consultation, and often now sit within influential positions and hold leadership roles which shape service delivery models.

6.5 Methodological Considerations

The use of Thematic Analysis (TA) to analyse the data was both appropriate and helpful in attempting to answer the research question; 'what goes unheard when

struggling mothers speak?'. The flexible and inductive nature of TA enabled themes to emerge which may previously have been 'unheard' (and not coded for in traditional AAI scoring protocols). Quality frameworks of Elliot et al. (1999) and Yardley (2000) helped the researcher to maintain a reflexive stance throughout the research process and view the material for what it was, rather than trying to impose predetermined ideas or theories onto it. Further strengths and unique aspects of the study will now be discussed, and consideration given to the limitations of the study.

6.5.1 Strengths of the study

The use of TA methodology to understand the AAIs of mothers with PD who have had their children removed, has not been done previously in the UK. The current study is therefore unique in its attempt to understand the attachment narratives of this complex and marginalised group of mothers. Hearing the mother's stories in a different way allowed for themes to emerge which are helpful in understanding the maternal sequelae of having a history of unresolved trauma and loss. Furthermore, the use of TA highlighted themes such as strength and resilience which are not currently attended to in the AAI scoring protocols. The current study has therefore contributed to the literature and complemented Bakermans-Kranenburg & van Ijzendoorn's (2009) recommendation which stated that attachment research should start to focus on the 'counterintuitive resilience' of individuals (p. 253).

Lyons-Ruth and colleagues have conducted AAIs with socially disadvantaged mothers in the US; however the mothers did not have PD and had not had their children removed. Engaging 'hard to reach' mothers with PD adds to the unique aspect of the current study. Lyons-Ruth et al. (2005) described a need to extend 'adult attachment constructs and assessments to at-risk or clinical populations' (p. 1) and the current study has achieved this.

In addition to the unique method and sample of the current study, a high standard of qualitative research was upheld, in particular, the sample size was deemed sufficient to reach data saturation and the process of analysing themes was robust.

Furthermore, data was triangulated and all themes were agreed by the researcher and supervisor. The researcher made use of a reflective journal throughout the research process in order to help 'bracket' her assumptions and process her emotional responses to the data.

6.5.2 Limitations of the study

A potential limitation of the study was the absence of a comparison group. It may have been helpful to have compared the sample with a less disorganised group of mothers with PD who still had their children with them and who may not have experienced as much loss.

The eight participants had been recruited from a personality disorder service where they were attending weekly MBT group therapy; they could therefore be considered to have a degree of motivation and a wish to make changes in their life. Aldridge (2012) argues that researchers should try to access hard to reach groups as otherwise they become more marginalised. With this in mind the current study might have conducted AAIs with the mothers who 'dropped out' of the group, thus helping to understand attrition rates.

There is a growing body of literature which suggests that BPD is in fact a form of complex PTSD (see De Zulueta, 2009) and therefore one may question the reliability of the participants PD diagnoses; while coined a PD service, was it in fact a PTSD service? Childhood onset PTSD is different in important ways to adult onset and may go some way towards helping to reduce stigma as people are more likely to ask 'what happened to you?' rather than 'what's wrong with you?'.

In order for AAIs to be reliably coded, adherence to the interview protocol is essential. While this is understandable, it limited the interaction between the researcher and the participants and did not allow for additional or ad hoc questions to be asked. Also the interview has to be taped, transcribed and rated by a trained rater according to the manual, therefore while it may be regarded as the 'gold standard' it is somewhat cumbersome and unwieldy.

Another possible limitation was that the attachment status of the participant's children was not formally known, therefore when discussing transgenerational transmission a degree of speculation was required. Finally, the generalisability of the findings of the current study are limited to mothers with PD who have had their children taken away; however these numbers are not small.

In terms of process, some of the challenges of conducting AAIs with non-normative samples reported by Turton et al. (2001) were found in the current study. The language used by participants often displayed high levels of hostility which Turton et al. (2001) report may be coded as dismissing, when in fact such hostile remarks may be 'licenced'. An example of this was seen when one of the participants remarked "he's dead now, thank God" when speaking of her father. While this may be interpreted in a negative light, it was important to understand the context surrounding her statement; her father had repeatedly physically and sexually abused her as a child and she had felt "terrified" of him.

A further challenge reported by Turton et al. (2001) had been the level of censorship. The participants of the current study appeared open and shared difficult and meaningful information with the researcher, however when speaking about their relationships with their children it was unclear the degree of censorship that may have been used. The researcher was surprised by the generosity and altruism described by participants when wishing their children much happiness, success and love for their futures; the researcher had expected to uncover a greater degree of ambivalence and envy. The latter did not surface when analysing the data and while this may indicate the degree of progress made by participants, it may also suggest some censorship of their true feelings towards their children. Many of the participants still had a high level of involvement with social services and were frequently supervised, evaluated and assessed, therefore withholding information which they feared may incriminate them in some way or hinder their chances of having children returned to them, would be understandable.

6.6 Recommendations for future research

Further research using Thematic Analysis methodology to analyse AAIs is recommended and may wish to focus on mothers who have a similar PD profile and have experienced the removal of their children, but who have not actively engaged in psychological therapies. It is likely that engagement and issues of attrition may pose significant challenges to this task. A further recommendation is to analyse the AAIs of mothers who have a similar PD profile who have *not* had their children removed. Such research may enable us to learn more about the development and effects of motivation, resilience and protective factors in this marginalised population.

Additional methodologies to analyse AAIs may wish to be considered, such as Narrative Analysis; this may help us to understand more about how mothers develop and (re)negotiate their maternal identities.

A common criticism of attachment theory and research has been the lack of attention paid to fathers and thus 'there is clearly an urgent need for further research into the contribution of father-child attachment security and insecurity to children's development' (Fearon, Bakermans-Kranenburg, van Ijzendoorn, Lapsley, & Roisman, 2010, p. 448). It is therefore recommended that future research attends to the experiences of fathers who have 'lost' their children; by way of court order or as a result of custody proceedings. Such research may highlight similar narratives whereby complex trauma and loss are present in the father's histories.

In addition to recommendations for future research, it is recommended that clinicians working with mothers with PD refer to the works of Zanarini who states:

Patients who do not feel that people care about them or hear them are not going to be happy that someone, however well intentioned, is trying to take away their pain' and 'a useful approach is not crowding the patient with an externally imposed version

of the truth of their life but instead listening carefully as they develop or, more probably, simply relate a personal narrative they have been quietly, even secretly, working on for years (Zanarini, 2005, p. 21)

The importance of truly listening and hearing the needs of mothers was described by Bowlby almost eighty years ago when he wrote:

A weekly interview in which their problems are approached analytically and traced back to childhood has sometimes been remarkably effective. Having once been helped to recognize and recapture the feelings which she herself had as a child and to find that they are accepted tolerantly and understandingly, a mother will become increasingly sympathetic and tolerant toward the same things in her child (Bowlby, 1940, p. 23)

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8.0 APPENDICES

8.1 Appendix 1 – Adult Attachment Interview (AAI) schedule

This material is not a substitute for training in AAI administration procedure. It is provided because it is important for consumers of AAI research to have easy access to the interview questions. Without them, it is difficult to evaluate published research. Seeing the full interview protocol can also help consumers of AAI based research appreciate the level of interview information and detail underlying AAI scores. It can also help them make important decisions about the adequacy of procedures in various reports they may encounter.

The authors of the AAI make the scoring manual available only in conjunction with their training courses. Researchers interested in understanding more about the logic of scoring the AAI can however see the scoring manual for Crowell & Owens' Current Relationship Interview (CRI) which is available in full on this site. The logic and procedures for scoring the CRI closely parallel those for the AAI. The primary difference is that the AAI focuses on relationships to parents and the CRI on relationships to adult attachment figures. At present this is the only detailed source of insights into the criteria for scoring the AAI available to those who do not take the training course.

EW

ADULT ATTACHMENT INTERVIEW PROTOCOL

George, C., Kaplan, N., & Main, M. (1985). *The Adult Attachment Interview*. Unpublished manuscript, University of California at Berkeley.

(Note: This document is for illustration only. Contact the authors for information about training and the most current version of the interview protocol.)

Introduction

I'm going to be interviewing you about your childhood experiences, and how those experiences may have affected your adult personality. So, I'd like to ask you about your early relationship with your family, and what you think about the way it might have affected you. We'll focus mainly on your childhood, but later we'll get on to your adolescence and then to what's going on right now. This interview often takes about an hour, but it could be anywhere between 45 minutes and an hour and a half.

1. Could you start by helping me get oriented to your early family situation, and where you lived and so on? If you could tell me where you were born, whether you moved around much, what your family did at various times for a living?

This question is used for orientation to the family constellation, and for warm-up purposes. The research participant must not be allowed to begin discussing the quality of relationships here, so the "atmosphere" set by the interviewer is that a brief list of "who, when" is being sought, and *no more than two or three minutes* at most should be used for this question. The atmosphere is one of briefly collecting demographics.

In the case of participants raised by several persons, and not necessarily raised by the biological or adoptive parents (frequent in high-risk samples), the opening question above may be *"Who would you say raised you?':* The interviewer will use this to help determine who should be considered the primary attachment figure (s) on whom the interview will focus.

> *Did you see much of your grandparents when you were little? If* participant indicates that grandparents died during his or her own lifetime, ask the participant's age at the time of each loss. If there were grandparents whom she or he never met, ask *whether this (these) grandparents) had died before she was born.* If yes, *continue as* follows: *Your mother's father died before you were born? How old was she at the time, do you know?* In a casual and *spontaneous way,* inviting only a very brief reply, the interviewer then asks, *Did she tell you much about this grandfather?*
>
> *Did you have brothers and sisters living in the house, or anybody besides your parents? Are they liv-*

ing nearby now or do they live elsewhere?

2. I'd like you to try to describe your relationship with your parents as a young child if you could start from as far back as you can remember?

Encourage participants to try to begin by remembering very early. Many say they cannot remember early childhood, but you should shape the questions such that they focus at first around age five or earlier, and gently remind the research participant from time to time that if possible, you would like her to think back to this age period.

Admittedly, this is leaping right into it, and the participant may stumble. If necessary, indicate in some way that experiencing some difficulty in initially attempting to respond to this question is natural, but indicate by some silence that you would nonetheless like the participant to attempt a general description.

3. Now I'd like to ask you to choose five adjectives or words that reflect your relationship with your mother starting from as far back as you can remember in early childhood--as early as you can go, but say, age 5 to 12 is fine. I know this may take a bit of time, so go ahead and think for a minute...then I'd like to ask you why you chose them. I'll write each one down as you give them to me.

Not all participants will be able to think of five adjectives right away. Be sure to make the word *relationship* clear enough to be heard in this sentence. Some participants do use "relationship" adjectives to describe the parent, but some just describe the parent herself --e.g., "pretty"... "efficient manager"--as though they had only been asked to "pick adjectives to describe your mother". These individual differences are of interest only if the participant has heard the phrase, "that reflect your childhood *relationship"* with your mother. The word should be spoken clearly, but with only slight stress or emphasis.

Some participants will not know what you mean by the term *adjectives,* which is why we phrase the question as "adjectives or words". If the participant has further questions, you can explain, "just words or phrases that would describe or tell me about your relationship with your (mother) during childhood".

The probes provided below are intended to follow the entire set of adjectives, and *the interviewer must not begin to probe until the full set of adjectives has been given.* Be patient in waiting for the participant to arrive at five adjectives, and be encouraging. This task has proven very helpful both in starting an interview, and in later interview analysis. It helps some participants to continue to focus upon the relationship when otherwise they would not be able to come up with spontaneous comments.

If for some reason a subject does not understand what a memory is, you might suggest they think of it like an image they have in their mind similar to a videotape of something which happened when they were young. Make certain that the subject really does not understand the question first, however. The great majority who may seem not to understand it are simply unable to provide a memory or incident.

The participant's ability (or inability) to provide both an overview of the relationship and specific memories supporting that overview forms one of the most critical bases of interview analysis. For this reason it is important for the interviewer to press enough in the effort to obtain the five "overview" adjectives that if a full set is not provided, she or he is reasonably certain that they truly cannot be given.

The interviewer's manner should indicate that waiting as long as a minute is not unusual, and that trying to come up with these words can be difficult. Often, participants indicate by their non-verbal behavior that they are actively thinking through or refining their choices. In this case an interested silence is warranted. Don't, however, repeatedly leave the participant in embarrassing silences for very long periods. Some research participants may tell you that this is a hard job, and you can readily acknowledge this. If the participant has extreme difficulty coming up with more than one or two words or adjectives, after a period of two to three minutes of supported ttempts ("Mm... I know it can be hard ...this is a pretty tough question... Just take a little ore time"),

then say something like "Well, that's fine. Thank you, we'll just go with he ones you've already given me." The interviewer's tone here should make it clear that the participant's response is perfectly acceptable and not uncommon.

> *Okay, now let me go through some more questions about your description of your childhood relationship with your mother. You say your relationships with her was (you used the phrase) Are there any memories or incidents that come to mind with respect to (word)*

The same questions will be asked *separately* for *each* adjective in series. Having gone through the probes which follow upon this question (below), the interviewer moves on to seek illustration for each of the succeeding adjectives in turn:

> *You described your childhood relationship with your mother as (or, `your second acyective was", or "the second word you used was"). Can you think of a memory or an incident that would illustrate why you chose to describe the relationship?*

The interviewer continues, as naturally as possible, through each phrase or adjective chosen by the participant, until all five adjectives or phrases are covered. A specific supportive memory or expansion and illustration is requested for each of the adjectives, separately. In terms of time to answer, this is usually the longest question. Obviously, some adjectives chosen may be almost identical, e.g., "loving ... caring". Nonetheless, if they have been given to you as separate descriptors, you must treat each separately, and ask for memories for each.

While participants sometimes readily provide a well-elaborated incident for a particular word they have chosen, at other times they may fall silent; or "illustrate" one adjective with another ("loving ...um, because she was generous"); or describe what usually happened--i.e., offer a "scripted" memory--rather than describing specific incidents. There are a set series of responses available for these contingencies, and it is vital to memorize them.

If the participant is silent, the interviewer waits an appropriate length of time. If the participant indicates nonverbally that she or he is actively thinking , remembering or simply attempting to come up with a particularly telling illustration, the interviewer maintains an interested silence. If the silence continues and seems to indicate that the participant is feeling stumped, the interviewer says something like, "well, just take another minute and see if anything comes to mind". If following another waiting period the participant still cannot respond to the question, treat this in a casual, matter of fact manner and say "well, that's fine, let's take the next one, then". Most participants do come up with a response eventually, however, and the nature of the response then determines which of the follow-up probes are utilize

If the participant re-defines an affective with a second adjective as, "Loving ---she was generous", the interviewer probes by repeating the original adjective (loving) rather than permitting the participant to lead them to use the second one (generous). In other words, the interviewer in this case will say, "Well, can you think of a specific memory that would illustrate how your relationship was loving?" The interviewer should be careful, however, not to be too explicit in their intention to lead the participant back to their original word usage. If the speaker continues to discuss "generous" after having been probed about loving once more, this violation of the discourse task is meaningful and must be allowed. As above, the nature of the participant's response determines which follow-up probes are utilized.

If a spgcific and well-elaborated incident is given, the participant has responded satisfactorily to the task, and the interviewer should indicate that she or he understands that. However, the interviewer should briefly show continuing interest by asking whether the participant can think of a second incident.

- If one specific but poorly elaborated incident is given, the interviewer probes for a second. Again, the interviewer does this in a manner emphasizing his or her own interest.

- If as a first response the participant gives a "scripted" or "general" memo[y, as "Loving. She always took us to the park and on picnics. She was really good on holidays" or "Loving. He taught me to ride

a bike"--the interviewer says, "Well, that's a good general description, but I'm wondering if there was a particular time that happened, that made you think about it as loving?"

- If the participant does now offer a specific memory, briefly seek a second memory, as above. If another scripted memory is offered instead, or if the participant responds "I just think that was a loving thing to do", the interviewer should be accepting, and go on to the next adjective. Here as elsewhere the interviewer's behavior indicates that the participant's response is satisfactory.

4. ***Now I'd like to ask you to choose five adjectives or words that reflect your childhood relationship with your father, again starting from as far back as you can remember in early childhood--as early as you can go, but again say, age 5 to 12 is fine. I know this may take a bit of time, so go ahead and think again for a minute...then I'd like to ask you why you chose them. I'll write each one down as you give them to me. (Interviewer repeats with probes as above).***

5. ***Now I wonder if you could tell me, to which parent did you feel the closest, and why? Why isn't there this feeling with the other parent?***

By the time you are through with the above set of questions, the answer to this one may be obvious, and you may want to remark on that ***("You've already discussed this*** a bit, but I'd like to ask about it briefly anyway..."). Futhermore, while the answer to this question may indeed be obvious for many participants, some--particularly those who describe both parents as loving--may be able to use it to reflect further on the difference in these two relationships.

6. ***When you were upset as a child, what would you do?***

This is a critical question in the interview, and variations in the interpretation of this question are important. Consequently, the participant is first encouraged to think up her own interpretations of "upset", with the interviewer pausing quietly to indicate that the question is completed, and that an answer is requested.

Once the participant has completed her own interpretation of the question, giving a first answer, begin on the following probes. Be sure to get expansions of every answer. If the participant states, for example, "I withdrew", probe to understand what this research participant means by "withdrew". For example, you might say, "And what would you do when you withdrew?"

The interviewer now goes on to ask the specific follow-up questions below. These questions may appear similar, but they vary in critical ways, so the interviewer must make sure that the participant thinks through each question separately. This is done by placing vocal stress on the changing contexts (as we have indicated by underlining).

-----When you were <u>Upset</u> <u>emotionally</u> when you were little, what would you do? (Wait for participant's reply). *Can you think of a specific time that happened?*

-----Can you remember what would happen when you were <u>hurt.</u> physically? (Wait for participant's reply). *Again, do any specific incidents (or, do any other incidents) come to mind?*

-----Were you ever M when you were little? (Wait for participant's reply). Do *you remember what would happen?*

When the participant describes going to a parent, see first what details they can give you spontaneously. Try to

get a sense of how the parent or parents responded, and then when and if it seems appropriate you can briefly ask one or two clarifying questions.

Be sure to get expansions of every answer. Again, if the participant says "I withdrew", for example, probe to see what the participant means by this, i.e., what exactly she or he did, or how exactly they felt, and if they can elaborate on the topic.

If the participant has not spontaneously mentioned being held by the parent in response to any of the above questions, the interviewer can ask casually at the conclusion to the series, ***"I was just wondering, do you remember being held by either of your parents at any of these times--I mean, when you were upset, or hurt, or ill?"***
In earlier editions of these guidelines, we suggested that if the participant answers primarily in terms of responses by one of the parents, the interviewer should go through the above queries again with respect to the remaining parent. This can take a long time and distract from the recommended pacing of the interview. Consequently, it is no longer required.

> ***What is the first time you remember being separated from your parents?***
>
> ***- - -How did you respond? Do you remember how your parents responded?***
>
> ***- - -Are there any other separations that stand out in your mind?***

Here research participants often describe first going off to nursery school, or to primary school, or going camping.

In this context, participants sometimes spontaneously compare their own responses to those of other children. This provides important information regarding the participant's own overall attitude towards attachment, so be careful not to cut any such descriptions or comparisons short.

8. ***Did you ever feel rejected as a young child? Of course, looking back on it now, you may realize it wasn't really rejection, but what I'm trying to ask about here is whether you remember ever having rejected in childhood***

> *-----How old were you when you first felt this way, and what did you do?*
>
> *----Why do you think your parent did those things--do you think he/she realized he/she was rejecting you?*
>
> Interviewer may want to add a probe by refraining the question here, especially if no examples are forthcoming. The probe we suggest here is, *Did you ever feel pushed away or ignored?"*
> Many participants tend to avoid this in terms of a positive answer.
> *So, were you ever frightened or worried as a child?*

Let the research participant respond "freely" to this question, defining the meaning for themselves. They may ask you what the question means, and if so, simply respond by saying "It's just a more general question". Do not probe heavily here. If the research participant has had traumatic experiences which they elect not to describe, or which they have difficulty remembering or thinking about, you should not insist upon hearing about them. They will have a second, brief opportunity to discuss such topics later.

9. ***Were your parents ever threatening with you in any way - maybe for discipline, or even jokingly?***

> *-----Some people have told us for example that their parents would threaten to leave them or send them away from home.*
> -----(Note to researchers). In particular communities, some specific kind of punishment not generally

considered fully abusive is common, such as "the silent treatment", or "shaming", etc. One question regarding this one selected specific form of punishment can be inserted here, as for example, *'Some people have told us that their parents would use the silent treatment---did this ever happen with your parents?':* The question should then be treated exactly as threatening to send away from home, i.e., the participant is free to answer and expand on the topic if she or he wishes, but there are no specific probes. The researcher should not ask about more than one such specific (community) form of punishment, since queries regarding more than one common type will lead the topic away from its more general intent (below).

Some people have memories of *threats or* of *some kind* of *behavior that was abusive.*

-----Did anything like this ever happen to you, or in your family?

-----How old were you at the time? Did it happen frequently?

-----Do you feel this experience affects you now as an adult?

-----Does it influence your approach to your own child?

-----Did you have any such experiences involving people outside your family?

If the participant indicates that something like this did happen outside the family, take the participant throught the same probes *(age? frequency? affects you now as an adult? Influences your approach to your own child?).* Be careful with this question, however, as it is clinically sensitive, and by now you may have been asking the participant difficult questions for an extended period of time.

Many participants simply answer "no" to these questions. Some, however, describe abuse and may some suffer distress in the memory. When the participant is willing to discuss experiences of this kind, the interviewer must be ready to maintain a respectful silence, or to offer active sympathy, or to do whatever may be required to recognize and insofar as possible to help alleviate the distress arising with such memories.

If the interviewer suspects that abuse or other traumatic experiences occurred, it is important to attempt to ascertain the specific details of these events insofar as possible. In the coding and classification system which accompanies this interview, *distressing experiences cannot be scored for Unresolved /disorganized responses unless the researcher is able to establish that abuse (as opposed to just heavy spanking, or light hitting with a spoon that was not frightening) occurred.*

Where the nature of a potentially physically abusive (belting, whipping, or hitting) experience is ambiguous, then, the interviewer should try to establish the nature of the experience in a light, matter-of-fact manner, without excessive prodding. If, for example, the participant says "I got the belt" and stops, the interviewer asks, "And what did getting the belt mean?". After encouraging as much spontaneous expansion as possible, the interviewer may still need to ask, again in a matter-of-fact tone, how the participant responded or felt at the time. "Getting the belt" *in itself will* not qualify as abuse within the adult attachment scoring and classification systems, since in some households and communities this is a common, systematically but not harshly imposed experience. Being belted heavily enough to overwhelmingly frighten the child for her physical welfare at the time, being belted heavily enough to cause lingering pain, and/or being belted heavily enough to leave welts or bruises will qualify.

In the case of sexual abuse as opposed to battering, the interviewer will seldom need to press for details, and should be very careful to follow the participant's lead. Whereas on most occasions in which a participant describes themselves as sexually abused the interviewer and transcript judge will have little need to probe further, occasionally a remark is ambiguous enough to require at least mild elaboration. If, for example, the participant states `and I just thought he could be pretty sexually abusive', the interviewer will ideally follow-up with a

query such as, ` well, could you tell me a little about what was happening to make you see him as sexually abusive?'. Should the participant reply that the parent repeatedly told off-color jokes in her company, or made untoward remarks about her attractiveness, the parent's behavior, though insensitive, will not qualify as sexually abusive within the accompanying coding system. Before seeking elaboration of any kind, however, the interviewer should endeavor to determine whether the participant seems comfortable in discussing the incident or incidents.

All querying regarding abuse incidents must be conducted in a matter-of-fact, professional manner. The interviewer must use good judgment in deciding whether to bring querying to a close if the participant is becoming uncomfortable. At the same time, the interviewer *must not avoid the topic or give the participant the impression that discussion of such experiences is unusual.* Interviewers sometimes involuntarily close the topic of abuse experiences and their effects, in part as a well-intentioned and protective response towards participants who in point of fact would have found the discussion welcome.

Participants who seem to be either thinking about or revealing abuse experiences for the first time-- "No, nothing ....no... well, 1, I haven't thought, remembered this for, oh, years, but ...maybe they used to... tie me.... "-- must be handled with special care, and should *not* be probed unless they clearly and actively seem to want to discuss the topic. If you sense that the participant has told you things they have not previously discussed or remembered, special care must be taken at the end of the interview to ensure that the participant does not still suffer distress, and feels able to contact the interviewer or project director should feelings of distress arise in the future.

In such cases the participant's welfare must be placed above that of the researcher. While matter-of-fact, professional and tactful handling of abuse-related questions usually makes it possible to obtain sufficient information for scoring, the interviewer must be alert to indications of marked distress, and ready to tactfully abandon this line of questioning where necessary. Where the complete sequence of probes must be abandoned, the interviewer should move gracefully and smoothly to the next question, as though the participant had in fact answered fully.

10. In general, how do you think your overall experiences with your parents have affected your adult personality?

The interviewer should pause to indicate she or he expects the participant to be thoughtful regarding this question, and is aware that answering may require some time.

Are there any aspects to your early experiences that you feel were a set-back in your development?

In some cases, the participant will already have discussed this question. Indicate, as usual, that you would just like some verbal response again anyway, "for the record".

It is quite important to know whether or not a participant sees their experiences as having had a negative effect on them, so the interviewer will follow-up with one of the two probes provided directly below. The interviewer must stay alert to the participant's exact response to the question, since the phrasing of the probe differs according to the participant's original response.

If the participant has named one or two setbacks, the follow-up probe used is:

---Are there any other aspects of your early experiences, that you think might have held your development back, or had a negative efect on the way you turned out?

If the participant has understood the question, but has not considered anything about early experiences a setback, the follow-up probe used is:

---Is there <u>any thin</u> about your early experiences that you think might have held your development back, or had a negative effect on the way you turned out?

Although the word ***anything*** receives some vocal stress, the interviewer must be careful not to seem to be expressing impatience with the participant's previous answer. The stress simply implies that the participant is being given another chance to think of something else she or he might have forgotten a moment ago.

RE: PARTICIPANTS WHO DON'T SEEM TO UNDERSTAND THE TERM, SETBACK. A few participants aren't familiar with the term, ***set-back.*** If after a considerable wait for the participant to reflect, the participant seems simply puzzled by the question, the interviewer says,

"Well, not everybody uses terms like ***set-back*** *for what I mean here. I mean, was there anything about your early experiences, or any parts* of *your early experiences, that you think might have held your development back, or had a negative effect on the way you turned out?"*

In this case, this becomes the main question, and the probe becomes

-Is there anything else about your early experiences that you think might have held your development back, or had a negative effect on the way you turned out?

11. Why do you think your parents behaved as they did during your childhood?

This question is relevant even if the participant feels childhood experiences were entirely positive. For participants reporting negative experiences, this question is particularly important.

12. Were there any other adults with whom you were close, like parents, as a child?

--- Or any other adults who were especially important to you, even though not parental?

Give the participant time to reflect on this question. This is the point at which some participants will mention housekeepers, au pairs, or nannies, and some will mention other family members, teachers, or neighbors.

Be sure to find out ages at which these persons were close with the participant, whether they had lived with the family, and whether they had had any caregiving responsibilities. In general, attempt to determine the significance and nature of the relationship.

13. Did you experience the loss of a parent or other close loved one while you were a young child--for example, a sibling, or a close family member?

(A few participants understand the term "loss" to cover brief or long-term separations from living persons, as, "I lost my mom when she moved South to stay with her mother". If necessary, clarify that you are referring to death only, i.e. specifically to loved ones who had died).

-----Could you tell me about the circumstances, and how old you were at the time?

-----How did you respond at the time?

-----Was this death sudden or was it expected?

-----Can you recall your feelings at that time?

-----Have your feelings regarding this death changed much over time?

If not volunteered earlier. *Did you attend the funeral, and what was this like for you?*

If loss of a parent or *sibling. What would you say was the effect on your (other parent) and on your household, and how did this change over the years?*

-----*Would you say this loss has had an effect on your adult personality?*

-----Were relevant *How does it affect your approach to your own child?*

13a. ***Did you lose any other important persons during your childhood?***
(Same queries--again, this refers to people who have died rather than separation experiences).

13b. Have you lost other close persons, in adult years? (Same queries).

Be sure that the response to these questions covers loss of any siblings, whether older or younger, loss of grandparents, and loss of any person who seemed a "substitute parent" or who lived with the family for a time. Some individuals will have been deeply affected by.

Probe any loss which seems important to the participant, including loss of friends, distant relatives, and neighbors or neighbor's children. Rarely, the research participant will seem distressed by the death of someone who they did not personally know (often, a person in the family, but sometimes someone as removed as the friend of a friend).

If a participant brings up the suicide of a friend of a friend and seems distressed by it, the loss ***should be fully*** probed. The interviewer should be aware, then, that speakers may be assigned to the unresolved/disorganized adult attachment classification as readily for lapses in monitoring occurring during the discussion of the death of a neighbor's child *experienced during the adult* years as for loss of a parent in childhood.

Interviewing research participants regarding loss obviously requires good clinical judgment. At maximum, only four to five losses are usually fully probed. In the case of older research participants or those with traumatic histories, there may be many losses, and the interviewer will have to decide on the spot which losses to probe. No hard and fast rules can be laid out for determining which losses to skip, and the interviewer must to the best of his or her ability determine which losses--if there are many--are in fact of personal significance to the participant. Roughly, in the case of a participant who has lost both parents, spouse, and many other friends and relatives by the time of the interview, the interviewer might elect to probe the loss of the parents, the spouse, and "any other loss which you feel may have been especially important to you". If, however, these queries seem to be becoming wearying or distressing for the participant, the interviewer should acknowledge the excessive length of the querying, and offer to cut it short.

14. ***Other than any difficult experiences you've already described, have you had any other experiences which you should regard as potentially traumatic?***

Let the participant free-associate to this question, then clarify if necessary with a phrase such as, ***I mean, any experience which was overwhelmingly and immediately terrifying.***

This question is a recent addition to the interview. It permits participants to bring up experiences which may otherwise be missed, such as scenes of violence which they have observed, war experiences, violent separation, or rape.

Some researchers may elect not to use this question, since it is new to the 1996 protocol. If you do elect to use it, it must of course be used with all subjects in a given study.

The advantage of adding this question is that it may reveal lapses in reasoning or discourse specific to traumatic experiences other than loss or abuse.

Be very careful, however, not to permit this question to open up the interview to all stressful, sad, lonely or upsetting experiences which may have occurred in the subject's lifetime, or the purpose of the interview and of the question may be diverted. It will help if your tone indicates that these are rare experiences.

Follow up on such experiences with probes only where the participant seems at relative ease in discussing the event, and/or seems clearly to have discussed and thought about it before.

Answers to this question will be varied. Consequently, exact follow-up probes cannot be given in advance, although the probes succeeding the abuse and loss questions may serve as a partial guide. In general, the same cautions should be taken with respect to this question as with respect to queries regarding frightening or worrisome incidents in childhood, and experiences of physical or sexual abuse. Many researchers may elect to treat this question lightly, since the interview is coming to a close and it is not desirable to leave the participant reviewing too many difficult experiences just prior to leave taking.

15. Now 1'd like to ask you a few more questions about your relationship with your pants. Were there many changes in your relationship with your parents (or remaining parent) after childhood? We'll get to the present in a moment, but right now 1 mean changes occurring roughly between your childhood and your adulthood?

Here we are in part trying to find out, *indirectly* (1) whether there has been a period of rebellion from the parents, and (2) also indirectly, whether the participant may have rethought early unfortunate relationships and "forgiven" the parents. Do not ask anything about forgiveness directly, however--this will need to come up spontaneously. This question also gives the participant the chance to describe any changes in the parents behavior, favorable or unfavorable, which occurred at that time.

16. Now I'd like to ask you, what is your relationship with your parents (or remaining parent) like for you now as an adult? Here I am asking about your current relationship.

----Do you have much contact with your parents at present?
----What would you say the relationship with your parents is like currently?
---Could you tell me about any (or any other) sources of dissatisfaction in your current relationship with your parents? any special (or any other) sources of special satisfaction?

This has become a critical question within the Adult Attachment Interview, since a few participants who had taken a positive stance towards their parents earlier suddenly take a negative stance when asked to describe current relationships. As always, the interviewer should express a genuine interest in the participant's response to this question, with sufficient pause to indicate that a reflective response is welcome.

17. I'd like to move now to a different sort of question--it's not about your relationship with your parents, instead it's about an aspect of your current relationship with (specific child of special interest to the researcher, or all the participant's children considered together). How do you respond now, in terms of feelings, when you separate from your child / children? (For adolescents or individuals without children, see below).

Ask this question exactly as it is, without elaboration, and be sure to give the participant enough time to respond. Participants may respond in terms of leaving child at school, leaving child for vacations, etc., and this is encouraged. What we want here are the participant's feelings about the separation. This question has been very helpful in interview analysis, for two reasons. In some cases it highlights a kind of role-reversal between parents and child, i.e., the participant may in fact respond as though it were the child who was leaving the parent alone, as though the parent was the child. In other cases, the research participant may speak of a fear of loss of the child, or a fear of death in general. When you are certain you have given enough time (or repeated or clarified the question enough) for the participant's natural ly-occuring response, then (and only then) add the following probe:

-----Do you ever feel worried about (child)?

For individuals without children, you will pose this question as a hypothetical one, and continue through the remaining questions in the same manner. For example, you can say, now I'd *like you to imagine that you have a one-year-old child, and I wonder how you think you might respond, in terms of feelings, if you had to separate from this child?" Do you think you would ever feel worried about this child?".*

18. If you had three wishes for your child twenty years from now, what would they be? I'm thinking partly of the kind of future you would like to see for your child I'll give you a minute or two to think about this one.

This question is primarily intended to help the participant begin to look to the future, and to lift any negative mood which previous questions may have imposed.

For individuals without children, you again pose this question in hypothetical terms. For example, you can say, *"Now I'd like you to continue to imagine that you have a one-year-old child for just another minute. This time, rd like to ask, if you had three wishes for your child twenty years from now, what would they be? I'm thinking partly of the kind of future you would like to see for your imagined child I'll give you a minute or two to think about this one':*

19. Is there any particular thing which you feel you learned above all from your own childhood experiences? I'm thinking here of something you feel you might have gained from the kind of childhood you had.

Give the participant plenty of time to respond to this question. Like the previous and succeeding questions, it is intended to help integrate whatever untoward events or feelings he or she has experienced or remembered within this interview, and to bring the interview down to a light close.

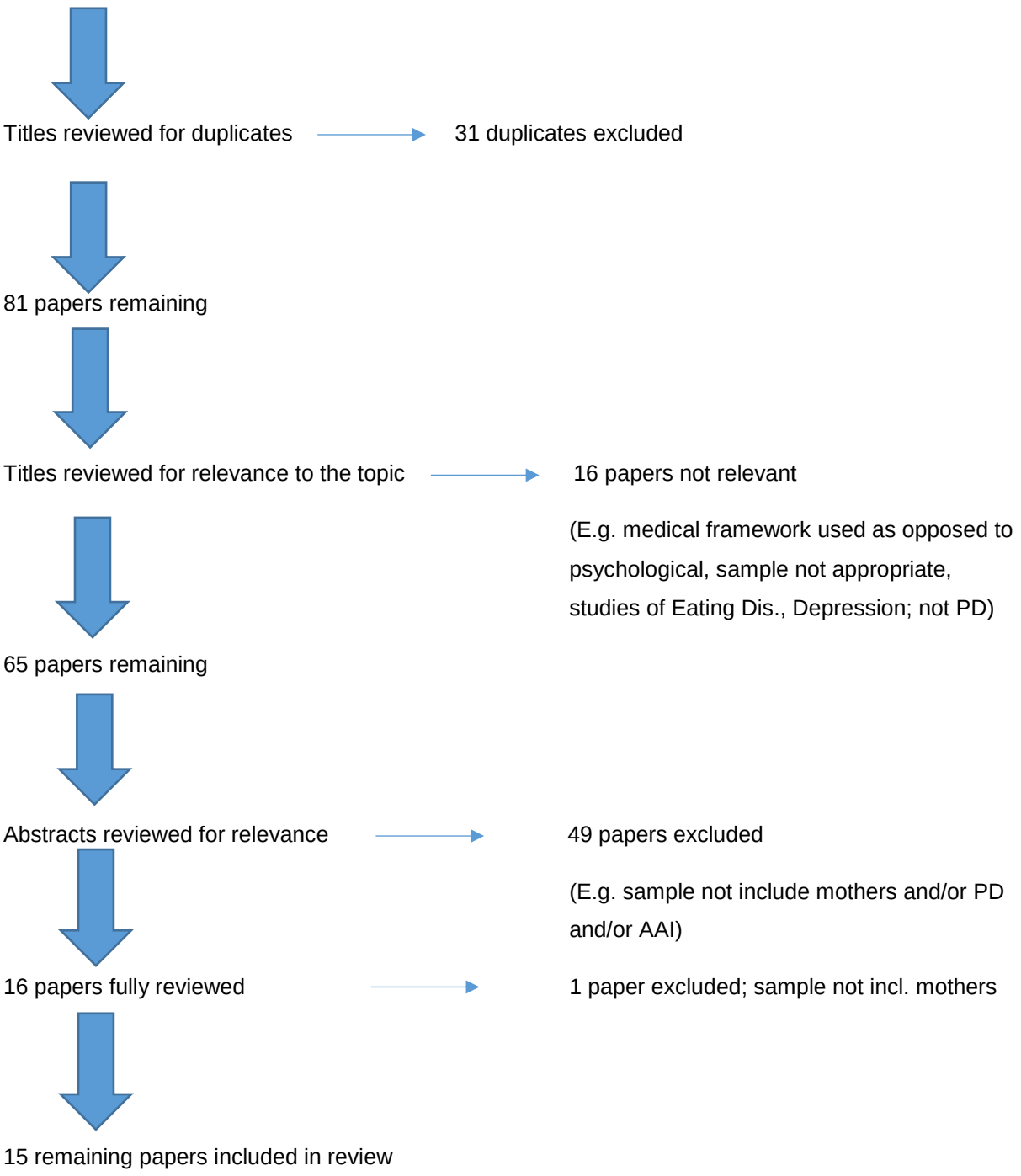
20. We've been focusing a lot on the past in this interview, but I'd like to end up looking quite a ways into the future. We've just talked about what you think you may have learned from your own childhood experiences. 1'd like to end by asking you what would you hope your child (or, your imagined child) might have learned from his/her experiences of being parented by you?

The interviewer now begins helping the participant to turn his or her attention to other topics and tasks. Participants are given a contact number for the interviewer and/or project director, and encouraged to feel free to call if they have any questions.

8.2 Appendix 2 – Literature search strategy

Search engines: Web of Science, PsyARTICLES, and PubMed

Search terms: “adult attachment interview*” AND “personality disorder*”



8.3 Appendix 3 – Summary of the 15 research papers reviewed

No.	Title of paper	Author/s	Date	Type of paper/study	Aims of paper	Strengths (How relevant to my thesis)	Weaknesses (Reasons why not helpful)	Summary of findings
1	Adult attachment interviews of women from low-risk, poverty, and maltreatment risk samples: comparisons between the hostile/helpless and traditional AAI coding systems	A. Frigerio, E. Costantino, E. Ceppi, & L. Barone	2013	Quantitative Introduces the Hostile/Helpless (HH) category in addition to standard AAI coding n=102	Investigate correlation between HH state of mind and traditional AAI coding methods	Three groups included: low risk, poverty and maltreatment. Maltreatment group relevant to my sample	Paper was quantitative in that its purpose was to test the construct validity of HH (not directly relevant)	Found that HH classification increased with the complexity of the sample (i.e. high rates of HH amongst 'maltreatment group)
2	The Adult Attachment Interview: Rating and classification problems posed by non-normative samples	P. Turnton, G. McGauley, L. Marin-Avellan, & P. Hughes	2001	Qualitative Reflective/observational account of the author's experiences of using the AAI with non-normative/forensic populations n=45	Highlight areas of difficulty when scoring AAI using traditional Main & Hesse (1990) method	Well written and accessible paper. Helpful that they provide verbatim eg.s to illustrate their scoring dilemmas. Highlighted areas for future research	Although sample was non-normative (relevant for my study) it was based on a forensic offender population which is not my demographic	While the AAI has many strengths it was developed for use with non-clinical, middle class populations. Therefore there are non-normative populations who do not score within the distinct categories. Categories should be developed further to account for complex clinical presentations
3	Adult Attachment Classification and Self-Reported Psychiatric Symptomatology as Assessed by the Minnesota Multiphasic Personality Inventory-2	R. C. Pianta, B. Egeland, & E. K. Adam	1996	Quantitative Descriptive paper highlighting relations between attachment classification and self-reported symptoms n=102	Examine differences in mothers' AAI classifications and their scores on the MMPI	Very relevant sample (1st time mothers from high-risk poverty sample) Critiques self-report measures, such as MMPI Used a control group	Sample size limited comparison between control and TAU group (which would've been interesting) Used only 1 personality measure (which was self-report MMPI-2) MMPI administered while women were pregnant (accuracy?)	Mothers in each of the three main AAI classification groups showed different rates of reporting symptoms. Dismissing group showed very little (although may be under-reporting). Nearly half of the autonomous/secure group reported symptoms (however this may be that they are more able to introspect and evaluate their needs and thus report more accurately). Preocc. group reported a high level of symptoms indicative of serious mental illness. From these results it would appear that a preocc. att. style is related to higher levels of mental difficulties/impairment
4	Childhood Maltreatment and Prospectively Observed Quality of Early Care as Predictors of	Z. Shi, J-F. Bureau, M. A. Easterbrooks, X. Zhao, K. Lyons-Ruth	2012	Quantitative Prospective longitudinal design n=120	Explores the developmental antecedents to ASPD	Comprehensive statistical analysis conducted Unique (no longitudinal	Focussed solely on ASPD Small sample size	Interestingly found that attachment in infancy was not a significant predictor of ASPD in adulthood, however maternal withdrawal in infancy was.

	Antisocial Personality Disorder Features			'Low income' young adults assessed for ASPD on the SCID, Conflict Tactics Scale, Traumatic Experiences Scale, and AAI.		studies like this) Several thoughtful hypotheses Demonstrated flexibility: They made a minor amendment to the AAI (asked about instances of abuse; I have also made amendments by asking about parenting) Reviewed biological research showing impact of inattentive early care on developing brain of infant Shows similarities between ASPD & BPD develop.	Missing data was inevitable therefore statistical procedures followed to provide estimates	Concluded that in order to reduce rates of ASPD, need to intervene early with withdrawing mothers, work to reduce child abuse, 'monitor emergence of hyperactive and maladaptive behaviour at school', and target 'disorganised' attachment relationships – as all of the above predict ASPD
5	Comparing models of borderline personality disorder: Mothers' experience, self-protective strategies, and dispositional representations	P. M. Crittenden & L. Newman	2010	Quantitative Comparison of two coding methods of scoring AAIs; Main and Goldwyn (M+G) method and Dynamic Maturational Model (DMM) method n=32 Australian mothers; 15 with diagnosis of BPD	To identify differences between mothers with and without BPD in their use of protective psychological strategies. Also, use both coding systems (M+G and DMM) to identify which captures classification more accurately	Clearly describe the differences in the scoring methods Made a nice adaptation to the method by using 16 "distracter" transcripts Give multiple and specific recommendations for future research	Sample size too small to rule out 'sample-specific effects'	The DMM method of classification holds potential to differentiate between clinical conditions Discriminant analysis supported notion doe the DMM classifications, but not the M+G ones
6	excluded							
7	Another step closer to measuring the ghosts in the nursery: preliminary validation of the Trauma	K. Ensink, N. Berthelot, O. BernazzaniL. Normandin & P. Fonagy	2014	Quantitative Examining the validity of the Trauma Reflective	To test validity of the T-RF Scale and also investigate RF in pregnant	Nice inclusion of transgenerational factors Good intro to concept of	They don't report any weaknesses, apart from to say it needs replicating	Attachment classification does not necessarily predict maternal behaviour, however ability to Mentalize does

	Reflective Functioning Scale			Functioning Scale n=100	women with trauma histories	RF/Mentalizing Report that RF was better than expected in some women which alludes to resilience/external protective factors		Convergent and Discriminant validity of the T-RF Scale was found Found a 'dose effect' related to frequency and severity of abuse
8	Mothers with Borderline Personality Disorder: Transition to Parenthood, Parent-Infant Interaction, and Preventive/Therapeutic Approach	J. Wendland, et al.	2014	Qualitative/descriptive account of a piece of mother-infant psychotherapy work (n=1)	Explore 'possible consequences of this mental disorder' (i.e. BPD) for women transitioning to parenthood, and the impact on child dev.	Written in an accessible way Uses clinical case/quotes to illustrate points Recommend necessity of early interventions Reports changes over 3 years	Only reports on one case Would've been interesting to know if the client had completed any psychometrics (and what were the results, and how did these change over time)	Not so much 'findings' per se, but the case they used certainly did provide support for the research/theory they write about at the start of the paper re. BPD, transition to motherhood, and transgenerational issues
9	Unrelenting catastrophic trauma within the family: When every secure base is abusive	H. Steele	2003	A qualitative/commentary paper describing his experience of using AAIs with females who have been ritually abused and present with Multiple Personality Disorder (MPD)/Dissociative Identity Disorder (DID) Doesn't say sample size	To apply AAI to clinical and high-risk sample	Relevant for my study as the sample is considered 'non-normative' Very emotive language (e.g. horrid pain', 'dumb', and 'radically mistaken') which personally I rather like as it brings the material to life, however should be used with caution. Described a clinical example of a patient becoming disturbed during an AAI. Consider confounding variables such as loyalty to the abuser/parent.	Sample were females however not necessarily mothers It doesn't mention the DMM which seems strange considering Steele speaks of a need for more categories No n reported!	Non-normative samples may require more scoring categories on the AAI due to the 'unique' and 'fragmented' speech they present with. Steele found that the multiple 'alters' which appeared in the AAIs each corresponded to a different attachment pattern serving a distinctive function. Suggests that males tend to take an ASPD or Psychopathic path, as opposed to females who take a DID one. Finding support previous research by Liotti (999) whereby children who suffer early abuse tend to deactivate their attachment system.

						A very respectful conclusion referring to the 'brave victims' who 'deserve no less than…'		
10	Intergenerational Transmission of Attachment in Abused and Neglected Mothers: The Role of Trauma-Specific Reflective Functioning	N. Berthelot, K. Ensink, O. Bernazzani, L. Normandin, P. Luyten, & P. Fonagy	2015	Quantitative paper using a 20-month longitudinal design to evaluate the transmission of disorganized attachment from mothers (who have been neglected and abused) to their infants Used measures: PBI, CECA, and AAI. N= 57	Measures the transmission of attachment from mother to infant and investigates how Reflective Function (RF) may predict rate of transmission. They predict that failures in Mentalizing/low RF will play a key role in transmission of disorganized attachment	Introduces RF method of scoring AAIs. Comprehensive demographics section. Linked/followed on from another paper (Ensink et al., 2014) Prospective design and 'state of the art' measures of attachment in mothers and infants They make recommendation for further research into parents RF-T and parent-child interaction Unique findings Recent – 2015	The causal relationship between MBT/RF-T and transmission of attachment remains hypothetical.	Experiencing trauma does not necessarily lead to poor mentalizing ability. Their hypothesis was supported in that higher rates of mentalizing and RF in relation to trauma (RF-T) in mothers led to increased rates of secure attachment in offspring. Unique finding and the first of its kind. Discordant maternal behaviour may have more impact than first thought. Fraiberg (presence) Vs Fonagy (absence) idea Mentalization/RF play a mediating role in transmission of attachment
11	My life is a longing: Child abuse and its adult sequelae	H. Massie & N. Szajnberg	2006	Mixed Methods (provides statistical analysis, as well as discussing clinical case examples) Used 5 measures: GAF, DSM-IV, Erikson psychosocial dev., AAI & DSQ. N=10 (A brilliant paper!)	Uses data from 10 participants of the Brody longitudinal study who suffered maltreatment in childhood.	Talks of resilience and strength of participants (which not many others papers seem to). very respectful language and acknowledges the sadness (even by way of the title) Gives comprehensive background	Barely any weaknesses – a brilliant paper!	On each of the 5 measures, the maltreated children fared significantly worse than their non-abused counterparts. Found that the maltreated children had lower overall functioning, poorer progression through Erikson's stages of psychosocial attainment, higher rate of psychiatric diagnoses, more troubled attachments and used more primitive psychological defense mechanisms. Hopeful message: 'Given the chance, children's biological and psychological

						of the Brody study Provides a helpful diagram showing the emotional sequelae of childhood abuse in adulthood using a continuum rather than categorical approach Use moving case studies Start discussion by outlining the topics to be discussed. Very clear and easy to read. Introduce concept of 'earned-secure' attachment (hope that attachment style can change) Gave clear (bulleted) recs		plasticity allows affectionate bonding to take place even in the face of mistreatment'.
12	An Attachment Theoretical Framework for Personality Disorders	K. N. Levy, B. N. Johnson, T. L. Clouthier, J. W. Scala, & C. M. Temes	2015	Qualitative / discussion paper reviewing current literature round attachment theory and PD. They discuss how PD may develop (in particular BPD) No sample (n) – more of a lit. review	Aim was to 'outline and elaborate on attachment theory as a foundation for the etiology and pathology of PDs' and highlight implication for treatment. Interested in linking particular attachment style to specific PD.	Cover a lot in the paper: summary of AT and development of PD, review empirical research, focus on neuro, biological/genetic and physiological aspects of AT and PD (particular reference to Oxytocin). They apply the theory/research discussed to clinical issues of attrition and outcome. They discuss how	They refer to treatments for PD, such as MBT and Transference-focused psychotherapy (TFP), however do not acknowledge the many other treatments available (such as CAT, TCs etc.). They briefly refer to a study using DBT. Therefore they appear to give a limited view of treatments for PD.	From reviewing literature found that children with avoidant attachment in Strange Situation may be more distressed physiologically than they appear. Same found in avoidant adults in the AAI. They comment on the amount of research which has found links between anxious, fearful, disorg. attachment and development of BPD. Suggests attachment acts as a protective mediator as to whether develop PD. Conclude with hopeful message that therapies focussing on transference have found change in PD symptoms & attach. security, however say

						the different attachment styles (and subsequent PDs) may engage, or not, in therapy.		more research needed into other PDs (not just BPD).
13	Mothers with borderline personality and their young children: Adult Attachment Interviews, mother-child interactions, and children's narrative representations.	J. Macfie, S. A. Swan, K. L. Fitzpatrick, C. D. Watkins, & E. M. Rivas	2014	Quantitative paper Studied mothers' AAIs, their parenting, and the children's narrative representations. They did AAI's with mums, watched mums and children doing puzzle together, then did story stem with children. N=62 (31 children with BPD mothers, and 31 'normative' children)	They expected to find the mothers with BPD to score in the insecure, preoocupied, disorg. range and to show signs of maladaptive parenting.	Had 6 hypotheses which were stated clearly. Used a control group. Measured BPD symptoms on continuum rather than categorical in order to provide more statistical power. Range of geography (5 regions; urban and rural) Spent time trying to control for confounding variables of Axis-I and II disorders They used Cohen's K (inter-rater reliability) – found good agreement. Make rec. (Dyadic child-parent psychotherapy)	Used pathologizing language a lot. Did not refer to strengths. Results were underwhelming and seemed to be saying the same thing but in different ways. Unclear which of their hypotheses were supported (could've been set out more clearly) Only make 1 rec. Causal relationships were not assessed. Limited middle class and BME participants. Language in the conclusion was very insensitive ('BPD is an excellent disorder' and ' BPD and their offspring are an ideal population') Disjointed style of writing (I suspect the authors wrote diff. sections & some more research oriented than clinically – i.e. good strengths and weakness section, but poor recom.s section)	Children of BPD mothers showed more aggression, disorg. and role reversal in their narratives. Found that 'parenting' mediated intergenerational transmission of BPD.
14	Personality disorder and the mental representation	M. Patrick, R. P. Hobson, D. Castle, R.	1994	Quantitative paper Conducted one	Studied 2 groups of females (BPD and Dysthymia)	Summarise other theories which have tried to	Data cannot be regarded as representative (as sample	BPD sample reported lower maternal care, higher maternal overprotection. More preoccupied & 'U' AAI

	of early social experience	Howard, & B. Maughan		interview which included the use of: AAI, Parental Bonding Instrument (PBI) and BDI. N= 24 (12 BPD, 12 Dysthymic)	to examine whether specific forms of psychopathology were associated with particular kinds of abnormality in mental representations.	explain personality development, such as social information processing, learned hopelessness, object relations etc. Start with nice phrase about child's resilience State their position that by focusing on pathology they are hoping to learn more about 'normal' Introduce role (and dev.) of psychological defences Clear intro to AAI (M&G coding method) and each of the measures used Clear about their excl. criteria Samples well matched (on age, SES, education etc.) They discuss their limitations & make rec's. Statistically sound (yielded sig. p)	were highly selected) – they make this transparent however Small sample size means cannot generalize findings	classif. among BPD than Dysthymia.
15	Expanding the concept of unresolved mental states: Hostile/Helpless states of mind on the Adult Attachment Interview are associated with disrupted mother-infant communicatio	K. Lyons-Ruth, C. Yellin, S. Melnick, & G. Atwood	2005	Quantitative paper N=45 low SES mothers had AAIs conducted with them. Also, Strange Situation conducted with their 18	Aim was to validate HH as an additional category to score AAIs	Introduce the concept that expansion of AAI constructs is necessary as does not fit with high risk clinical samples	Only refers to Crittenden's DMM once which is very strange(!) Not able to imply causal relationship nor comment upon HH transmission to infants	Shows that HH classification is a helpful classification system in its own right. HH class. Captured mothers' AAIs which would otherwise have scored as U or CC. Particular parts of HH linked strongly to degree of infant's

	n and infant disorganizatio n			month infants, and the AMBIANCE used to score for disrupted maternal communicat ion. AAIs scored using M+G method, and then HH n (Lyons-Ruth)		Discuss idea of protection Vs abuse Refer to neuro lit. Interesting idea of horizontal and vertical splitting Give clear history of dev. Of HH category and what it 'looks like'. Generate theory re. how HH develops Consider how the changes they made to the AAI may have impacted results State need for replication		disorganisation (e.g. mo. laughter at pain → more disorganized attachment in infant) If we don't use specific and accurate classifications then data may seem misleading (this leads onto my study nicely)

8.4 Appendix 4 – Copy of a consent form

[redacted] SERVICE

Telephone: [redacted]
Facsimile: [redacted]

[redacted] CONSENT FORM

[redacted] is committed to developing and maintaining high standards for all clinical and educational practices within [redacted] Psychotherapy Services. This means that on occasion we use actual recordings of therapist practice for service evaluation, educational development, and the publication of research. Please sign below if you agree that anonymised data relating to your time at [redacted] can be recorded for these purposes. Witholding your consent will have no bearing upon the quality of care you receive while accessing the service.

My therapist .....(Therapist name) has spoken to me about the processes and procedures regarding the taping of my treatment sessions .....(Client signature).

I feel fully informed about this process and on the basis of this I agree to my sessions being taped .....(Client Signature).

I have been informed that the audio material will be used for the purposes of education, supervision, and the continued development of quality practices at [redacted] and will remain strictly within the bounds of professional confidentiality.....(Client Signature).

Many clinicians at [redacted] hold a research interest in evaluating treatment outcomes and publish regularly in the wider professional domain. I agree that anonymous data from my treatment experience can be used as part of the research practice at [redacted] .....(Client Signature). [1]

Signed ----------(Client)

Witnessed ---------- (Therapist)

Date ----------

[1] Please do not hesitate to ask for more explicit information about this item.

8.5 Appendix 5 – Correspondence with IRAS re. Ethics

From: Queries HRA (HEALTH RESEARCH AUTHORITY) <hra.queries@nhs.net>
Sent: Thu 01/10/2015 10:30
To, Anna, Williams

ENQUIRY TO QUERIES LINE

Dear Anna,

You should refer to guidance at: http://www.hra.nhs.uk/resources/research-legislation-and-governance/governance-arrangements-for-research-ethics-committees/ , http://www.hra.nhs.uk/news/dictionary/service-evaluation/ and http://www.hra.nhs.uk/documents/2013/10/differentiating-audit-service-evaluation-and-research-version-1-1.pdf

RE: to evaluate a group therapy treatment being routinely delivered within the [redacted] Service

Thank you for your email regarding whether your project should be classified as research requiring NHS Research Ethics Committee (REC) review.

We note that you have used the HRA's decision tools which have provided a decision regarding whether the proposed project is classified as research and whether it requires review by an NHS REC. We note that you are seeking confirmation of that decision.

The results obtained from the HRA's decision tools can be taken as an authoritative decision and are line with:

- The harmonised UK-wide edition of the Governance Arrangements for Research Ethics Committees (GAfREC), which came into effect on 01 September 2011;
- Research Governance Framework for Health and Social Care (Second edition, 2005)
- The National Research Ethics Service (NRES) leaflet, *Defining Research* and the algorithm *Does my project require review by a Research Ethics Committee?*.

The decision obtained from the decision tools should not be interpreted as giving a form of ethical approval or endorsement to your project on behalf the

HRA. However, it may be provided to a journal or other body as evidence if required.

You should also be aware that:

- The decision tools only cover whether your project is classified as research and whether it requires review by an NHS REC. You are strongly advised to consider other approvals that may be required for your project.
- All types of study involving human participants should be conducted in accordance with basic ethical principles, such as informed consent and respect for the confidentiality of participants. Also, in processing identifiable data there are legal requirements under the Data Protection Act 1998. When undertaking an audit or service/therapy evaluation, the investigator and his/her team are responsible for considering the ethics of their project with advice from within their organisation.
- If you have a specific query in relation to how to answer the questions asked by the decision tools please email hra.queries@nhs.net making the reason for your uncertainty explicit. Our advisors will need this explanation along with a screenshot of the decision tools and a copy of your protocol or one page (1,000 word max) summary in order to clarify the outcome.

Regards
Queries Line
REF 07/07

The Queries Line is an email-based service that provides advice from HRA senior management, including operations managers based in our regional offices throughout England. Providing your query in an email helps us to quickly direct your enquiry to the most appropriate member of our team who can provide you with an accurate written response. It also enables us to monitor the quality and timeliness of the advice given by the HRA to ensure we can give you the best service possible, as well as use queries to continue to improve and to develop our processes.

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80 London Road
London SE1 6LH
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From: Williams, Anna [Student-LMS]
Sent: Wed 30/09/2015 17:26
To: hra.queries@nhs.net

Good afternoon,

I am writing to enquire about whether I need to complete an IRAS form and gain ethical approval for my thesis which I am currently undertaking.

I am a 3rd year Trainee Clinical Psychologist studying at the University of Hertfordshire and have recently started working on my thesis. The local R&D department (from the NHS Trust where I collected the data) felt that I would not require ethical approval via IRAS as I am using secondary data that was obtained via 'usual' practice as part of a service evaluation. Also, consent was obtained to use the data for teaching, training and research purposes and the data is anonymised. The university have said that I do not require ethical approval from them as I collected the data prior to commencing my studies and the service evaluation is now complete. Below is a summary of my plan:

Summary of plan
Approximately 18 months ago my supervisor and I decided to evaluate a group therapy treatment being routinely delivered within the [redacted]). As part of standard care, data was collected which included psychometric questionnaires and the Adult Attachment Interview (AAI). As this was a service evaluation it was not deemed necessary to seek ethical approval. All service users signed a consent form allowing their anonymised data (including demographic, questionnaire and interview transcriptions) to be used for teaching, training, and future research purposes. I plan to conduct a thematic analysis of 8 interview transcripts which I collected as part of my previous NHS role.
As I say, the university do not feel that university ethical approval is required and the R&D department feel that my using secondary data does not require ethical approval either. I completed the 'HRA Decision Tool' online and it said that my thesis would not be considered research. I just wanted to clarify/confirm that ethical approval would not be required via IRAS for my project?

Thank you very much for your assistance and I look forward to hearing from you.

With best wishes,

Anna Williams

Trainee Clinical Psychologist
DClinPsy Programme (Year 3)
University of Hertfordshire
College Lane Campus,
Hatfield,
Herts,
AL10 9AB

8.6 Appendix 6 – Communication with University of Hertfordshire re. Ethics

From: hhsecda, uh
Sent:Tue 07/07/2015 11:27
To: Anna, Williams

Dear Anna,

The Vice-chairman has confirmed that UH ethics would not be required in this case and has offered the following advice with regards NHS R&D approval:

The R & D department should be able to advise about the NHS ethics requirements. Alternatively there is an enquiry line on the HRA (http://www.hra.nhs.uk/) website to which you can forward a summary of the proposed research and they will confirm what is required.

Additional information can also be found via the Ethics Approval StudyNet Siet (link below). Please refer to the Sponsored Research page from the left hand menu.

I hope this helps but please do get in touch should you have any further concerns.

Kind regards,

Lesley Powell

Academic Services Officer (Ethics)
Academic Services
MacLaurin Building
de Havilland Campus
University of Hertfordshire

Ext – 1254

Ethics Approval StudyNet Site available here:
http://www.studynet2.herts.ac.uk/ptl/common/ethics.nsf/Homepage?ReadForm

ECDA email addresses:

Health & Human Sciences – hhsecda@herts.ac.uk
Science & Technology – stecda@herts.ac.uk
Social Sciences, Arts & Humanities – ssahecda@herts.ac.uk

From: hhsecda, uh
Sent: Mon 06/07/2015 15:02
To: Anna, Williams

Dear Anna,

Thank you for responding so quickly. I have forwarded your message to the Vice-chairman and will confirm his advice as soon as he responds.

Kind regards,

Lesley Powell

Academic Services Officer (Ethics)
Academic Services
MacLaurin Building
de Havilland Campus
University of Hertfordshire

Ext – 1254

Ethics Approval StudyNet Site available here:
http://www.studynet2.herts.ac.uk/ptl/common/ethics.nsf/Homepage?ReadForm

ECDA email addresses:

Health & Human Sciences – hhsecda@herts.ac.uk
Science & Technology – stecda@herts.ac.uk
Social Sciences, Arts & Humanities – ssahecda@herts.ac.uk

From: Williams, Anna [Student-LMS]
Sent: Mon 06/07/2015 13:44
To: Lesley, Powell

Good afternoon Lesley,

I can confirm that the data collection was soley as part of my NHS role and nothing to do with the university. I can also confirm that the participants consented to their data/information being used for all reseach and teaching/training purposes. The data is anonymised.

I will contact the manager of the Service where I collected the data to enquire about getting R&D approval.

How can I find out if I need NHS ethics; is that something which you can advise me on or will it be the R&D department who tell me this?

I hope this answers some of the queries. If you need any more information then please let me know.

Thank you for your help Lesley.

Best wishes,
Anna

From: hhsecda, uh
Sent: Thu 02/07/2015 11:57
To: Anna, Williams

Dear Anna,

Further to your enquiry below, the Vice-chairman of the Health and Human Sciences Ethics Committee with Delegated Authority (HHS ECDA) has requested some further information/clarification - see below.

You mention that the original data collection was considered service evaluation so ethics was not considered necessary. Please confirm if the original data collection was undertaken solely as part of your NHS role - i.e. nothing to do with any UH course? As long as there was no UH module/course involved then UH ethics would not have been required.

As the proposal now is to use existing data UH ethics will not be required, but you would need confirmation from your Research and Development department that they are happy for you to use the data in this way (i.e. for

your UH thesis). Please would you also confirm whether your original consent process informed participants that their data might be used for future research for a different purpose and whether the data is now anonymised in order that it can be ascertained whether it is necessary to contact the original participants to regain their consent.

Kind regards,

Lesley Powell

Academic Services Officer (Ethics)
Academic Services
MacLaurin Building
de Havilland Campus
University of Hertfordshire

Ext – 1254

Ethics Approval StudyNet Site available here:
http://www.studynet2.herts.ac.uk/ptl/common/ethics.nsf/Homepage?ReadForm

ECDA email addresses:

Health & Human Sciences – hhsecda@herts.ac.uk
Science & Technology – stecda@herts.ac.uk
Social Sciences, Arts & Humanities – ssahecda@herts.ac.uk

From: hhsecda, uh
Sent: Tue 30/06/2015 16:10
To Anna, Williams

Dear Anna,

Thank you for sending this information. I have passed it to the Vice-chairman and will be in touch as soon as I have his response.

Kind regards,

Lesley Powell

Academic Services Officer (Ethics)
Academic Services
MacLaurin Building
de Havilland Campus
University of Hertfordshire

Ext – 1254

Ethics Approval StudyNet Site available here:
http://www.studynet2.herts.ac.uk/ptl/common/ethics.nsf/Homepage?ReadForm

ECDA email addresses:

Health & Human Sciences – hhsecda@herts.ac.uk
Science & Technology – stecda@herts.ac.uk
Social Sciences, Arts & Humanities – ssahecda@herts.ac.uk

From: Williams, Anna [Student-LMS]

Sent: Mon 29/06/2015 16:51
To: hhsecda, uh;

Hi Lesley,

Thank you for the information you just gave me during our phone call. Please find below a brief overview of my research. If I have missed any important information then please just let me know.

I plan to conduct a thematic analysis of 8 interview transcripts which I have collected.

Approximately 18 months ago my supervisor and I decided to evaluate a group therapy treatment being delivered within the [redacted] Service (part of [redacted] NHS Foundation Trust). On entering the Service, all service users sign a consent form allowing their anonymised data to be used for teaching and research purposes. I set about collecting the data from various psychometric questionnaires they had completed at different timepoints throughout treatment. As this was a service evaluation it was not deemed necessary to seek ethical approval. Group members were invited to attend an interview (based on the Adult Attachment Interview; AAI). Those who were interested opted in and signed an extra consent form allowing their interviews to be recorded, transcribed, anonymised and used for research purposes. I then met with each of the members and conducted the interviews. These make up the 8 interview data sets that I have which I am now in a position to analyse for my thesis.

I am wondering if I need NHS or UH ethics in order to now use this data?

Please let me know if you need any further information.

Thank you very much,

Anna Williams
Trainee Clinical Psychologist
DClinPsy Programme (Year 2)
College Lane Campus

8.7 Appendix 7 – Correspondence with R&D Department re. Ethics

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From: Williams Anna (NHS NET MAIL)
Sent: 01 October 2015 13:35
To: [redacted] Stephen
Subject: update re. my ethics query

Good afternoon Stephen,

I have chased up my queries concerning whether or not I need NHS ethical approval with IRAS (as you suggested) and below is their response. It seems that you were correct when you emailed me back in June saying that as it is secondary data I will be using (which was obtained via service evaluation project which I have consent to use) I would not require NHS ethical approval. You wrote:

'Research limited to secondary use of information previously collected in the course of normal care (without an intention to use it for research at the time of collection) is generally excluded from REC review, provided that the patients or service users are not identifiable to the research team in carrying out the research (see C4 above). This exception also applies to research undertaken by staff within a care team using information previously collected in the course of care for their own patients or clients, provided that data is anonymised or pseudonymised in conducting the research.'

I will now start analysing the data for my doctoral thesis. Please can you let me know if you require any further information.

Thank you,

Anna Williams

From: [redacted] Stephen [[redacted].nhs.uk]
Sent: 16 July 2015 15:52
To: Williams Anna ([redacted] NHS FOUNDATION TRUST)
Subject: RE: Research ethics query

Dear Anna

Thanks for your detailed explanation. If it is a service evaluation you will not be required to get NHS Ethic approval but your University ethics approval may be required for this. Furthermore, NHS ethics approvals is not required for any research involving NHS staff.

Research limited to secondary use of information previously collected in the course of normal care (without an intention to use it for research at the time of collection) is generally excluded from REC review, provided that the patients or service users are not identifiable to the research team in carrying out the research (see C4 above). This exception also applies to research undertaken by staff within a care team using information previously collected in the course of care for their own patients or clients, provided that data is anonymised or pseudonymised in conducting the research.

As I said can we have further discussion about this next Monday, please give me a ring.

Kind regards

Stephen [redacted]
[redacted]

Audit, Evaluation, or Research?
http://www.hra-decisiontools.org.uk/research/

" The NHS will do all it can to ensure that patients, from every part of England, are made aware of research that is of particular relevance to them" NHS Constitution (2009).

From: Williams Anna ([redacted] NHS FOUNDATION TRUST)
Sent: 06 July 2015 15:31
To: stephen.[redacted].nhs.uk
Subject: Research ethics query

Good afternoon Stephen,

I am contacting you regarding some research which I have been involved with and require some advice about ethics.

For several years I worked in [redacted] Service (part of [redacted]). During my time there I was heavily involved with service evaluation work, in particular a group known as [redacted]. This is a group for mothers who have lost their children into the care system.

When service users enter the [redacted] Service they are asked to sign a consent form allowing their (anonymised) information and data to be used for research, teaching and training purposes. As part of evaluating the [redacted], Adult Attachment Interviews (AAI) were conducted with each of the group members. Group members were provided with information about the AAI and asked if they were interested in completing one. I then met with those who opted in and gave their consent. In total I conducted 8 interviews and the data was recorded and transcribed accordingly. We presented our (preliminary) findings of the service evaluation at the 6th International Attachment Conference in Italy in 2013, however unfortunately it was not possible (due to resources) to analyse the AAI data.

I am now entering my 3rd (final) year of my doctorate in Clinical Psychology based at the University of Hertfordshire and am about to start my thesis. My plan is to use the AAI data and analyse it using Thematic Analysis methodology. The data is anonymised and I have signed consent forms from each of the 8 participants allowing me to use their information for research purposes. I have liaised with the University of Hertfordshire (UH) and they do not feel that I need UH ethics, but suggested I seek R&D approval. After speaking to my old Service Manager at [redacted]) he provided me with your details.

I am wondering what type of ethical approval I might need?

I hope this makes sense and that you don't mind me emailing you. If there is any additional information you need then please just let me know.

I look forward to hearing from you.
With many thanks,
Anna Williams
Trainee Clinical Psychologist

8.8 Appendix 8 - Correspondence with course tutors re. Ethics

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From: Ellis-Caird, Helen
Sent: 07 October 2015 11:48
To: Williams, Anna [Student-LMS]
Cc: Norris, Clare
Subject: RE: Ethics query

Hi Anna,

Sorry for the delay in getting back to you on this!
From reading the information below, it looks like you have done all you can to ensure ethics approval is not necessary.
I think that you can relax, I can't see that there is anything that you have missed or further steps that you could have taken- I think you have covered all bases.

Best Wishes,

Helen

From: Williams, Anna [Student-LMS]
Sent: Thu 01/10/2015 15:54
To: Helen, Ellis-Caird

Hi Helen,

I wonder if you would be able to read through my attached email to Clare and let me know if I can relax (a bit) yet?!

Thank you very much,

Anna

From: Norris, Clare
Sent: Thu 01/10/2015 15:08
To: Anna, Williams

Hi

Could you discuss with Helen as she is heading up ethics and will know if what you have is sufficient (or send her this e mail)

Thanks

Clare

From: Williams, Anna [Student-LMS]
Sent: Thu 01/10/2015 13:22

To: Clare, Norris

Hi Clare,

Just to bring you up to speed quickly regarding my MRP ethics...

- I have an email from the uni to say I do not need UH ethics.

- The R&D dept at the NHS Trust (where I collected my data from) felt that as it was secondary data and I already had collected it (and had obtained consent) then I would probably not require NHS ethics, but they asked me to check. I subsequently completed the HRA decision tool which said I do not need ethical approval as it is data from a service evaluation project and therefore not classed as 'research'.

- I emailed IRAS to confirm this and below is their response.

Have I covered all necessary bases?

Thanks Clare,

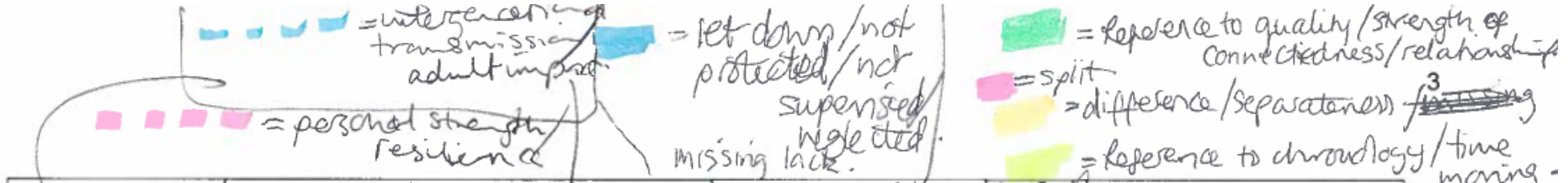
Anna

8.9 Appendix 9 – Section of an analysed transcript

AAI Interview with Hannah

Speaker R=researcher P=participant	Content	Sub-themes (& any emerging overall themes)	Process comments
R	We have signed the consent form, if I just read out a little bit to start with. So our service has started asking parents about the way they feel, the kind of parenting they had in childhood has had an effect on them as parents and as people, so we would like to ask you a little bit about your early relationships with your family and what you think about the way it might have affected you. So I will be asking you mainly about your childhood but we will also get on to later years and what's going on right now and this whole interview will probably take us an hour	- warning me. - pushing boundary - need for control → she decides how long it will take.	
P	**1.) OK, maybe longer, I could chat for England**		
R	Maybe longer, if it takes longer that's OK, so we can do it in whatever timescale you want. OK, so I will mainly just be asking questions and listening, I might write a few things at times but that is only to help my memory and those notes I will shred afterwards. OK, it would be helpful if we could start by you just telling me a little bit about who was in your family, so apart from you, who was it when you were a kid, growing up, who was around you?		
P	**2.) My mum, my dad, my brother and my two sisters, my grandma, grandad on my mum's side, and on my dad's side, I didn't have, well... I did have them in my life from a young age from when I was newborn to about 8 months old something like that, and then I didn't have them in my life, so I just had my mum's side in**	- Wanting to be thorough. Incl. everything.	- A lot of detail. No pauses. - Timescale important to her - 'side' of family important to - How would she have known from newborn - 8 months? Family

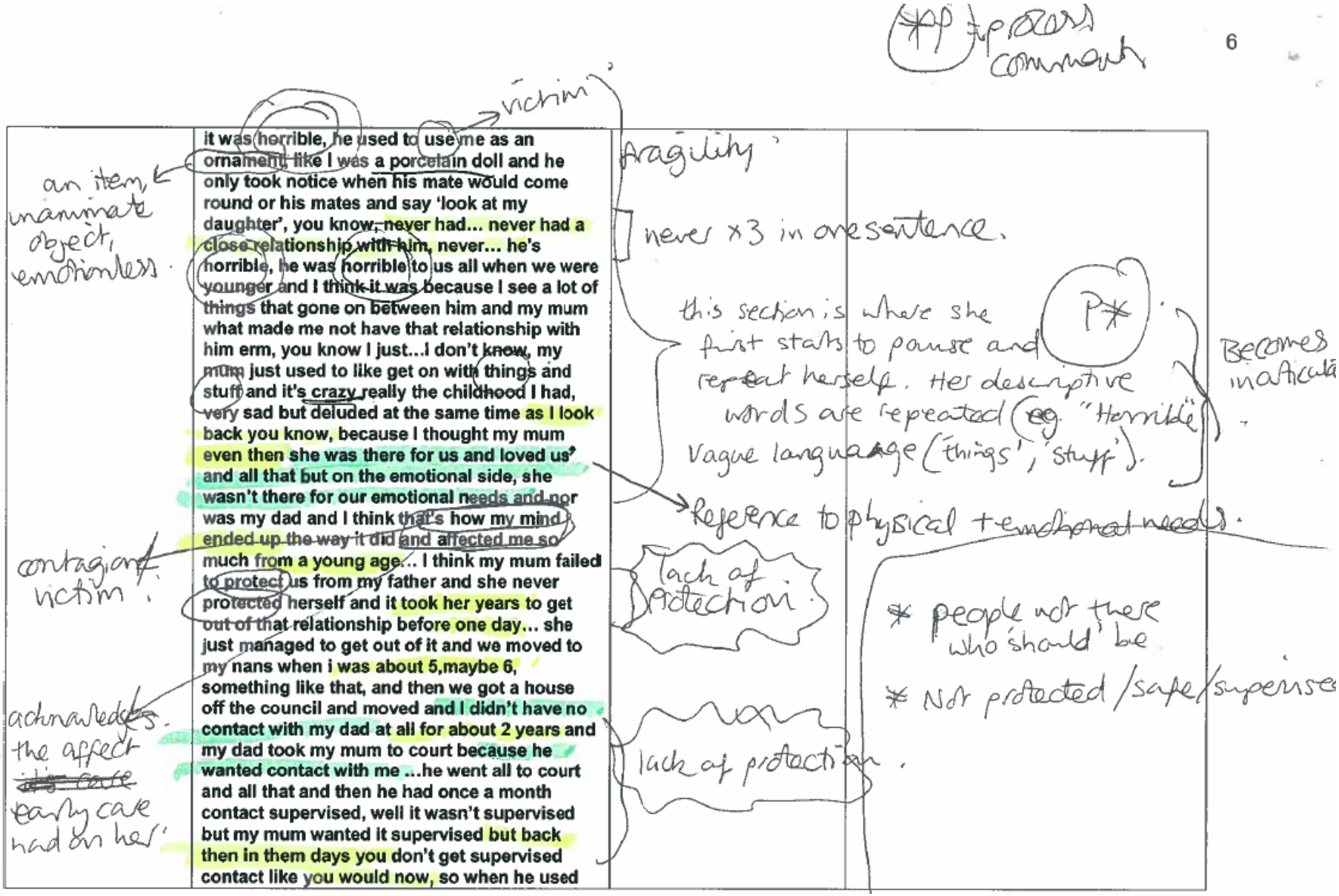
	my life more than my dad's side. **3.) My uncle Bob on my dad's side, he played a big role in my childhood when I was little, that is it really**	clearly finished sentence. Signalled to me she'd finished.	
R	OK, whereabouts did you live?		
P	**4.) I was born in Wales and I grew up in there**	Stability Roots.	
R	OK, did you move around a lot, can you remember moving a lot?		
P	**5.) No, Wales was like my life being brought up there**	All encompassing. Bubble?	
R	And in your family home it was you, mum, dad, brother and two sisters?		
P	**6.) Until my older sister moved... she left because she didn't like my father because they were born from another man, well conceived I should say, not born... so we were like half-siblings**	very detailed. corrected herself. provided reason unprompted. who's language: conceived?.	
R	OK		
P	**7.) She found it difficult living with my dad because my dad was quite abusive towards me brother and that, and towards my mum, so she left and lived with my nan on my mum's side for many years**	Difficulty living with a parent. Detail.	Possibly anxious as it's the start of the interview ∴ need to please? / provide details tt.
R	How old were you?		
P	**8.) I was very young, 3 maybe 4, so I didn't have much relationship with Rosy when she lived with my nan and that, and she was much older than me**	strength of relationship/ connection referred to. Difference in age.	
R	Was she the eldest?		
P	**9.) Yes**		
R	How many years older than you was she?		
P	**10.) She must be about... she's in her late forties, she is about 47, something like that, I**		



	am not too sure, then there's Emma, she's about 41 now, then there's John, well there's Rosy, erm... John, Emma and then me and I don't have no contact with my brother. **11.) I did when I was little because we all lived together except for Rosy, me and my brother were really close and that**	Offers more info spontaneously without me asking. Attention to detail → Chronology important to her. Quality / connectedness to brother referred to.
R	You and your brother had the same parents?	
P	**12.) No all half-siblings**	
R	All half-siblings to you,	
P	**13.) Yes, they have got a separate dads**	Comments on separate dads not same mums. → Difference highlighted.
R	OK so you have all got the same Mum?	
P	**14.) Yeah**	
R	OK, what about when you were little, can you remember, did Mum or dad, did they go to work, what did they do?	
P	**15.) Yeah, my mum and dad went to work, my mum was a cleaner in a school and my dad used to be a post man and that so... they worked round us kids, so either mum or dad would be home to look after us, so half the time my dad wasn't around so my brother used to look after me**	Sense of people pulling together to care for her? teamwork?
R	Your brother?	
P	**16.) Yeah, John**	
R	So he cared for you?	
P	**17.) Yeah**	
R	You said that you don't have contact with John now?	
P	**18.) No not for many years, he's got his own life**	ownership. Outside of someones life.
R	Do you have contact with any of your family?	

P	**19.) Yeah, Rosy I do, I don't with Emma because she is a waste of space, I just can't be bothered with her, so I have cut all ties from her, but Rosy, we are in close contact and it's nice actually because we never had that when we was kids and now we do, it's really weird**	Uses well known phrases eg ① 'waste of space' ② 'cut all ties." ③ 'could chat for England'. Split: 1 good, 1 bad.	→ Chronology / time difference (was/is)
R	Does she live close by?		
P	**20.) Wales, she's got her own business and everything, she's done really well in her life**	ownership.	
R	So she's the only sibling or half-sibling that you have contact with now?		
P	**21.) Yeah, and I have got a younger brother, Woody but my mum ...like... divorced my dad, stayed on her own for years and years and years and then she met Woody's dad, Frank, his name is, he's from Barbados and Wood's 17 and we are really close, cause he looks at me as his younger sister and-that**		
R	Do you get to see much of Woody?		
P	**22.) Yeah, they live up North but I do get to see my mum and Frank and they come and visit me and I go up there, so... I get on really well with my step-dad... they have been married for about ...must be about 16 years now**		
R	This is Frank?		
P	**23.) Yeah, and he's always been there for me, more than what my real dad has been**		
R	How often would you say that you get to see your mum and Frank?		
P	**24.) I would say, well it used to be quite regular, when we used to make it like once a month and stuff like that, but lately because of things going on in my life, I haven't been up there so much so I do miss them a lot, so I talk to my**	Detail.	

	mum everyday on the phone and my brother Woody and that, and me step-dad, cause he likes motor racing and I do as well, so we have a lot in common me and him. **25.) I would like to see them a bit more but at the moment I can't... there are things getting in the way to me going up there to see them**	Barriers.	
R	OK, so that's helpful, because I understand a bit more now who was around when you were growing up and who's around you now. I wonder if you could try and describe what your relationship was like with your parents when you were a little girl, so if you start back as far as you can remember		
P	**26.) I remember loads of things, I can even remember when my dog had puppies at 3.** **27.) Underneath the stairs and that**	Detail. ++.	
R	So you have lots of memories from being very young?		
P	**28.) Yeah, if you asked me what I was doing last week, I wouldn't have a clue but back then... maybe because I have relived it for so many years because of all the therapy I have done you know... things start to open up more in the mind**	"Relived" ⇒ repeated, rehearsed, scaffolded, enhanced, re-told, storied memory?	
R	Your very earliest memories of your parents, can you remember what was your relationship with them like?		
P	**29.) My relationship with my mum was good, you know she would hug us, love us, tell us that she loved us all the time, keep us clean and house tidy and food and all that, never neglected us in that way, but my dad, erm... I didn't have a good relationship with him at all,**	what does love mean?	description of love.


victim
an item, inanimate object, emotionless.
it was horrible, he used to use me as an ornament, like I was a porcelain doll and he only took notice when his mate would come round or his mates and say 'look at my daughter', you know, never had... never had a close relationship with him, never... he's horrible, he was horrible to us all when we were younger and I think it was because I see a lot of things that gone on between him and my mum what made me not have that relationship with him erm, you know I just...I don't know, my mum just used to like get on with things and stuff and it's crazy really the childhood I had, very sad but deluded at the same time as I look back you know, because I thought my mum even then she was there for us and loved us' and all that but on the emotional side, she wasn't there for our emotional needs and nor was my dad and I think that's how my mind ended up the way it did and affected me so much from a young age... I think my mum failed to protect us from my father and she never protected herself and it took her years to get out of that relationship before one day... she just managed to get out of it and we moved to my nans when i was about 5,maybe 6, something like that, and then we got a house off the council and moved and I didn't have no contact with my dad at all for about 2 years and my dad took my mum to court because he wanted contact with me ...he went all to court and all that and then he had once a month contact supervised, well it wasn't supervised but my mum wanted it supervised but back then in them days you don't get supervised contact like you would now, so when he used
contagion/ victim.
acknowledges the affect early care had on her.
fragility.
never x3 in one sentence.
this section is where she first starts to pause and repeat herself. Her descriptive words are repeated (eg. "Horrible") Vague language ('things', 'stuff').
P*
Becomes inarticula
Reference to physical + emotional needs.
lack of protection.
* people not there who 'should' be
* Not protected / safe / supervise
lack of protection.

	to pick me up once a month, sometimes he never turned up and I would wait and wait and wait and then I would take me anger out on me mum and say it was all her fault he hasn't turned up, you must have said something to him and all that... why he don't want me and all that, but my mum never ever slagged my dad off in front of us, or mainly in front of me because I was the only child to him you know	Anger expressed → ~~CONTRA~~ COUNTER EVIDENCE: Protection/ containment.	
R	If you think about when you were a little girl, a small child and your relationship and memories of your mum, I wonder if you could think of 5 words that would describe your relationship		
P	**30.) With my mum?**		
R	Yes, with your mum, and I might write these down because that can just help me remember, take your time to think about them, but just think of 5 words that would describe your relationship with your mum, when you were a young child?		
P	**31.) I would say it was close, loving, affectionate, caring and always there I suppose, I think that's all I can think of**	→ finished her list by, again, making it a sentence. (need for clarity/ boundary)	
R	OK, so now let's think about why you chose those words? So you started by using the word 'close', what made you say 'close', did a memory come to mind?	⊛ words such as: ~~close~~, still, all the time ~~always~~ always refer to time elapsing.	
P	**32.) My mum was there all the time, like mum parented us not me dad so I felt close to her because she parented us more than him**		
R	She was around more?		
P	**33.) Even though she worked, she was still around and she had, you know she had very close relationship with us kids, all of us, even Rosy, even though she lived at me nans, she still had a close relationship with Rosy ...and I**	⊛ words such as close and there refer to distance between	

→ Mo. was good in spite of ... .

	know that she loved us and she still does		
R	Can you think of a time or a memory of when it felt as though she loved you? There might be lots of memories but does anything spring to mind? When you think back to being a little girl?	Love.	
P	**34.) To be honest I don't think that she's ever stopped loving us, I think she's loved us from the day when we were born**	No acknowledgment of maternal ambivalence.	
R	And that's always come across?		
P	**35.) Yeah, like a say, it's the emotional side what she doesn't show at all really, that she's ...lack of inside her, because she never had that from her parents, even though they loved her and they were there for her, brought her up best they could, you know, it's the emotional side where I think my mum got affected and I think that's the same going with me father as well because his mum and dad were quite nasty towards him when he was growing up and he was shipped off to the Army... he didn't have a close relationship with his mum or dad at all and I think my dad found it hard inside himself to love me because he didn't know how to love because he wasn't loved by his parents which is sad, really, but with my mum's parents, they love her but they wasn't fully there on the emotional bits when she was like getting bullied at school and things like that, so I think that's why my mum lacked on that side, that showing her love, she feels that's all rolled in with the emotional side but it's not, it's totally different**	Reference to physical + emotional needs. making generational link. distance. sense of contagion. Reference to intergenerational transmission. describing how dad was 'shipped off' and mo was bullied. Generational exclusion.	forgiving in-spite of...
R	go on, what		
P	**36.) well love and emotional emotions together is like you're there all the time, you don't let**		

	that person down, you know, you can't keep swapping and changing your mind what you going to be doing and you cannot let that person down and you have to be there for the emotional side because sometimes we all get upset but with me mum, she can't handle it, she don't know how to handle that side when you get upset, she would brush it under the carpet and say 'oh, pull yourself together' and I think, Jesus Christ, pour out your feelings... it's about knowing each other really, connecting with each other, with your feelings and if you aint got that then it won't connect properly but with the love it's like ...hugs and kisses to me and she was more that than the emotional side	Confusing/ mixed message/ double binds hugs and kisses show love, but need the emotional support too. tactile love Vs emotional love. felt rejected when mo. brush things under the carpet. Dilemma of - How to show love Lack of ~~maternal~~ emotional containment from mo.
R	So she gave you hugs and kisses	
P	37.) Yes, always told us that she loved us, always ,but I wanted a bit more, out of her, like I knew there was something, lack of her inside... when I was younger and I knew I was missing something but I couldn't quite understand what the hell it was at that age, it... god you know, but as time's gone on, as I said, now I understand it more because I've done a lot of therapy to wonder why my mum and dad not ending up, not being there emotionally there for me and for the rest of us really, but mainly me, I felt like I was pushed out all the time and she... you know she said she never pushed me out, but to me I feel like she did favour Emma and John the most, it's like me and Rosy were like pushed away, even though she says she loves us and hugs us and kisses and all that mallarky ...me and Rosy were pushed away, she always, like I don't know, gave Emma and John more	- Wanting more. - needs not met - Feeling pushed away - Not the favoured child - feeling as though she was missing something, but didn't know what.

	than what she did me and Rosy		
R	Is there a memory that's coming to mind when you say that?		
P	**38.) Yeah I just think that it's sad really to be honest, because I've bought this up with my mum and she's just in denial, 'oh don't be daft' she says, I've always loved you, I said I know you've loved me but it's the emotional side you need to understand, but my mum don't understand.. she still doesn't understand how my parenting affected me with my kids, she can't get it in her head, maybe because it's the truth and maybe she's scared to face the truth because she's always brushed things under the carpet when we were little, you know, so...**	Tried to discuss emo. as an adult but mo. not understand	⇒ 2nd layer of neglect? + rejection Reparation?
R	The final word you used was 'always there'...		
P	**39.) Yeah, even though she went to work she was always there to make sure we were bathed, you know clean clothes, food in our bellies, she would starve for us, my mum would, like... if there weren't enough food, cause my dad was a right idiot when we were younger and he had all these different mood swings going on, it was like one minute he wouldn't have no money, the next minute he would come in with all wads of cash and me mum would be like, 'where the hell did you get that from', he said 'come on, we're all going shopping, get your coats on', but my mum... when they split up, my mum still lived in the house and then she moved to me nans with us all and then it just went pear shaped after all that, but she always made sure there was food in our bellies, she never made us starve, she never neglected us in that way, she neglected herself by not eating to make sure us kids had**	Love? practical but not emotional. Parental Mh issues. ⇒ A sign of love? self-sacrafice/Altruism?	

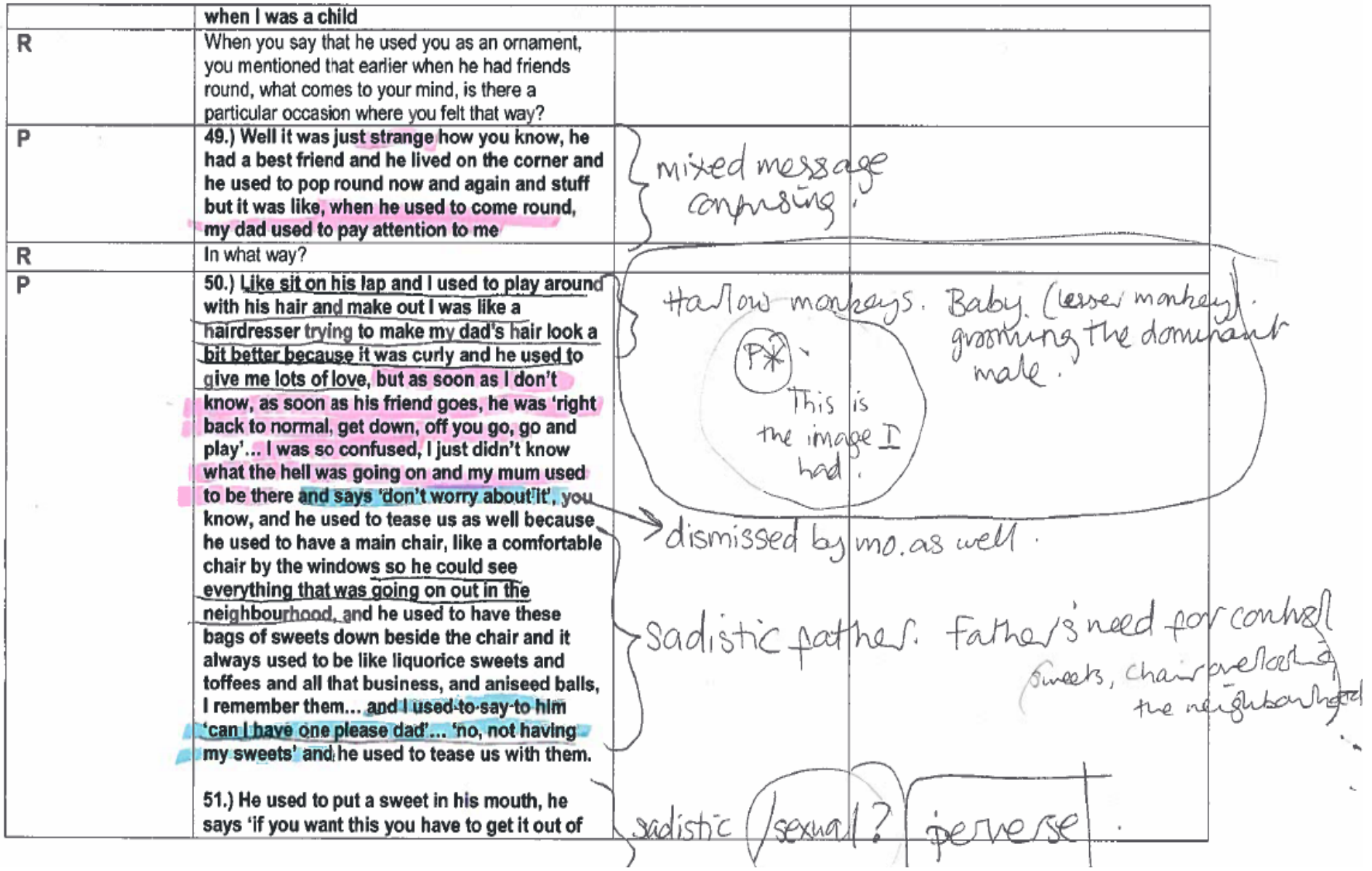
	beans on toast or something, and like any left overs, me mum used to just have the scraps and I used to always say to my mum when I was about 5 'mummy why are you not eating anything', 'oh mummy will have hers later', you know, my mum used to say things like that and I knew there was something not right because it was becoming a regular thing and at the age of 5 recognising things like that is so big to take on.. mad	Protection from mo. growing up quickly/mature	
R	That mum was going without for you to have food, and that was as young as 5 you can remember feeling that		
P	**40.) Yeah**		
R	Let's think more about your dad. I am going to ask you to do the same thing and think of 5 words that you describe your relationship with your dad like from when you were as young as you can remember, so thinking from that very young place, what your relationship was like with him		
P	**41.) My relationship with my dad back in the day, no love, no affection, no hugs or kisses, didn't care whether or not we had food in our stomachs, or electric on in the house and used me as an ornament, put me on the shelf and took me off when he feels like it and put me back on when he gets bored** → used/victim.	used opposite language to words chose for mum. Lack of articulation. (Hannah seems to become mindless when dad discussed	
R	You started by saying no love		
P	**42.) Yes, never got nothing**		
R	No hugs or kisses, no affection, ever?		
P	**43.) Not ever**		
R	Do you have any memories of him giving you a hug or kiss or being affectionate?		
P	**44.) No, not at all, he wasn't even affectionate to**		

vulnerability and protection roles switch between parent + child.

	the other kids, my half-siblings or to my mum, he was a horrible man, nasty, he tried raping my mum one night, in the bedroom, he locked her in and I hear my mum crying, and I tried to get in the bedroom to try and help her and I was only about between 5 and 6	She's used this word before. Traumatic event. Helpless to protect mother	
R	very erm…		
P	45.) Yeah, my dad used to start arguments just so he could get out of the house and when he used to like raise his voice and stuff to my mum I had a Mr Man chair and I used to go between the sofa and the chair in the living room and put the Mr Man chair over myself so I could protect myself, so I could block out the noise what was going on in the background between my mum and him and in the end it was that draining I actually fell asleep	self protection (from inanimate object) High anxiety threat	like the reverse of the Harlow experiments
R	Under the chair?		
P	46.) Yeah, many times that chair, it was my shield, my protection	P* sadness ++.	perhaps the metal cage is safer?!
R	Can you remember a feeling to those memories, it sounded like that happened more than once		
P	47.) Yeah, I hated him, didn't understand why he was being so nasty towards my mum and myself, scared me, he used to, with his voice, and I see him beat up my brother at times as well… on a regular basis and my brother used to… he had a bedroom door but it was slats and my brother used to kick it all in, kick all the slats in where he was so upset and angry because my dad would beat him up and many a times my mum tried to stop him but she got the same, I think it was quite abusive. 48.) Deluded house what I was brought up in	- witnessed violence ++ - THREAT. - SCARED.	

'Deluded' / 'mad' / 'crazy' ⇒ these are random words which Hannah uses. 12
⇒ symbolizes the chaos, and indeed madness?

	when I was a child	
R	When you say that he used you as an ornament, you mentioned that earlier when he had friends round, what comes to your mind, is there a particular occasion where you felt that way?	
P	**49.) Well it was just strange how you know, he had a best friend and he lived on the corner and he used to pop round now and again and stuff but it was like, when he used to come round, my dad used to pay attention to me**	mixed message confusing.
R	In what way?	
P	**50.) Like sit on his lap and I used to play around with his hair and make out I was like a hairdresser trying to make my dad's hair look a bit better because it was curly and he used to give me lots of love, but as soon as I don't know, as soon as his friend goes, he was 'right back to normal, get down, off you go, go and play'... I was so confused, I just didn't know what the hell was going on and my mum used to be there and says 'don't worry about it', you know, and he used to tease us as well because he used to have a main chair, like a comfortable chair by the windows so he could see everything that was going on out in the neighbourhood, and he used to have these bags of sweets down beside the chair and it always used to be like liquorice sweets and toffees and all that business, and aniseed balls, I remember them... and I used to say to him 'can I have one please dad'... 'no, not having my sweets' and he used to tease us with them.** **51.) He used to put a sweet in his mouth, he says 'if you want this you have to get it out of**	Harlow monkeys. Baby (lesser monkey) grooming the dominant male. P* This is the image I had. dismissed by mo. as well. sadistic father. Father's need for control sweets, chair overlooking the neighbourhood sadistic / sexual? perverse.



	my mouth' and you know, things like that he used to do, spiteful things, and he used to count his sweets cause he used to leave the bag of sweets by the side of the chair so if he goes out he had to count them first before going out, so if you come back and there was a sweet missing, oh my, you wouldn't dare touch his sweets... he would be like a volcano going off in the household if anyone touched his sweets and my mum moved them once, put his sweets, picked them up and put them on like this big old fashioned cupboard we had that had shelves, and she put them on top, all my days... he went mad when he comes in and his sweets weren't at the side of the chair, and she goes 'I've put them up there, out the way of the kids'.. nasty man, I am glad he's dead, he died just over a year ago	- spiteful - perverse/sexual undercurrents. - control (counting sweets!). ~~-THREAT.~~] HATE	
R	Oh dear		
P	52.) He made my life hell, we didn't speak for about 11 years because he beat me up, in the street... and that was all to do with me ex-partner lying and saying I was cheating on him and that, and I had my 3 boys by then, my 3 first boys but this idiot... he told my dad loads and loads of lies and me dad come round and started on me in the street.. I lived 2 doors away from him as well and my mum was at the window and she couldn't even be bothered to come round and help me to get him off me because he was hitting me like with his knee, like he was booting his knee up my bum	VICTIM OF VIOLENCE - Dad beat her up. - Absence of communication for 11 yrs Mo. not protect her from dad. (let down by mo.)	
R	This was your dad?		
P	53.) Yeah, so it would hurt me, he grabbed me, pulled my hair, so I had enough and I swung		

= personal strength / resilience.

	round and I punched him straight in the face and he landed straight on the floor of the kerb and I just called him all the names under the sun and I took him to court because of the abuse he give me and the beating I thought 'he aint getting away with it with me'... I thought my mum might let him get away with it but I am not. 54.) I had had enough and because I took him to court he said he didn't ever ever want to speak to me again and he made my life, and he made sure that he was going to make my life hell and he did, he told social services loads of lies about me...that was why I lost my kids because of him and he stuck by my ex-partner what used to beat me up, and he allowed him to beat me up and I told my dad once when we split up and I said to my, said before all this happened, I went round to my dad's and I asked for help... I said 'he's beating me up and I can't cope any more'	She stood up for herself as an adult and protected herself: punched dad, called him names, anti-social, pro-social / took him to court. DOMESTIC VIOLENCE AS AN ADULT. Dad sided with her ex; she was outcast. — Dad did not protect her from abusive partner. Asked dad for help.
R	What did your dad do?	
P	55.) Well he said that he was going to give him a hiding for what he's doing to me and that, for suffering years of domestic violence, and he never kept to his word... he believed Chris and have since, he always believed him, so my dad, when we split up, me and Chris, and cos my dad wasn't speaking to me cause I took him to court because he beat me up and all that, he said that he was gonna make sure that he gets the kids off me so Chris can have them and that he'd do anything in his power to support Chris because I don't deserve to have my kids	Dad let her down. Did not protect her. Did not stick to his word. – Dad favour ex-partner.

R	And you say that your father died last year		
P	**56.) Yeah, I only find out through my older son David, my first boy, erm, because I had contact with them see, but him and Joe don't, but recently I have been with Lee, but back in the day I didn't, but, erm, yeah David, his girlfriend told me because when I phoned up David to speak to him, she said 'oh he's gone to a funeral'... I went 'a funeral?' so where's he gone, she goes 'to your Dad's funeral, he's died', I went 'what?' I was like, Jesus hells bells, but it's really weird because I have only been in Surrey for 3 years, just over 3 years now and I went back to Wales because I seen me nieces and nephews, that's me sisters kids, Emma's kids.** **57.) I still have contact with them even though I can't be dealing with her, she still lets me in and sees the kids and stuff,** **58.) But with Emma I have to take her with a pinch of salt, I can't take anything on board because so many fancy stories going on with her really, so... but just before me dad died, it must be about 3 months, not even that, but I went to me sister's and I stayed over the night and woke up really early that morning and I left her house, about just after 6 in the morning it was, and she lived in the same area as me dad, in Wales, and me dad always goes out early in the morning to get a paper but I didn't expect to see him, I was like 'God', I was shocked and there he comes out the paper shop as I was walking round by the shop and I just looked at**	-Sudden loss of father. -Unresolved. Trying to maintain contact with family members, even when difficult to get on with.	

him and I thought he looks ill... he just didn't look like me dad you know, grey and old and just like something's eating away at him inside and I said, I don't know what made me, it's like if me feet got stuck to the ground, I couldn't move, and part of me body just swung round and I shouted out 'Dad', and he sort of swung round and looking up and looking down and he said 'you talking to me?' and I said 'yeah', he goes 'well what?', 'well' I said 'it's me' and it was like 'yeah, you have a nice day won't you' and I looked at him and I said 'yeah you too', but me feet were still stuck to the floor, and I wanted to move but I couldn't move and then he trots off down the road and I am thinking, why aren't me feet moving... but in the end, I don't know it was just the glue come off or whatever it was and me feet started walking but you know what, me heart like got ripped out, it was like I was just so hoping in a way that my dad would say 'come here, let's have a chat' and like my mum said many times before, you need to shut the door on that man you know, and I say but I can't, I can't shut the door completely, you know, there is still something inside me what needs to come face to face with him and ask him questions really, but she said you won't get no questions or answers out of him, you're wasting your time... so in the end I shut the door but I didn't shut it completely and I thought I did shut it completely, but obviously not from that day... it still in my heart, knowing that I didn't shut my dad out completely out of my life and out of my heart, but as I was walking down the road, I was like, you could feel yourself building up inside with sadness

DISMISSED/~~NEGLECTED~~ AS A CHILD, BUT ALSO AS AN ADULT.

she wanted her dad to talk to her, but he dismissed her again.

→ no. dismiss her emotions again.

- Trying to 'shut out' dad, but couldn't completely.
- Still wanted a relationship w him.

	really, to know that was my dad there and I hadn't spoke to him for 11 years and he looks ill... and then it must have been about 3 months after... that's when I found out he was dead, a blood clot of something to the heart, something to do with a heart attack, a blood clot was wizzing around in his body and he died and that was the last day I ever saw him, that morning early, them words were the last words I had with him, madness... crazy really to know that he only had a few words to each other and then he's dead and you always, well I'm always gonna remember that, you know, I wasn't allowed to go to the funeral, it was a big secret, if it weren't for my son's girlfriend telling me I don't think I would have known from this day that he had died to be honest because he didn't want me to know ...even though he might have shut me out of his life, I never shut him out of mine completely, I didn't		
R	It sounds like out of your two parents you were closer to your mum than your dad		
P	**59.) Yeah**		
R	When you were upset when you were a little girl, if you think of a time when maybe you were upset, what would you do? You mentioned one memory of having this chair that you used as a shield, can you think of other times when you might have felt upset for some reason?		
P	**60.) No, just in the house, that chair was my shield, it was like, protects me from the noise in the background, it only happened in the house**		
R	What would you do if you were upset if you'd argued with one of your siblings or if you had a tummy ache, what would you do?		

surely she'd have to swallow the mum

P	**61.) Tell my mum, but we never used to like argue us siblings, we were close, but if I had a tummy ache or if I was sick I always went to my mum not my dad, never, always my mum, and my mum used to like get like a quarter of paracetamol crush it between two spoons, put a bit of milk on there, wiz it around, pop it in my mouth to make my belly feel a bit better**	→ strong/extreme words. described the practical response of mo. when she felt poorly
R	How old do you think you were when you can remember that happening?	
P	**62.) I was about 3, yeah about 3, I was very forward for my age… I was very aware of what was going on around my face, as well as around, I was very observed as well sometimes, like between me and my siblings play like monopoly game on the floor and my brother said to me once, sit on the end of my feet, and there's me sitting on the end of his feet, the next thing I went 'wee' up in the air and I just dropped down and broke all me arm and my mum come rushing in from the kitchen, cos she was washing up, 'what the bloody hell's going on in here?'**	Accident. Brother/injure her arm. Mo was present.
	63.) I can remember it, I was crying and crying and crying… John's just thrown me up in the air mum and I hurt me arm, 'you bloody idiot' she said to him, stupid boy	⇓ responded c anger
R	And then what happened?	
P	**64.) Hospital, me granddad took me up the hospital**	
R	Your mum's dad?	
P	**65.) Yeah**	
R	And you'd broken your arm	

victim? done to?!

I notice I'm looking for / more sensitive to the negative aspects → am I assuming they're

P	66.) Yeah, my sister and John had to go to me Nan's, she looked after them while I was up the hospital with me mum and granddad getting me arm fixed up, crazy things me and them used to do.', we used to have boxing matches, play fight on the sofa... it was all fun, it didn't turn into nothing violence or aggressive or anything like that, it was all fun, I was more of a tomboy I think... I don't feel, when my mum used to put dresses on me, all my days, I used to get them off, I didn't like dresses, didn't like skirts, didn't like nothing, it was always jeans or trousers... I think I was more of a tomboy than actually a petite little girl at that time and I used to play Scalectrix with my brother, we had like this 6 foot glass table, long thing with Scalectrix whizzing along underneath it and we used to lay down on the floor and have races and that with the cars, and there would be 4 cars on the track, he would have 2 cars and I would have 2 cars, we used to race round the track and that, it used to be fun	pathology as punctuation. identity / gender? fun x3.	
R	Where would mum be at those times?		
P	67.) In the house, yeah, mostly washing up, hoovering, sorting out bedding, like little bits like that, my dad always out, we hardly see him much and he would come in and start arguing but that was about it, my dad had a lot of affairs, a lot of sexual affairs behind mum's back because my sister Emma took me swimming at Mill Road in Wales and I must have been about 8, she took me swimming and I said to Emma 'I want to go and see dad' I said, he worked in this place called Bar Five in the town centre and downstairs, as you go down	dad unfaithful to mo. traumatic memory of catching her dad kissing another woman.	

	the stairs, there used to be like all snooker tables and pool tables and that is where he worked, selling pool and snooker tables, and we went down the stairs once and I saw him with another lady on top of a pool table, kissing her and stuff, so Emma took me back upstairs like... she tried to shove me out the way and I said to Emma 'why is daddy kissing that lady?' and I don't even know what she said back to me but when I got home I told my mum, I said to my mum 'I saw daddy at work kissing a lady on a table' and my mum was like, oh yeah most likely his friend, and tried to brush it under the table because she didn't want to come out and say... but I knew, I knew something wasn't right, for my dad to kiss someone else and then in the end he had a job, another job, taxi driving, he had loads of affairs there with women, yeah...	traumatic incident. honest, did not keep the secret. No. dismissed it. deceit secrets.
R	I was wondering if you could remember the first time you were separated from your parents, you have a very good memory of being very young and I wondered...	
P	**68.) I think it's because my nan... my brother... looked after me once and my mum went to work and after that my nan starting looking after me when my mum go to work and stuff**	cared for by grandparents.
R	What's your earliest memory of being separated?	
P	**69.) I think about 3, yeah my mums always worked but I reckon around about 3 I can remember my nan looking after me**	
R	Can you remember what that felt like for you, what did it feel like?	
P	**70.) Well it felt OK because I was really close to my nan and granddad and I liked going round**	

	there because she made me sausage, mash and peas for me dinner and she used to make some nice fish cakes too and my granddad used to make me laugh too, he used to have like, an old fashioned tin on the coffee table with biscuits in and I used to say 'granddad can I have a biscuit please', 'no' he used to say, 'no the biscuits are all mine' and then in the end he would say 'OK you can have one' and I used to have only one because that was all we was allowed to have, we weren't allowed to have anymore. 71.) I used to sit on me granddad's knee and play with him and kiss him and hug him and he used to always tell me he loved me and stuff. 72.) My nan was very... not like that in that way, but she always loved us and always looked after us with food and things to make sure, but my granddad was a bit more affectionate towards us kids when we were little and he didn't like his daughter, like my mum's sister, her kids, he couldn't stand her kids... but me I was like a favourite one with my granddad	How is love shown? gran → food (like mo-) granddad → made her laugh / tactile. This biscuit story is very similar to her dad's sweets, however granddad let her have one and dad did not. * the favoured one! *	
R	You felt safe, can you remember how your mum responded to having to leave you?		
P	73.) No, she just used to say 'give me a kiss goodbye' and 'I am going off to work now' and I used to watch her out the window. 74.) She walked down that long path, coz my nan used to say, like, live here, and my mum used to like, say, walk down Bristol road to go to work, but it's like... it sort of like a distance,		

8.10 Appendix 10 – Selection of reflective journal excerpts

‘Why am I so interested in this area; often people become interested in areas that they can relate to and have a personal connection with. I was raised by two incredibly loving parents who are still doting parents to this day, even though I am now an adult. I never spent time in care, nor do I have friends who have been in care, or had children who have been taken into care. Is it more about the vulnerability of children, or mothering ability, or both?

On reflection, I can relate to the vulnerability of children as I was a particularly anxious child and have vivid memories of my despair at being separated from my mum. Many of these memories have a visceral reaction still some 30 years later. I grew up with the story that my mum had to have me on her hip even when she hoovered the house; the message being that I could not be separated from my mum. I would go to extreme lengths not to be separated from my mum; mushing up wet toilet paper to make it look as if I had been sick and therefore didn't have to go to school, or eating too many oranges so that I actually was sick and thus stopping my parents go out for an evening and leave me with a babysitter. I felt like I could not exist without my mum.

The idea that some children do not have a loving mum who adores and cares for them, breaks my heart. I don't mean that in a condescending or patronising way, I genuinely feel sad to think of what life would be like for those children; I can't imagine it.

This leads me to be both interested in and frightened of motherhood. Interested in that our mum's (and dad's) make us who we are, and frightened because what if I muck up as a mum? From my clinical work I have seen the potential for damage to be done by mothers (not necessarily consciously).’

‘I wish I was not limited by a word count because you could write a whole thesis on complex trauma alone. If I had more space I think I would talk more about the comparisons between Complex PTSD and BPD.’

‘I suspect my project will be like a piece or art, in that I will always look back at it and spot things I wish I’d done differently.’

‘…I want to thank them for their openness. While their willingness to share such detailed and personal accounts was appreciated I could not help but feel a little unsettled at the time by how forthcoming they were; they didn't know me from Adam and yet they were disclosing so much. Were they just automatically trusting as I was in a professional role? Were they frightened by my professional role and simply 'doing what they were told'? Were their stories actually easier to tell than I may think as they have told them many times before (and to a range of people) and so they didn't consider telling me to be a big deal? Or were they vulnerable with permeable boundaries and indiscriminate in their relating?’

‘It feels so difficult to cut out quotes from my Results section, almost disrespectful. It is as if I’m deciding that some people’s ‘voices’ are ‘better’ than others and this makes me feel incredibly uncomfortable; especially given that the rationale of my study is to help give voice to people who have been silenced.’

‘It has been a shame that I have not been able to have more Service User involvement in my study, but the AAIs had already been conducted (and it would not have been possible to change the structure of the interviews anyway). It may be that I think of ways to involve SUs in the dissemination of the research?’

‘I will be sad to finish this project as I have carried the participants in my mind for the past few years and when analysing their transcripts one cannot help but become immersed in their stories. I can picture their faces and hear their voices; the transcripts are not just sets of 'data', they are people's lives.’

‘The concept of resilience and survival has been fascinating for me and I feel I have a lot more thinking to do around these concepts. Certainly the findings of my study have highlighted to me the difference between survival and resilience. I realise that before now I had merged the two in some way, however realise that resilience may be more

than simply continuing to breath. This poses an uncomfortable question for me however as I find myself wondering if the participants did show resilience or did they simply carry on breathing. I cannot help but feel however that while ‘continuing to breath’ sounds passive, the participants could have ended their lives. In my career so far I have known 7 patients/clients commit suicide. Is suicide a strange form of resilience? As I say, I have much thinking to do around this topic as resilience may not simply be ‘ploughing on’ like I first thought.’