Dissertation volume:

Literature Review
Empirical Research Project
Reflective Commentary

University College London
Submitted in partial requirement for the Doctorate in Psychotherapy
(Child and Adolescent)

DECLARATION
I declare that the material submitted for examination is my own work. The ideas and findings of others have been referenced in accordance with the guidelines provided and any work by others has been acknowledged.
I understand that anti-plagiarism software may be used to check for appropriate use of referencing.

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Table 1 NPCS & TA

Glossary

List of abbreviations used throughout the thesis presented below in alphabetical order

AAI: Adult Attachment Interview
AFC: Anna Freud Centre
AFNCCF: Anna Freud National Centre for Children and Families

BPD: Borderline Personality Disorder
CAMHS: Children and Adolescent Mental Health Services
IMPACT: Improving Mood with Psychoanalytic and Cognitive Therapies

IWM: Internal Working Models
LP: Lighthouse Project
MBT: Mentalization Based Treatment
MBT-F: Mentalization Based Treatment – Family
NICE: National Institute for Health and Care Excellence
NICHD: National Institute of Child Health and Human Development
NSPCC: National Society for the Prevention of Cruelty to Children
NPCS: Narrative Process Coding System
PAI: Parent Attachment Interview
PDI: Parent Development Interview
PTSD: Post Traumatic Stress Disorder

RF: Reflective Functioning
TA: Thematic Analysis
WMCI: Working Model of the Child Interview

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Part 1: Literature Review

The representations of the child in parents with borderline personality disorder.

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Abstract

Borderline personality disorder (BPD) poses significant challenges for parents when they attempt to establish a relationship with their child. Difficulties with interpersonal relationships are a key aspect of BPD, and have been suggested to be linked to their difficulty in holding a consistent and stable representation of others' and one's own mind in mind (Liotti, 2002). Parents with BPD are at risk of developing distorted representations of their children which in turn may hinder the parent-child relationship and the child's development. Though the topic of mental representations has been widely researched and its links to parenting documented, there still remains a paucity of research into the representations that parents with BPD hold of their children. This review aimed to provide a narrative synthesis of the key recent studies on the representations that parents with BPD hold of their children. Seventeen studies were identified that had set out to explore and/or assess the representations that parents with BPD held of their children via the parents' descriptions (i.e., verbal accounts) of their children and/or way(s) of relating to them (i.e., observable

behaviour), in accordance with the current paper's operationalisation of representations. Although fathers were not excluded from being study participants by the literature search, all the participants of the studies identified in this literature review were mothers. By exploring the findings of the studies identified, four salient and common themes emerged: role reversal, emotional misattunement, hostility and absences. These themes allowed for the image of a misrepresented and absent child to emerge, giving rise to different types of representations that mothers with BPD appear to hold of their children: a child seen as needing to support his/her mother and meet her needs; a child misunderstood in his/her signaling; a child depicted and perceived in negative regard; a child who is absent from the mother's mind. These representations highlight the potential risks that children of mothers with BPD face. This review also underlines the need for further research and studies to be developed in order to enrich the current understanding of this phenomenon and, consequently, adapt and improve therapeutic interventions that aim to help parents develop clearer and undistorted representations.

1.0 Introduction

1.0.1 Borderline Personality Disorder

Borderline personality disorder (BPD) is a serious mental disorder that affects 1.6%–5.9% (Grant et al., 2008) of the population, predominantly (about 75%) females. It is characterised by a pervasive pattern of instability in interpersonal relationships, self-

image and marked impulsivity (American Psychiatric Association, 2013). Frankenburg and Zanarini (2004) suggested that there is an association between non-remitting BPD and elevated rates of chronic physical health syndromes and medical hospitalisation. Consequently, the diagnosis is associated with one of the highest rates of health service utilisation (Bender et al., 2001), posing significant public health risks (Gunderson, 2009).

The word 'borderline' was first used by the psychoanalyst Stern, who referred to those patients lying on the 'border' between 'neurosis' and 'psychosis' (Stern, 1938). One main feature of these patients was the extreme difficulty of being handled 'effectively by any psychotherapeutic method' (Stern, 1938, p. 467). The resistance to treatment and poor prognosis of these patients were subsequently confirmed and documented by several reports (Choi-Kain & Gunderson, 2009).

The development of empirically validated BPD-specific treatments and findings from longitudinal research (e.g., Skodol et al., 2005) have promoted its change in reputation from an untreatable disorder to one that can be responsive to treatment (Choi-Kain & Gunderson, 2009). Several meta-analyses have shown that psychotherapy is effective for reducing BPD pathology (e.g., Cristea et al., 2017); psychotherapies specifically developed for BPD have been found more effective than nonspecialised psychotherapies (Oud et al., 2018). Among the interventions specifically designed for BPD, mentalization-based treatment (MBT) has gained popularity in recent years (Bateman & Fonagy, 2008; Fonagy & Bateman, 2006). MBT is an integrative approach to therapy that focuses on the mental processes and mind of the patient (Fonagy & Allison, 2012); it aims to improve mentalization in patients with BPD, especially within everyday interpersonal interactions. Mentalization refers to engaging in a form of

imaginative mental activity that enables us to perceive and interpret human behaviour in terms of intentional mental states (e.g., needs, desires, feelings, beliefs, goals, purposes and reasons) (Allen, Fonagy, & Bateman, 2008).

Difficulties with interpersonal relationships are a key aspect of BPD. Adults with a diagnosis of a form of severe personality disturbance, such as BPD, have usually themselves experienced early attachment-related trauma and maltreatment. As a result, they frequently experience core difficulties in understanding and responding to socio-emotional information and interpersonal interaction, leading to a significant impact on parenting capacity and child development (Newman, 2015). Fonagy et al. (1996) described their capacity for mentalization as impaired, this impairment being the likely result of a dysfunctional attachment system found to be largely disorganised and insecure (e.g., Agrawal, Gunderson, Holmes, & Lyons-Ruth, 2004), causing challenges in the realm of parenthood and child rearing.

One of the possible explanations for the dysfunction in attachment relationships with which BPD individuals present lies in the difficulty they have with holding in their minds a consistent and stable representation of others' and their own minds (Liotti, 2002). Schore (1997) maintained that borderline pathology is associated with unstable mental representations that 'encode a dysregulated self-interaction-with-a-misattuning-other' (p. 38).

Representations and related mentalising processes are viewed as 'the carriers of experience' (Carlson et al., 2009, p.1328) that link early attachment to later psychopathology, demonstrating their pivotal role in normal development and healthy relationships. The concept of representation has proven to be a valuable concept for the understanding and treatment of BPD (Outcalt et al., 2016). Studies have found

that, when patients' capacity to relate to themselves and others is improved (by strengthening their representations of self and other in healthier and more realistic ways or by improving their mentalisation capacity to understand themselves or others in less destructive ways), negative affect, emotional dysregulation and impulsivity decrease (Bateman & Fonagy, 2009; Clarkin et al., 2007). Mentalisation allows for thoughts and feelings to be experienced as representations; this, in turn, enables mental states to be seen as separate from, yet potentially causing, actions (Fonagy et al., 2003). This cognitive capacity underpins the development of a coherent self-structure; it is described as an important determinant of individual differences in self-organisation and as being the basis of many defining features of selfhood, such as self-consciousness, autonomy, freedom and responsibility (Bolton & Hill, 1996).

1.0.2 Mental Representations

Mental representations constitute cognitive and affective schemas that are shaped by primary early relationships and are active in new and present interpersonal situations (Erbe, 2014). According to Fonagy et al. (1993), they are linked to emotional experience and 'not only store our past experience but also guide our perception and influence our experience of our external and internal worlds' (p. 11). In the course of early development, internalised experiences are increasingly integrated and grouped into different types of representations (i.e., self-representations and other-representations). Eventually, individuals rely on these representations to swiftly shape their experience and response to a particular situation. Representations act as a guide throughout people's lives, helping them making choices on the basis of the content of their representations. According to Main et al. (1985), individuals' mental representations relate to patterns of language and of non-verbal behaviour.

The formation of complex, coherent and reasonably positive self- and other-representations is fundamental to developing the foundations necessary for establishing identity and functioning interpersonally in early childhood (Blatt, 2008; Kernberg, 1984). Overall positive, realistic and *stable* content (i.e., not reliant on primitive defenses and distortions) in the representations of the self allows for a greater sense of stability and more acceptance of occasional, situational shifts away from individuals' desired or 'ideal' way of being. Similarly, stable and reasonably positive representations of others are associated with an increased capacity to accept other's minor shortcomings, to understand other's thoughts and feelings and, consequently, to manage negative or aggressive feelings directed towards others (Siefert & Porcerelli, 2015). At the root of the individual's representation of the other, there is an integration of a variety of attributes about the other 'into a single system' (Fonagy et al., 1993, p. 11). These attributes may be connected on the basis of experience, wishes, fantasies, fears or other affective structures; they can distort the internal organisation of the individual's mental life and increase their vulnerability to psychopathology.

In normal development, parents' representations of their children allow the children to grow in their understanding of the self and of others as psychological beings and to develop a mental representation of their own emotional states; this has an impact on a host of psychosocial outcomes, such as their ability to mentalise and their confidence in the world. Parents' representations of their children affect several aspects of the parent–infant relationship, including perception and understanding of infant affective communication, affect attunement and regulation, emotional availability, sensitivity and responsivity. These, in turn, influence the socioemotional development of the infant in such areas as stress regulation, attachment organisation and self-

development (Fonagy, Gergely, Jurist, & Target, 2004; Schore, 2003; Stern, 1985). According to Gergely and Watson (1996), the formation of representations lies in a social bio-feedback that establishes itself naturally between mother and baby and is based on parental mirroring of affects. Through this, parents modulate or represent in a modified form the infant's affect by naturally reflecting in a marked and exaggerated form the baby's emotions. This allows the infant to achieve a series of developmental consequences, such as the ability to access and attribute emotion-states to the self via the internalisation of the parents' representation of their affects; this, in turn, will affect the infant's capacity to control, reason about and regulate his/her emotion-states (Gergely & Watson, 1996).

1.0.3 Parents with BPD and Their Representations

BPD poses significant challenges for parents when they attempt to establish a relationship with the infant. For these parents, who often have a background of unresolved attachment-related trauma and maltreatment, the relationship with the infant is an opportunity for a reworking of their own background, though this brings with it a risk of traumatic and unempathic relational dynamics (Newman & Stevenson, 2008). The parents' lack of capacity to reflect and respond to their children's inner experiences deprives them of a core psychological structure that serves the purpose of building a worthwhile sense of self (Fonagy et al., 2002). Neurodevelopmental, psychological and emotional developmental implications may follow, and infants (as young as two months of age) may show signs of trauma such as dissociation and withdrawal (Fraiberg et al., 1975). These signs, if persistent, are linked to poor developmental outcomes, including later dissociative symptoms, depression and features of borderline personality functioning (Newman, 2015).

Parents who are unable to contain and become overwhelmed by their infant's affects, such as in cases of borderline parents, can be expected to show impairment in the mirroring of their infant's affects, as described above (Gergely & Watson, 1996). It can be speculated that BPD parents might have malevolent and distorted representations of their children and might be unable to think about them positively (if at all) and, therefore, to mirror their affects appropriately.

A malevolent and dangerous inner world has been suggested to be fundamental to borderline patients (Arnow & Harrison, 1991; Tramantano et al., 2003), who experience emotions in an intense and crude manner. Adults with BPD also experience sudden changes from extremely good to extremely bad representations that lead to the chaotic nature of their experience (Suvak et al., 2011).

Zeanah et al. (1993) suggested that internal working models or mental representations are strongly predictive of a mother's behaviour with her child. Studies have associated mothers' negative perceptions or representations of their young children with a maternal history of maltreatment (Gara, Allen, Herzog, & Woolfolk, 2000) and with a punitive parenting style (Lorber, O'Leary, & Kendziora, 2003). Distorted maternal representations include disturbed ideas, thoughts and feelings that a mother holds about her child; they are influenced by the mother's early attachment-related trauma history and her capacity to develop a psychological understanding of the infant without reliance upon primitive defenses and distortions (Slade, 2005). They may be characterised by hostility, rejection, negativity and fear of the infant (George & Solomon, 1996; Lyons-Ruth, Melnick, Bronfman, Sherry, & Llanas, 2004). They are frequently associated with difficulties in interpersonal relationships, emotional dysregulation, social risk (Flykt et al., 2012; Lyons-Ruth et al., 2004; Newman & Stevenson, 2008) and disturbances in mother–infant interaction. These can lead to

poor child developmental outcomes, including disorganised infant attachment, signs of trauma such as dissociation and withdrawal in infants (Fraiberg et al., 1975) emergence of internalising and externalising problems in middle childhood and onset of BPD in adolescence (Madigan et al., 2006). Nonetheless, mental representations are dynamic and can be adjusted in response to later relationship experiences and/or targeted interventions; balanced and secure parental representations (i.e., characterised by narrative coherence and richly elaborated descriptions, emotional warmth, acceptance of the child and sensitive responsiveness to the child's needs) can be developed, impacting the security of the parent–child relationship (Rosenblum et al., 2018).

In view of the aforementioned risks associated with distorted and negative representations and the link between representations and behaviour, exploring the representations that parents with BPD hold of their children represents an important step towards the identification of parent–child dyads at risk of relational disturbance and possibly towards the enhancement of interventions that aim to improve parental representations of the child and related mentalizing capacities. This, in turn, could improve developmental trajectories of children otherwise vulnerable to consequences of transgenerational trauma (Sleed & Fonagy, 2010) and neurodevelopmental, psychological and emotional developmental implications (Newman, 2015), and could lessen the longer-term socioeconomic cost of childhood attachment disorders (Oates, 2007).

Though the topic of mental representations has been widely studied and researched and its links to parenting documented, there still remains a paucity of research into the

representations that parents with BPD hold of their children. Mental representation research focusing on parents with BPD is needed, as this population has been suggested to be at greater risk of facing heightened challenges in parenting, with deleterious repercussions on child development (Stepp et al., 2012).

2.0 Aims and Method

This review aims to explore the representations that parents with BPD hold of their children. It does not aim to be exhaustive but provides a narrative synthesis of the key recent studies in this area. The research question that this paper will attempt to answer is the following:

- What do we know from the literature about the different types of mental representations that parents with BPD have in relation to their children?

Several definitions currently exist on the widely researched topic of mental representations. According to some authors, this reflects a lack of clarity about the concept because of its complexity and abstraction (e.g., Gallistel, 2001). Less research concerns the topic of mental representations of the child in parents with BPD, posing further challenges to their conceptualisation and operationalisation for the purpose of the current review.

The definitions highlighted in Paragraph 1.0.2 attempt to provide the basis for their conceptualisation and operationalisation in the current paper. Mental representations are described as cognitive and affective schemas that are active in new and present interpersonal situations (Erbe, 2014); they are linked to emotional experience (Fonagy et al., 1993), and relate to patterns of language and of non-verbal behaviour (Main et al., 1985).

As Kilbride (2020) suggested, different ways of capturing representations of the child exist via assessing parenting narratives, and these include the Working Model of the Child Interview (WMCI; Zeanah et al., 1994) and the Parent Development Interview (PDI; Slade et al., 2003); these interviews include asking the parents for their perceptions and experience of their child's characteristics and of their relationship with their child. These systems for assessing parenting narratives appear helpful in allowing researchers to draw inferences about representations on the basis of parents' speech (i.e., verbal description of the child and/or of their relationship to the child), and were considered to inform the inclusion criteria of this review search.

On the basis of the above, papers exclusively exploring and/or assessing parents' descriptions of their child initially characterised the inclusion criteria of this review's search. However, in view of the lack of studies that an initial search run through these criteria elicited, the inclusion criteria were revisited. The new inclusion criteria included studies not only exploring/assessing parents' descriptions (i.e., verbal account) of their children but also parents' way of relating to them via their observable behaviour with their children. It was thought that looking at both parents' verbal accounts and their interaction with their children could provide an enriched picture of the parents' mental representations of their children. This way of capturing mental representations was not considered to be rigorous; nonetheless it aimed to provide a tool for a qualitative synthesis of parents' potential representations of the child.

For the purpose of this study, parents' representations of the child were operationalised in terms of the parents' thoughts and perceptions of their children, including cognitive and affective schemas about the child. They were explored via

parents' descriptions (i.e., verbal accounts) of their children and parents' ways of relating to them (i.e. the more observed and often non-verbal facets of the parent–child relationship). Specifically, delving into parental representations of the child included exploring the variety of attributes that parents used to describe their children, as well as the different qualities and layers characterising how they relate to them, as is laid out in this literature review.

Literature for this review was compiled primarily through advanced database searches on PsycINFO and ScienceDirect. The keywords 'BPD' (or 'borderline'), 'child', 'parent' (or 'mother' and 'father'), 'representations' (or 'mental representations' and 'internal representations'), 'images', 'perceptions', 'attributes', 'relationship' (or relating) and other variants were used to search journal article titles.

Studies exploring or assessing the representations that parents with BPD held of their children, as operationalised above, were selected. These included studies exploring parents' descriptions (i.e., verbal accounts) of their children as well as parents' way of relating to them (i.e. observable behaviour). Parents with a diagnosis of BPD and with children aged 0 to 18 years old were included. Parents of children older than 18 did not meet the inclusion criteria. Studies focusing on parents with BPD undergoing or having completed a therapeutic intervention were excluded in view of their focus on the efficacy of an intervention rather than on describing the population. Systematic reviews and studies in languages other than English were also excluded, as were papers published prior to 2000 to allow for more recent articles to be explored, with the aim of providing an account of the current understanding of how parents with BPD represent their children.

There were 1904 studies that were initially identified through database searching. The articles were screened through abstract and title and full-text articles assessed for eligibility. Seventeen full-text articles were identified to meet the criteria; these had set out to explore and/or assess the representations that parents with BPD held of their children via the parents' descriptions (i.e., verbal accounts) of their children and way(s) of relating to them (i.e., observable behaviour). These studies will be presented in the next paragraph.

3.0 Results

Details of what emerged from the review and analysis of the selected studies (n = 17) on the types of representations that parents with BPD hold of their children are presented below. A thematic structure was chosen to present the findings of the current review, in view of the emergence of shared themes/thematic categories in the studies identified. The methodology of theme selection drew upon aspects of thematic analysis, such as the identification and the summary of important concepts within the data set (i.e., within each of the studies identified), and the emergence of patterns within the same studies and/or among the different studies identified. The themes/thematic categories were discussed in research supervision where they were verified. The salient and common themes were selected and extracted across the 17 papers that pertained to the characteristics of the parents' representations.

With regard to the methodology of the studies identified, 14 of them adopted a quantitative design (n = 14), two were qualitative studies and one utilised a mixed design. By exploring the findings of these studies, four main themes emerged: role reversal, emotional misattunement, hostility and absences. These themes are not mutually exclusive; the studies often identified more than one theme and were

explored within more than one thematic section. These thematic categories aimed to provide structure and guidance to the presentation and discussion of the results via a narrative synthesis, while paying regard to overlaps and interrelations.

It is important to note that, although fathers were not excluded from being study participants by the literature search, all the participants of the studies identified in this literature review were mothers. Consequently, the term 'mothers', as opposed to 'parents', will be adopted in the presentation of the thematic categories.

3.0.1 Role Reversal

Role reversal arose as a theme from four papers whose findings showed some disturbances in the mother–child relationship where mothers had a diagnosis of BPD. These mothers struggled to hold a parental role and placed inappropriate demands and responsibilities on their children. Trupe et al. (2018) and Macfie et al. (2017), for example, found that mothers with BPD and their latency-aged children (4–7 years old) exhibited some degree of role reversal in the interaction with their child. Both studies used a quantitative design and observational measures to examine the dyads' interactions; however, their focus varied slightly.

Trupe et al. (2018) investigated how mother-child emotional availability (warmth and closeness) relates to risk factors for BPD, including mother-child role reversal; they were not specifically concerned about a sample comparison between mothers with BPD and without. Macfie et al. (2017) examined levels of parent–child role reversal, among several other aspects of parenting, namely, sensitivity, hostility, support for autonomy and fearful/disoriented behaviour, in mothers with BPD and without. Moreover, the former study (Trupe et al., 2018) included 70 children and their mothers

(36 mothers with BPD, and 34 without) who were filmed in dyads, during a ten-minute storytelling task. Their interactions were coded with the Emotional Availability Scales (EAS), (3rd Edition) (Biringen et al., 1998), concerned with emotional communication and interaction in the parent–child dyad. As aforementioned, their analytic plan did not particularly focused on a sample comparison between mothers with BPD and mothers with no BPD disorder. Nonetheless, it was thought that this study would still elicit useful information for the purpose of the current review by looking exclusively at the findings linked to mothers with BPD and specifically related to role reversal. In line with this, the children's narrative representations of mother-child relationship expectations that Trupe and colleagues had also assessed, were not reported in the current review; the findings concerning mothers were exclusively delineated. Of the 36 mothers with BPD, 9 mothers were specifically found to demonstrate low sensitivity and structuring, which were associated with the prevalence of role-reversal.

In a slightly different way and in a sample of similar size (i.e., 36 mothers in the control sample and 34 in the normative sample), Macfie and colleagues used a 10-minute puzzle-solving activity to examine levels of parent–child role reversal, among several other aspects of parenting, namely, sensitivity, hostility, support for autonomy and fearful/disoriented behaviour. The interactions were coded from videotapes utilizing the Qualitative Ratings of Parent/Child Interaction at 54 months (Cox, February 1997), and more mother-child role reversal was found in dyads in which mothers had BPD than in the comparisons.

Furthermore, although each of above studies adopted its own operationalisation regarding role reversal, a degree of homogeneity in its conceptualisation also transpired, which enabled a comparison between the studies' findings. In particular,

while in the study by Trupe and colleagues over-responsiveness and over-involvement were at the basis of the operationalisation of parent–child role reversal (i.e. the child giving up some of what he/she needs in order to maintain the relationship on the parent's terms), Macfie and colleagues operationalised the term as including a lack of clarity throughout the session with regard to who is the parent and who is the child, continual lack of necessary limit-setting, the presence of a playmate relationship between the parent and child, parentification of the child or the presence of a high level of seductive behaviour from the parent. Nonetheless, both studies found some analogous outcomes with regard to the presence of difficulties in holding a parental role, among a BPD population of mothers of latency-aged children, and in placing appropriate demands/responsibilities on their children.

Similar results, in terms of role-reversal dynamics, seem to also apply to mothers of adolescent children with a diagnosis of BPD.

As shown by Ainsworth (2014), the adolescent children appeared to be needed to support their mothers, rather than vice versa. Five mothers who had children in their adolescent years or early adulthood (only one participant had a latency-age child) were interviewed using a semi-structured interview schedule. Although this study aimed to explore the experience of being a mother with a diagnosis of BPD and invited mothers to reflect on themselves as a parent rather than on their children, it also shed light on how mothers with BPD seemed to perceive and/or relate to their children; hence, it was included in the studies of this literature review. A qualitative design was adopted, and interpretative phenomenological analysis (IPA) (Smith, 1996; Smith & Osborn, 2003) was utilised to interpret the individual interviews. Role-reversal arose from the descriptions that mothers with BPD provided about the way they thought

about and related to their children. Some mothers discussed the importance of their children understanding their difficulties and needing support from them; one mother seemed to fear her child abandoning her, while another participant discussed feeling frustrated that other people saw her as meeting her own needs through her children.
A further study (Schact, 2003) aimed to increase understanding of both parenting styles of mothers with BPD and the functioning of their adolescent children (aged 10–18). This study, which had a mixed design (quantitative and qualitative), included questionnaires and interviews collected from both mothers and adolescents separately; for the purpose of this literature review, findings from mothers were exclusively looked at. The quantitative measures (Paulson, 2001) were used to enrich the qualitative findings (Schact, 2003) that are partly summarised below. Some mothers spoke about their children as friends in their semi-structured interviews and believed they had placed too much responsibility on their children. The adolescents had cared for themselves at an early age, and some had cared extensively for their mothers, which included cooking, tending to household chores, caring for their siblings and closely monitoring their mothers' status. Mothers in this sample appeared to have difficulty establishing their role of parental authority and were often in a position of seeking approval from their children that compromised their ability to accurately identify and/or act on situations with increased risk to the adolescent. These mothers' ability to assess adolescents' needs and strengths was compromised, and they were unable to evaluate the current situation relating to their children in a balanced manner (Schact, 2003).

It seems important to note that the four studies highlighted above (Ainsworth, 2014; Macfie et al., 2017; Schact, 2003; Trupe et al. (2018) varied in their design: they used

either a quantitative, a qualitative or a mixed design. This suggests some level of corroboration with regard to the identified role-reversal thematic category that, despite the slight variations in its operationalisation, emerges across studies with different designs as one of the ways possibly characterising their representations of their children.

3.0.2 Emotional Misattunement

Emotional misattunement emerged as another main theme underlying the way mothers with BPD represented their children. Findings from eight studies identified in this literature review indicated that mothers with BPD can appear emotionally misattuned with their children in terms of struggling to recognise and read their infants' mental states (e.g. beliefs, wishes, feelings and thoughts) (Bateman & Fonagy, 2004), misinterpreting them and responding to them inappropriately (e.g., mismatching infant signaling, mistimed responsiveness, inauthentic affect towards the child, confused/disoriented/frightened responses towards the child). This is often manifested in a lack of or impairments in the use of mental state-/mind-related comments. Schacht et al. (2013), for example, in their study on maternal mind-mindedness (MM), illustrated how mothers with BPD used fewer references in relation to children's mental states than mothers without a diagnosis of BPD. They recruited 20 mothers with BPD and 19 mothers without personality disorders and their children, aged 39–61 months, from a hospital. MM was defined as the mother's references to her infant's mental states during an interaction and was assessed by mothers' use of mental state references to describe their children during a brief interview measure (Meins & Fernyhough, 2010). Their results were analysed quantitatively and showed that mothers with BPD were more likely to mention behavioural, physical or general

attributes of their children when given an open-ended invitation to describe them than to refer to their children’s interests, imagination or feelings; maternal BPD was associated with fewer references to children’s mental states (46%) in comparison with the descriptors used by the control group (68%). In contrast, Marcoux et al. (2017) found that mothers with and without BPD appeared equally likely to envision mental states in their infants. Their study also attempted to assess MM, as earlier operationalised, via a quantitative design. A total of 38 mothers (10 with BPD and 28 without a psychiatric diagnosis) were observed during interactions with their 12-month-old infants. Mother–infant free play and verbal content was transcribed from videotape and coded using Meins’ and Fernyhough’s (2006) guidelines. Mothers with and without BPD were found to be quite similar in terms of how often they referred to mental states in their infants and did not differ in the proportion of total comments that was appropriate mind-related comments, as judged based on context and the infant’s activity. Marcoux et al. (2017) found that mothers with BPD were different from those without BPD not in the frequency of mental state references as Schact et al. (2013) evidenced, but in their content. Mothers in the BPD group were found to make 3.6 times more misattuned mind-related comments than control mothers, suggesting that mothers with BPD are more likely to misread their infants’ mental states. In comparison with the previous study (i.e., Schact et al. 2013), Marcoux et al. (2017) not only identified the presence of mental-state comments but also distinguished between attunement and misattunement elements in those comments, as aforementioned.

Elements of misattunement seem to also be relevant to mothers’ thoughts and recognition of a particular type of mental state in their children, namely, emotions. Elliot et al. (2014) examined how mothers with BPD perceive infant stimuli depicting happy,

sad and neutral emotions. In their quantitative study, 13 mothers with BPD and 13 healthy control mothers, with their babies aged between 3 and 14 months old, were presented with randomised, full-screen infant-face images using Experiment Builder software (Eyelink, Ontario, Canada) and were instructed to provide a verbal response. Mothers with BPD were found to be significantly poorer at infant emotion recognition overall. They especially displayed markedly reduced recognition accuracy for neutral infant expressions, demonstrating a strong negative misattribution bias for neutral, mistaking it 84.8% of the time as sad (Elliot et al., 2014).

Further details on how mothers with BPD tend to struggle to interpret the emotions and the mental states of their children emerge by looking at mothers' responses to them. Three quantitative studies examined mother–baby interactions during separation–reunion episodes of the Strange Situation test by Ainsworth et al. (1978) (Hobson et al., 2009) and during free play (Newman et al., 2007; Newman-Morris et al., 2020). One further study (Macfie et al., 2017) that was also described in the previous thematic section on role reversal (Paragraph 3.0.1), focused instead on older children (4–7 years old).

In Hobson et al. (2009), mother–baby interaction was rated using the Atypical Maternal Behavior Instrument for Assessment and Classification (AMBIANCE) (Lyons-Ruth et al., 1999), while Newman-Morris et al. (2020) and Newman et al. (2007) adopted the EAS (Biringen, 2008) to code mother–infant interactions. Newman-Morris et al. (2020) also provided mothers with BPD (n = 61) with a survey and a PDI (Aber et al., 1985; Slade et al., 2004) to complete prior to being invited to take part in an 8-minute free play session with their child, while Macfie et al. (2017) used a puzzle-solving play situation from which mother–child interaction variables were coded utilising the

Qualitative Ratings of Parent/Child Interaction at 54 months (Cox, 1997), as highlighted in Paragraph 3.0.1.

All four studies (Hobson et al., 2009; Macfie et al., 2017; Newman et al., 2007; Newman-Morris et al., 2020) showed elements of emotional misattunement in the way mothers with BPD related to their children (mostly infants): women with BPD showed disrupted affective communication with their children, which included persistent inappropriate responses to infant needs, parental responses mismatching infant signaling, significant difficulty around most physical contact with the infant, inauthentic affect towards the infant and inconsistent or mistimed responsiveness. In three of these studies (Hobson et al., 2009; Macfie et al., 2017; Newman, 2007), mothers with BPD were compared to a community group, and a higher proportion of women with BPD displayed the aforementioned responses than in the comparison groups; additionally, they appeared frightened of and withdrawn from their children, responding to the child with confusion, disorientation, fear or unusual voice quality. Interestingly, it was noticed that some mothers who were found to have relatively high reflective capacity also endorsed many distorted ideas about their infants (Newman-Morris et al., 2020). This suggests that mothers may have been engaging in hypermentalizing (erroneous and intrusive focus on mental states reflecting deficits in understanding the infant's inner states and subjectivity) (Sharp & Fonagy, 2008), as the authors highlighted and underlined the difficulties of detecting, assessing and exploring the thoughts that mothers with BPD hold about their children.

Finally, Geerling et al. (2019) appeared to further corroborate the above findings by utilising a different design (qualitative) to explore the experience of mothers in response to their infants crying. Six mothers with BPD were interviewed via semi-structured interviews that were analysed using IPA (Smith, 1995; 1996). Emotional

interpreting and attunement appeared to be compromised in these mothers in response to their infant's crying. An intense physiological and emotional response developed from their narratives that included mental shutdown, anxiety, distress, intense fear (i.e., perceiving that something was wrong with their child), frustration, agitation and anger, particularly when infant crying persisted for a long time. These responses appeared to detrimentally impact the mothers' reflective parenting and interpersonal functioning (Geerling et al., 2019) and seemed to prevent them from attuning with their children in those moments and to think of them as free from possible parental projections.

These studies, by investigating mothers' use of mental state references in relation to their children and their responses to them, seem to provide insights into the mental representations that mothers with BPD hold of their children. Although some conflicting results emerge in relation to the frequency of mental state references in mothers with BPD in comparison with mothers without BPD, a certain level of harmony transpires from the findings of the studies presented (e.g., Elliot et al., 2014) regarding the content of these references. Mothers with BPD tend to use more misattuned comments in relation to their children and to misinterpret their emotions, specifically misattributing sadness to neutral emotions. Moreover, the emotional misinterpreting also appears to be manifested in the way mothers' responses mismatch the infant's signaling and are at times characterised by fear, confusion (e.g., Hobson et al., 2009) or distress (e.g. Geerling et al., 2019).

3.0.3 Hostility

A further theme, hostility, captures the ways in which mothers with BPD seem to represent their children via their expression of negative emotions towards them, through words (e.g., devaluing language), behaviour (e.g., rough handling), intrusiveness and an active negative attitude towards the child (e.g., harshness, abruptness, disapproval). Hostility, in this literature review, further refers to a hostile caregiving stance that includes threatening and aggressive undertones.

This emerged from nine papers that looked at mothers with BPD with children at different stages of development (under five years old, latency and adolescence). Among these papers, there was one (i.e., Newman et al., 2007) that also identified another thematic category as described earlier and found no differences between mothers with BPD and without BPD with regard to a hostile type of relating. The authors used the EAS to code mother–infant interactions and focused exclusively on assessing mothers' interactions with their infants and their parenting perceptions by videotaping ten minutes of free-play mother–baby interaction to examine the parenting attributes of mothers with BPD. No significant difference was found between mothers with BPD and control mothers on the EA non-hostility scale, suggesting that mothers with BPD did not appear actively hostile and did not display frightening or threatening behaviours. This was considered to be a surprising finding and possibly the result of a small sample size that included 14 mothers with BPD; it was speculated that more active hostility would be observed in a larger sample (Newman et al., 2007).

Nonetheless, a few other studies with similar sample sizes showed elements of hostility in the way mothers with BPD related to their infants. Of these studies, some also identified other themes that have been described earlier (Hobson et al., 2009; Macfie et al., 2017; Newman-Morris et al., 2020).

Crandell et al. (2003) and Newman-Morris et al. (2020) used free play as one of the measures to assess mother–baby interactions. The interactions were rated according to the global ratings for mother–infant interactions devised by Murray et al. (1996) and to the EAS, respectively. In both studies, hostility emerged as one of the ways in which mothers appeared to represent their children, as captured by their hostile speech and behaviour towards the child. Specifically, mothers with BPD were found to be more insensitive towards their infants, which included intrusive speech and behaviour. Some mothers also displayed rejecting and demanding behaviour (Crandell et al., 2003).

Kiel et al. (2011) and Hobson et al. (2009), who recruited 22 and 10 mothers with BPD, respectively, as part of their study samples, also found traces of hostility in the way mothers with BPD related to their under-five-year-old children. Both studies focused on assessing mother–baby reunion following the Strange Situation procedure (Ainsworth et al., 1978) rather than during free play. Kiel et al. (2011) aimed to examine the dynamic nature of parenting in response to infant distress in mothers with and without clinically relevant levels of BP pathology and found that mothers with clinically relevant levels of BPD pathology were less likely than those without to display positive affect in response to infant distress. More specifically, the likelihood of insensitive parenting behaviours, including rough physical handling of the child, among mothers with clinically relevant levels of BP pathology was found to increase significantly as infant distress persisted for longer durations (a pattern not present for mothers without BP pathology). Similarly, Hobson et al.'s (2009) findings revealed more expression of negative affect and more intrusive behaviour in mothers with BPD.

These studies suggest that mothers with BPD possibly perceive and relate to their under-five-year-old children with more hostility than mothers with no BPD diagnosis,

as demonstrated by their interactions both during free play and in response to children's distress.

Mothers of older, latency-aged children (5–12) with a BPD diagnosis appear to perceive and relate to their children in a similarly hostile way to the mothers of younger children. Three studies (Kluczniok et al., 2018; Macfie et al., 2017; Trupe et al., 2018) assessed the interaction of mother–child dyads (distinguishing between BPD and non-BPD mothers) during a play situation. Macfie et al. (2017) and Trupe et. al., (2018), as detailed in previous Paragraphs 3.0.1 and 3.0.2, used a play situation from which mother–child interaction variables were coded. In addition to the role-reversal and/or emotional misattunement themes that emerged from these studies, more hostility emerged in the way mothers with BPD related to their children in comparison to normative sample, in terms of showing negative regard toward the child, including disapproval, abruptness, harshness and tense body or facial expressions, and being rejecting or antagonistic.

Similarly, Kluczniok et al. (2018) assessed the interaction of mother–child dyads during a standardised play situation using the EAS (4th Edition) (Biringen, 2008). They also found that mothers with BPD displayed increased hostility during mother–child interaction, showing signs of maternal anger, impatience and/or boredom either subtly or openly in words and/or deeds.

These responses seem to also apply to the mothers of adolescents. In a study investigating parental psychological control (Mahan et al., 2018), in a sample of mothers with a diagnosis of BPD (n = 28), normative comparisons (n = 28) and their adolescents (aged 14–18), the Psychological Control Scale–Observer Report (PCS-

OBS) (Barber, 1996) was used to measure observed maternal psychological control during a mother–adolescent problem discussion task. Mothers with BPD used more psychological control with their adolescents in comparison with normative mothers, which included interrupting or talking over them, negating expressed attitudes or emotions, blaming or mentioning past mistakes, shaming and burdening with responsibility for the parent's needs, physically demonstrating disapproval (e.g., rolling eyes and turning away) and responding with emotional inconsistency in relation to the adolescent.

Throughout all these studies, mothers' ways of representing their children appear tinged with hostility, regardless of the age of the child or the measures utilised. This seems to be further confirmed by a quantitative study focusing on a larger sample of mothers of children aged 3–18 (Dáu & Milan, 2021), where 214 mothers with more BPD symptoms were provided with self-report measures on parenting, open-ended questions about parenting experiences and computerised mentalization tasks: they were found to react with greater hostility towards their child, to put more blame on their child for misbehaviour and to feel more dissatisfaction in the relationship.

3.0.4 Absences

Absences are the last theme that transpired from ten of the studies identified in this literature review. Absences refer to mothers' lack of engagement and/or responsiveness towards their children – neglecting, ignoring, not caring and possibly struggling to hold the children in their minds and to 'see' them. This theme, in a similar way to the role reversal theme, reveals an abdication of mothers' parental role. However, the cornerstone of this thematic category lies more specifically in the

pervasive passive quality of their relationship to their children and lack of manifested parental care.

Of the ten studies, all except one (White et al., 2011) also elicited other types of representations through the themes that have already been described. With regard to absences as a theme, two studies examined mother–baby interactions (Crandell et al., 2003; Hobson et al., 2009) and found that mothers with BPD displayed a lack of responsiveness towards their infants. Less efficacy in structuring infants' activities also transpired from a few other studies (Newman et al., 2007; Newman-Morris et al., 2020), as did mothers ignoring infant distress (Kiel et al., 2011). Mothers of latency-aged children with BPD were found to be less likely to be sensitive in terms of responsiveness to their child's needs and cues and to provide autonomy support and structuring in terms of facilitating the child's play, exploration, or task completion (Macfie et al., 2017; Trupe et al., 2018); they were more likely to use fewer references in relation to their children's mental states (Schact, 2013) and to experience boredom during play with their children (Kluczniok et al., 2018).

One further study (White et al., 2011) showed absences in the way mothers with BPD appeared to represent their children. It examined mother–infant interactions in the context of women with BPD (n = 17), major depressive disorder (MDD) (n = 25), their co-occurrence (n = 20) and healthy controls (n = 25), via self-report measures and mother–infant interaction tasks involving free play. Behaviour ratings using the Interaction Rating Scale (Field, 1980) focused on infant behaviours and maternal behaviours. Several variables of mother and infant positive interaction behaviour were found to be disturbed within the context of BPD. In particular, the domains of maternal smiling, maternal touching, maternal game playing and maternal imitation were all

found to be reduced in mothers with either a diagnosis of BPD only or of BPD and major depressive disorder (MDD).

The studies presented in this paragraph demonstrate absences in how mothers with BPD relate to, attune with and possibly represent their children, also suggesting an absence of positive relational facets between mother and child. Lack of maternal smiling, maternal touching, maternal game playing and maternal imitation characterised the ways mothers with BPD interacted with their infants, as well as a lack of efficacy in structuring infants' activities and ignoring their distress. While this theme did not specifically emerge from any specific paper looking at a population of mothers of adolescent children, mothers of latency-aged children were found to be bored during play with their children, to struggle providing autonomy support and structuring, to use fewer mental state references in relation to their children and to show a general lack of responsiveness to their children's needs.

4.0 Discussion

The present literature review aimed to explore what previous research studies have informed us about the mental representations that parents with BPD might hold of their children. The mental representations of the child were operationalised in terms of the parents' thoughts and perceptions of their children and were explored via parents' tangible descriptions (i.e., verbal accounts) and ways of relating to them (i.e. the more observed and often non-verbal facets of the parent–child relationship). The current paper reviewed and qualitatively synthesised some of the recent key studies in the area.

Seventeen studies were identified as meeting the criteria for inclusion. Although the search criteria of this literature review referred to parents as both mothers and fathers, the participants of the studies identified were exclusively mothers. This may be the result of the predominantly female population affected by BPD (about 75%); nonetheless, it highlights the need for further research to illuminate the ways in which fathers may represent their children, to explore the potential differences from mothers' representations of their children and, consequently, inform clinical interventions.

With regard to the methodology of the studies in the current literature, the majority of them adopted a quantitative design (n = 14), two were qualitative studies and one utilised a mixed design. This suggests a lack of qualitative research on this topic that might add valuable nuances for better understanding. The main findings of the current studies were qualitatively synthesised via the thematic and interrelated categories that emerged: 'role reversal', 'emotional misinterpreting', 'hostility' and 'absences'. These themes each provided important information on how mothers with BPD related to their children and possibly represented them in their minds, taking into account the children's different stages of development and the studies' different designs, methods of analysis and procedures.

4.0.1 Role Reversal

As a thematic category, role reversal developed from four papers in which mothers with BPD struggled to hold a parental role and placed inappropriate demands and responsibilities on their children. Of these four papers, two looked at mothers of latency-aged children, and two focused on mothers of adolescents. Over-responsiveness, over-involvement, lack of necessary limit-setting, and high level of

seductive behaviour characterised mothers of latency-aged children. Similarly, mothers of adolescent children emerged as needing their children's approval and presence and appeared to need support from them in an exaggerated form. In some instances, they perceived their adolescents as taking on too many responsibilities, expressing thoughts on how their children had possibly learned that their needs were secondary to those of their mothers and had become responsible for caring for their mothers.

These findings resulted from studies that adopted different designs, measures and variations in the operationalisation of the term role reversal. Nonetheless, they seemed to show that these mothers struggled to hold a parental role and placed inappropriate demands or responsibilities on their children. This suggests that the children of mothers with BPD may be represented in their mothers' minds as needing to respond to their mother's needs rather than vice versa and pose questions as to whether mothers with BPD are able to perceive their children's needs and 'see' them at all. As Bradley & Westen (2005) reported, borderline patients experience difficulties with separation and emotion regulation, including their capacity for self-soothing. They may have to rely on the actual (rather than internalised) presence of another person, which may include their child (MacFie et al., 2017), in order to withstand their own abandonment fears, manage and tolerate emotions and provide them with a sense of security (Bradley & Westen, 2005).

Also of interest, in this review, is that role reversal was found exclusively in studies with mothers of children in their latency or adolescent years and not in infancy or in toddlerhood. It may be speculated that this particular way of relating may be more

explicit and apparent in mothers of older children who may have reached a certain degree of independence, from a developmental perspective. The rise in children's independence and in separation–individuation, in psychoanalytic terms, may trigger a fear of rejection or may be misinterpreted as a rejection by mothers with BPD who are prone to this particular emotional experience, especially as they struggled themselves during their own separation–individuation phase (Mahler, 1971). The child's normal strivings for autonomy, efforts to push the caregiver away and expression of anger are threatening to a caregiver who herself is vulnerable to feeling abandoned and rejected, such as in the case of mothers with BPD. This may contribute to set out role-reversal dynamics, with deleterious repercussion on child development, such as the development of a "false self" based on the caretaker's needs rather than on the child's own, and of borderline dynamics in the children (Bradley & Westen, 2005).

It would be interesting and important to further explore this specific theme of role reversal and gain further understanding of whether it characterises the relationship between mothers with BPD and younger children, and the possible reasons behind it. It can be speculated that traces of the role-reversal type of interaction may still be present in this population, although in less evident forms and in different variations; other ways of relating may come to the fore more evidently in mothers of young children. The definition used by Jacobvitz et al., (2004) may come useful in this context. According to Jacobvitz et al., (2004), role reversal is a subtype of boundary dissolution, that comprises various dimensions such as enmeshment, overprotectiveness, and in-trusiveness. These dimensions may be found to characterise role reversal especially in younger children. For example, by exploring seductive role-reversal in infancy, Jacobvitz & Sroufe (1987) found that mothers

sensually stroked the child's hair or face and often distracted the child from his or her task. Moreover, in the context of marital conflict, toddlerhood has been described to be particularly challenging for parents whose needs for care and intimacy are not being met by a spouse; these 'needy' parents have been hypothesised to not support their child's normative separation from them and may seek to keep their child close to meet their needs in a role reversal (Macfie et al., 2008). Similarly, mothers with BPD, struggling with their need for care and for intimacy, may compromise the child's gradual development and search for autonomy, and may relate to a toddler in ways that may reinforce the child's dependence to the parent (e.g., lack of boundaries, seductive behaviour, seeking to keep the child dependent). These mothers may often have difficulties attuning with their child, possibly in view of their heightened and stirred-up thoughts and feelings. This is further explored in the following paragraph.

4.0.2 Emotional Misattunement

Emotional misattunement was found to characterise the interactions that mothers had mainly with their infants, providing further insight into mothers' potential representations of their children. As in the role-reversal thematic category, mothers with BPD who appear emotionally misattuned from their children may struggle to place their children's needs before their own, as the studies identified in this paper suggest.

Eight of the studies in this literature review found that these mothers appeared emotionally misattuned in the way in which they struggled to recognise and read their infant's mental states, and their response to their infant's signaling was mismatched. For example, they experienced mental shutdown and fear and perceived that something was wrong with their child. Some mothers were also shown to misinterpret

neutral emotions as sadness and to make fewer mental state references related to their children, possibly in line with their impaired capacity for mentalization (Fonagy et al., 1996).

The majority of these studies focused on mothers of babies. Less is known about mothers of older children. Only two studies in this literature focused on mothers of older children (3–7 years old) and found that these mothers made fewer mental state references about their children, were more likely to mention behavioural, physical or general attributes of their children and displayed fearful and disorientated behaviour towards their child. These two studies on older children partially contribute to highlight some similarities between mothers of infants and of older children in the way their representations of the child appear coloured by emotional misattunement. However, they suggest the need for further research to examine this phenomenon in connection with older children and consider whether this thematic category might be harder to observe or to capture in this population of mothers.

The majority of these studies adopted a quantitative design (with the exception of one qualitative study) and either collected mothers' verbal accounts via interview measures or observed mothers during free play with their children. Only two studies focused on exploring specific moments of interaction, such as reunion after separation and infants crying. Moments of reunion after separation may be particularly difficult for these mothers due to their heightened fear of rejection and abandonment (Gunderson, 2009). Similarly, infants crying may be particularly triggering of feelings of rejection in this particular population. This could lead one to wonder whether the emotionally misattuned responses of these mothers may be specific to these particularly arousing moments. Looking at mothers in free-play interaction with their children, similar

emotionally misattuned responses emerge. However, studies collecting mothers' verbal accounts of their children do not measure the specific moments of collection, leaving open the question of whether they may have been collected during particularly arousing moments. Nonetheless, these findings appear relevant in the context of highlighting the emotional misattunement that characterises these mothers' responses to their children in a variety of situations and possibly reflects the state of their mental representations of their children. Their emotionally misattuned responses and descriptions may be a reflection of how misrepresented the children are in their mothers' minds.

It is interesting to note that all the papers whose findings elicited emotional misattunement as a theme focused on mothers of young children, mainly infants. This may be understood in the context of infancy being a stage where babies' development is particularly dependent on their mothers' attunement to them. Based on empirical infant research, Gergely and Watson (1996) described parents as having an inborn tendency to mirror their infants' emotions in a marked way, that is, exaggerated and mixed with other emotions. Through this natural mechanism, children become attuned to and capable of identifying their own internal processes, such as the basic emotions (Gergely & Watson, 1996), and gradually move from co-regulating their affects via the parents to self-regulating. In some cases, such as in parents with BPD, forms of pathological parental affect mirroring develop in which parents mirror the infant's emotions too realistically, without a moderation of affect, or mirror it incongruently (Gergely & Watson, 1996). These forms of pathological parental affect mirroring bear resemblance to the emotional misattunement theme that emerged from this literature review, with mothers misinterpreting their infants' emotions and responding

incongruently to their signaling, often with a heightened emotional response of fear, confusion and distress.

4.0.3 Hostility

Mothers with BPD were also found to relate to their children with hostility by expressing negative emotions towards them, both through words and behaviour; this hints at the possibility of mothers holding negative and hostile representations of their children. This thematic category overlaps with the previous role reversal and emotional misattunement themes in that the previous categories also appear to contain subtle elements of hostility. However, more active and evident elements of hostility were found in the ways mothers with BPD related to their children (e.g., rough handling, intrusive speech and behaviour, demandingness, disapproval, tense body expressions, abruptness, blaming, shaming), giving rise to a theme in its own right.

This thematic category emerged from the findings of nine quantitative studies exclusively, with mothers of children at different stages of development: under-fives, latency-aged children and adolescents. The studies adopted different methods of analysis, including observing free play interactions, interactions following a Strange Situation, response to infant distress and during a problem discussion task. However, despite these differences, they converged (with the exception of one study that did not find significant differences between mothers with BPD and those without on the EA non-hostility scale) in finding similar elements of hostility in how mothers related to their children, including how they spoke about them. Some elements of hostility included intrusively insensitive behaviour and speech, rejecting and demanding behaviour, rough physical handling of the child and showing negative regard toward

the child, including disapproval, abruptness, harshness and tense body or facial expressions. This suggests that mothers with BPD may perceive and represent their children in a potentially threatening and hostile way, which is in line with the idea that borderline patients may experience their inner world as malevolent and dangerous (Arnow & Harrison, 1991; Tramantano et al., 2003), possibly as the result of their often early experience of trauma and maltreatment; the unprocessed hostile experiences that these parents are likely to have been the target of may be projected on to their children, potentially contributing to the distorted representations of their children.

Also of note is that the lack of qualitative studies identifying hostility as one of the thematic categories of this literature underlines the need to further explore this specific way of relating via qualitative measures, such as via mothers' open accounts about their children. This may further enrich the understanding of how hostility may characterise the ways mothers with BPD represent their children.

4.0.4 Absences

Ultimately, mothers with BPD displayed a lack of engagement and/or responsiveness towards their children, neglecting, ignoring, feeling bored and possibly struggling to hold their children in their minds. This was particularly evident in ten quantitative studies whose participants were mothers of infants or latency-aged children. Mothers of infants tended to lack engagement, affect and imitation, while mothers of latency-aged children struggled to respond to their children's needs and cues, struggled to provide autonomy support or showed boredom during play.

As reported for the emotional misattunement thematic category, mothers with BPD may find it difficult to respond appropriately to their children, especially during early stages of development when children's dependency is high and necessary, as mothers' capacity to 'see' them in their 'true light' might be blurred. The dependence and demands of their children may be experienced as threatening by mothers with BPD, who may struggle with their sense of self and could potentially feel 'engulfed' by their children's needs. Mothers may not be consciously aware of this process and, as a result, may 'shut down' in their responses to their infants, unable to appropriately see their children as individuals in their own right. Many mothers with BPD have experienced trauma and abuse at the hands of attachment figures, which likely results in the psychological tasks of parenting being particularly overwhelming for this group; these parents find understanding and responding to their infants' emotional states difficult and may avoid their infants' communication; mothers who have experienced early abuse may be fearful of abusing their infant and become withdrawn (Newman et al., 2005). Furthermore, mothers have difficulty holding their children in their minds and/or acknowledging their independent psychological existence (Newman et al., 2005) due to an underlying fear of abandonment (Gunderson, 2009), as mentioned earlier, which may result in further difficulties for mothers in supporting their children reaching the necessary level of autonomy.

These four themes, that emerged by exploring the studies' findings, appear to overlap in their content and methodology. They showed how mothers with BPD, in different ways, tend to struggle meeting their children's needs: some mothers struggled to hold a parental role, placing inappropriate demands or responsibilities on their children (role reversal); some experienced difficulties to recognise and read their infant's mental

states, and their response to their infant's signaling was mismatched (emotional misattunement); other mothers related towards their children with more active hostility, for example with rough handling, intrusive speech and behaviour, demandingness, disapproval, tense body expressions, abruptness, blaming, and shaming (hostility); some mothers displayed a lack of engagement and/or responsiveness towards their children, neglecting, ignoring and feeling bored (absences). *Role reversal, emotional misattunement, hostility,* and *absences*, each emerged as a unique theme with its own different nuances, nonetheless interrelated in content with one another. For example, role reversal can represent the way mothers may emotionally misattune from their children, an hostile way to relate, or it could be seen as an absence of appropriate interaction.

As aforementioned, these themes also appear to overlap in their methodologies. The thematic categories emerged mostly from studies adopting a quantitative method of analysis. Each thematic category included quantitative studies. The thematic categories of role reversal and emotional misattunement contained also qualitative papers. The role reversal thematic category, albeit with the lowest number of papers, was the most varied in terms of methods of analysis used in the studies in this category: it included two quantitative studies, a qualitative study and a mixed design paper.

It is also important to note that, as observed in the Emotional Misattunement thematic category, the majority of the studies described in this paper, that collected mothers' verbal accounts of their children, did not measure the state of maternal emotional arousal at the point of data collection. This also applies to most of the studies that collected maternal behavioural responses. Measuring maternal emotional arousal at the point of data collection may be particularly important for this population as they

have difficulty regulating their emotions in the context of a heightened fear of rejection. The lack of measure of maternal emotional arousal at the point of data collection may therefore have implications in terms of further understanding the results. The data may have been collected during particularly arousing moments for these mothers and may be difficult to generalise or for them to be representative of a typical mother-child interaction.

Finally, these four themes give rise to different types of representations that mothers with BPD appear to hold of their children: a child seen as needing to support his/her mother and meet her needs; a child misunderstood in his/her signaling; a child depicted and perceived in negative regard; and a child who is absent from the mother's mind. These types of representations seem to converge in the way in which they elicit an overall image of a *misrepresented* and *absent*, highlighting the potential risks that children of mothers with BPD face, including the emergence of internalising and externalising problems (Madigan et al., 2006), difficulties in interpersonal relationships, emotional dysregulation, and social risk (Flykt et al., 2012; Lyons-Ruth et al., 2004; Newman & Stevenson, 2008).

5.0 Conclusions

By providing a qualitative synthesis of some of the recent key studies in the area, this review has identified four thematic ways in which mothers with BPD appear to be representing their children. While it attempted to identify discrete categories, overlaps and interrelations arose among them. Moreover, the studies identified were all found to address more than one thematic category, which contributed to further fluctuations across the themes. Nonetheless, this paper attempted to elicit the current understanding of how parents with BPD mentally represent their children by looking at

tangible ways in which mothers spoke and related to their children (i.e., observed behaviour).

The thematic categories, as classified in this review, gave rise to different types of representations that mothers with BPD appear to hold of their children. These representations converged in the image of a misrepresented and absent child, and highlight the potential risks and serious repercussions that children of mothers with BPD face, particularly regarding child development outcomes.
It is notable that, with regard to the age range of the offspring, the majority were in their infancy or early years, while only a few studies focused on mothers of older children (i.e., latency-aged children or adolescents).

The role reversal theme was found exclusively in studies with mothers of children in their latency or adolescent years and not in infancy or in toddlerhood. The opposite was illustrated by papers converging on the emotional misattunement theme, which was found in mothers of infants and young children exclusively. Hostility was the only theme that transpired from papers looking at mothers of children at different stages of development (i.e., under-fives, latency-aged children and adolescents), while mothers of adolescents were absent from studies grouped under the theme of absences. These results instil curiosity as to whether traces of emotional misattunement and of hostility might present in alternative forms in mothers of adolescents and whether traces of the role-reversal type of representation may be expressed differently in mothers of younger children.

From a psychoanalytic perspective, the thematic categories seem to indicate that mothers with BPD may be projecting onto their children thoughts, feelings and experiences that are likely to belong to them and that may not have been processed adequately. The unprocessed and often challenging histories of parents with BPD may present as 'ghosts in the nursery' (Fraiberg et al., 1975) in their representations of their children and may lead to distortions; the ghosts may leave only when the parents' 'own cries are heard'; 'she (the mother) will hear her child's cries', and a clear representation of the child may develop in the mother's mind.

5.0.1 Strengths & Limitations

Several limitations characterise this literature review. First of all, although the operationalisation of the term 'representation' for the purpose of the current paper attempted to overcome some of the challenges encountered and detailed in Paragraph 2.0, the focus on 'representation' remained broad. It included both parents' description of their children and parents' observed behaviour with their children, rendering it difficult to draw definite conclusions. The ages of the children varied widely and encompassed various developmental stages, such as infancy, childhood and adolescence, making it complicated to interpret whether findings are generalisable or age-specific. The small number of studies identified, their different sample sizes and the different sets of measures employed (e.g., observational tools; semi-structured interviews) also limits generalisability to a wider population of parents with BPD and suggests that caution should be exerted in drawing conclusions from the findings.

Despite these limitations, this review hopes to have contributed to broadening the understanding of and reflections on the types of mental representations that mothers with BPD appear to hold of their children. Despite the well-documented correlation

between representations and behaviour, in particular between negative representations and negative parenting, little is known regarding the representations of the child in parents with BPD. This study provides some details of the distortions and the losses that seem to tinge these representations in mothers with BPD.

5.0.2 Implications

This review has highlighted the lack of studies that have explored or assessed the mental representations of the child in parents with BPD, especially in parents of older children and in fathers. The absence of fathers in the studies identified has prevented the exploration of a crucial relationship in children's lives and of the representations that fathers with BPD may hold of their children. Further studies are needed on the paternal representations of the child, in a BPD population. Future research could focus on examining gender differences in parental representations of children at different ages and the impact of fathers' representations on children's socioemotional outcomes.

The lack of qualitative studies on the topic also underlines the importance for these specific studies to be developed as these could add valuable information on the topic, in view of their focus on in-depth exploration of a phenomenon.

Furthermore, with regard to potential theoretical implications, this review has identified challenges in the conceptualisation and operationalisation of mental representations. Several definitions currently exist on the topic, contributing to the lack of clarity on this abstract and complex concept (Gallistel, 2001). Nonetheless, this review exercise has possibly paved the way for a deeper examination of what we mean by mental representations. Moreover, regarding the methodological characteristics of the studies

identified, the variations in these studies' measures, in addition to the breadth of children's age, has rendered the topic of this review potentially quite diluted. This highlights the need for the whole field to be further researched, in more depth, by also analysing the use of different measures in a population of mothers/parents with BPD and with children of different ages.

Ultimately, the limited number of studies identified in this review promotes further research on the mental representations that parents with BPD hold of their children. This could enrich the current understanding of this phenomenon and, consequently, adapt and improve therapeutic interventions that aim to help parents develop clearer and undistorted representations. As a results, breaking the possible cycle of the intergenerational transmission of trauma may be enabled as well as healing the disastrous damage to children's developmental outcomes and reversing them towards a healthy developmental path.

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Part 2: Empirical Research Project

Being able to see your child.

The journey of a single mother in a MBT group for high-risk parents, through her representations of the child.

Candidate number: 14083791

Word Count: 8097

Abstract

Aims: This paper explores the parental representations of the child, through the case study of one member of the Lighthouse Project (LP), a mentalization-based intervention for parents of young children aged 1–2 years old, involved with the child welfare system as a result of their child's maltreatment. **Methods**: A single mother's representations of the child are analysed during the programme, through a qualitative lens. Narrative Processes Coding System (NPCS) and Thematic Analysis (TA) are used in combination, to elicit the mother's representations by identifying language modes and themes from her narratives about both her own and other children. **Findings**: The maternal representations of the child appeared to be less negative as the programme reached its end. The mother's reflexive language grew significantly in the middle phase of the programme and regressed during the last phase. However, the combined use of NPCS and TA showed an overall richer and less negative portrayal of the child during the ending phase. **Conclusion**: These findings suggest that during the course of the programme, the mother's journey, through her representations of the child, was characterised by progressions and regressions. There was also an emotional richness in the last phase of the programme that indicates the mother's engagement in the group and her overall positive journey towards the development and the strengthening of a less negative representation of the child. Despite its limitations, this study hopes to

provide insights for clinicians establishing and promoting interventions that aim to empower parents to clearly see their children.

Impact statement

The current study employed a qualitative approach in order to explore a mother's representations of the child, in the course of the LP mentalization group for high-risk parents. A number of limitations characterise this research. For example, being a single-case study, this research provides little basis for the generalisation of its findings to the wider populations. Nonetheless, by focusing on a single-case, it provides detailed information on how a mother's representations of the child developed during the LP, and has the potential to impact on policy, clinical, and research areas.

In particular, with regard to the implications within the LP, the current study might provide a more comprehensive understanding of parental representations of the child, which may serve as further evidence for the LP to promote mentalization programmes for high-risk parents. On a larger scale, this study's findings are in line with current policy (National Institute for Health and Care Excellence [NICE], 2015), which emphasises the importance for parents of children on the edge of care to be helped to improve their understanding of the child, and with other studies (e.g., Rosenblum et al., 2018) that have focused on parental representations and have found improvements in mothers' representations of their children, following a parenting intervention. Moreover, the in-depth exploration of the mother's narratives about

the child might endorse the importance of qualitative research in the context of therapeutic interventions, by providing access to patients' experience that could assist practitioners to identify routes that may help service users to make positive changes in their own and their children's lives; qualitative findings might be used to better inform outcome research by allowing a greater understanding of the reasons behind the importance of certain outcomes, and by ensuring that meaningful and accurate outcomes are taken forward. On a clinical practice level, the current study could help to enhance the interventions offered to both high-risk parents and their children, including the consultative role that clinicians are expected to hold within the network. Ultimately, this research project might inspire additional research in this area and contribute to further informing service policy and shaping clinical practice.

1.0 Introduction

There are currently 64,000 children in care in the UK in 2017, with over 60% being looked after due to abuse or neglect (NSPCC, 2018). Most of the parents of children who suffer neglect and other forms of maltreatment have themselves suffered abuse and neglect as children. A child's risk of neglect is increased by parental substance misuse and parental mental health problems (Antle et al., 2007; Brown et al., 1998; Dubowitz et al., 2011; Nikulina, Widom and Czaja, 2011).

Maltreatment in its various forms is linked to the likelihood of experiencing high levels of trauma symptoms and poor outcomes (Finkelhor et al., 2006; Higgins & McCabe, 2001). Complex trauma impacts negatively on the developing brain and on the child's ability to integrate sensory, emotional, and cognitive information; this may lead to uncontrollable responses to stress and long-term effects such as cognitive, behavioural, physical, and mental health problems (Petersen at al., 2014).

Fonagy and Target (1997) argue that parental reflective functioning (RF) is an important intervening variable. Recent research has referred to RF as capacity to *mentalize*, to engage in a form of imaginative mental activity that enables us to perceive and interpret human behaviour in terms of intentional mental states (e.g., needs, desires, feelings, beliefs, and reasons) (Allen, Fonagy, & Bateman, 2008).

Fonagy and Bateman (2008) conclude that the 'unresolved' parents most likely to exhibit frightening and insensitive parenting are those with low RF, with experiences of loss and trauma. Zeanah et al., (1993) suggested that the internal working models or mental representations are strongly predictive of a mother's behaviour with her child.

Representations and related mentalizing processes are viewed as 'the carriers of experience' (Carlson et al., 2009, p.1328) that link early attachment to later

psychopathology, demonstrating their pivotal role for normal development and healthy relationships. Studies have associated mothers' negative perception of their young children with a maternal history of maltreatment (Gara, Allen, Herzog, & Woolfolk, 2000) and with a punitive parenting style (Lorber, O'Leary, & Kendziora, 2003). These studies often focused on change of behaviour following treatment, rather than on maternal attributions and representations (Schechter et al., 2006) which can be used as guidance to locate the psychological conflict (Lieberman,1999).

1.1 Defining concepts

Several definitions currently exist with regard to *mental representations*. The current study will focus on the following definitions.

Mental representations constitute cognitive and affective schemas that are shaped by primary early relationships and are active in new and present interpersonal situations (Erbe, 2014). According to Fonagy et al. (1993), they are linked to emotional experience and 'not only store our past experience but also guide our perception and influence our experience of our external and internal worlds' (p. 11). In the course of early development, internalised experiences are increasingly integrated and grouped into different types of representations (i.e., self-representations and other-representations). Eventually, individuals rely on the content of these representations to swiftly shape their experience and response to a particular situation (Fonagy et al., 1993).

Overall positive, realistic, balanced and *stable* content (i.e., not reliant on primitive defenses and distortions) in the representations of the self allows for a greater sense of stability and more acceptance of occasional, situational shifts away from individuals' desired or 'ideal' way of being. Similarly, stable and reasonably positive representations of others are associated with an increased capacity to accept other's

minor shortcomings, to understand other's thoughts and feelings and, consequently, to manage negative or aggressive feelings directed towards others (Siefert & Porcerelli, 2015). At the root of the individual's representation of the other, there is an integration of a variety of attributes about the other 'into a single system' (Fonagy et al., 1993, p. 11). These attributes may be connected on the basis of experience, wishes, fantasies, fears or other affective structures; they can distort the internal organisation of the individual's mental life and increase their vulnerability to psychopathology.

For the purpose of this research project, the above definitions will be used to inform the operationalisation of the *maternal representations of the child,* that will be outlined in Subparagraph 1.5.

Psychoanalysis, attachment theory and mentalization will represent the theoretical pillars on which to further consider the multifaceted meanings of mental representations, as outlined below.

1.2 Psychoanalysis: a brief perspective on mental representations

In the context of mental or internal representations, Breur and Freud (1885) defined the internal world as an internalised copy of the external world constructed from actual early experiences. According to the psychoanalytic view, the early relationships with the caregiver are internalised to form the basis of a model of interaction with others. In normal development, the relationship with the caregiver or 'good-enough mother' in Winnicott's terms, facilitates the natural process of maturation (Winnicott, 1971), the emergence of a psychological self and symbolic capacity, and enables the child to gradually build and consolidate a safe and trusting internal representation of the 'mother-container' (Weininger, 1993). 'The mother can see her (the child) and is en

rapport with her' (1971, p.132) Winnicott stated, allowing for a mother-image concept to develop, evoking that of mental representations.

Winnicott's idea of a facilitating environment, created for a child by a 'good-enough mother', rests easily alongside Bowlby's (1969) theory of attachment.

1.3 Attachment theory: a brief perspective on mental representations

Bowlby (1969; 1973; 1980; 1988) underlined the innate nature of attachment and the infant's basic need for and dependence upon secure and available attachment figures. Bowlby referred to mental representations as internal working models that the child develops from the relationship with his/her attachment figures.

Through the mother's undistorted mental representation of the infant's emotional states, he/she can begin to develop a mental representation of his/her own emotional states and to gradually grow in his/her understanding of the self and of others as psychological beings, benefiting from a host of psychosocial outcomes. The ability to mentalize is one example of the beneficial impact that balanced mental representations have on the development of the individual.

1.4 Mentalization: a brief perspective on mental representations

The development of balanced mental representations is strictly linked to the capacity to mentalize, which is crucial for self-regulation and constructive, intimate relationships (Bateman & Fonagy, 2006). Mentalization enables the formation of balanced mental representations of the other person (and vice versa), by imaginatively and rationally attributing beliefs and desires in order to anticipate behaviour. Fonagy, Steele, and Steele (1991) refer to mentalizing as the mother's capacity for RF. They found that mothers with higher RF were more likely to be securely attached, and mothers' antenatal RF was more predictive of their infant's security at one year old than the

mothers' adult attachment classification (Slade, 2005; Slade, Grienenberger, Bernbach, Levy, & Locker, 2005). By being mentalized, children learn to mentalize, to understand people's behaviour better and better respond to interpersonal relationships.

Parents perceive, understand, and interpret their children's personality and behaviour on the basis of representations which guide their choice and enactment of parenting practices (George & Solomon, 2008; Stern, 1995). These representations include parents' views, emotions, and internal worlds concerning their parenting and relations with their children; these might be verbal and non-verbal, and may involve different levels of awareness (Scharf, Mayseless, & Baron, 2015). Parents who are not equipped or are lacking in their capacity to reflect and respond to their children's inner experiences deprive them of a core psychological structure which serves the purpose of building a worthwhile sense of self (Fonagy et al., 2002).

Fonagy et al. (1991) assert that reflective self-function can be performed only if the caregiver's own experiences of being parented have been understood and reflected upon, allowing the development of self/other representations through an integration of different, even conflicting, aspects of the caregiver's own parenting. These conditions enable parents to clearly and mentally represent their child, freer from the intergenerational trauma that may otherwise affect the parent–child relationship.

High-risk mothers, such as those who have experienced trauma, are more likely to have non-balanced (distorted) representations and insecurely attached children, which in turn contributes to the intergenerational transmission of trauma and parental psychopathology. Distorted maternal representations include disturbed ideas, thoughts and feelings that a mother holds about her child; they are influenced by the mother's early attachment-related trauma history and her capacity to develop a

psychological understanding of the infant without reliance upon primitive defenses and distortions (Slade, 2005).

A mother's symptoms of psychopathology (e.g., social withdrawal, anxiety, emotional lability, fatigue) as well as traumatic histories, have been found to disrupt the interaction and the development of the mother-infant relationship; these mothers are impaired in their ability to recognise infant signals of distress and react with appropriate sensitivity and responsiveness to their children's needs, showing difficulties in bonding with their infants and adopting an intrusive, frightened, and frightening parenting style (Raval et al., 2001). These factors, as well as infant temperament, can lead to children developing impaired affect regulation, behavioural problems, and insecure and disorganised attachments (Rosenblum et al., 2018).

Importantly, mental representations are dynamic and can be adjusted in response to later relationship experiences and/or targeted interventions; balanced and secure parental representations (i.e., characterised by narrative coherence and richly elaborated descriptions, emotional warmth, acceptance of the child and sensitive responsiveness to the child's needs) can be developed, impacting on the security of the parent–child relationship (Rosenblum at al., 2018).

1.5 Parental interventions

Multiple studies have documented the capacity of many caregivers and infants to respond rapidly to parent–infant interventions and to sustain their effects, such as increased maternal sensitivity and security of child attachment (Van den Boom, 1994; Bakermans-Kranenburg, van IJzendoorn, & Juffer, 2003). A quantitative study (Dollberg et al.,2013) described changes in the relational and representational patterns that characterised mother–child dyads undergoing parent–infant psychotherapy; its results outlined positive outcomes at treatment completion, i.e.

better relational patterns, richer maternal narratives of the relationship, and a decrease in the association between negative maternal perceptions and behaviour. Similarly, Schechter et al. (2006) quantitatively investigated the effects of a single psychotherapy session involving video-feedback on maternal perception of their child, and found a reduction of negative maternal perception. Another and more recent quantitative study (i.e., Rosenblum et al., 2018) looked at the effect of a parenting programme on maternal representations, and found that programme participation was associated with improvements in mothers' representations of their children.

There is a lack of qualitative studies exploring how maternal representations evolve during a therapeutic group.

The current study sets out to address some of these gaps by exploring a mother's representations of the child, during a therapeutic intervention called the Lighthouse Project (LP), through a qualitative lens.

The *LP MBT-Parenting Programme* represents a therapeutic group developed to promote mentalizing modes of thinking and parenting in a high-risk population. It aims to enhance secure attachment and attunement in parent–child relationships, and reduce disorganisation as well as risk of harm and of trans-generational transmission of psychopathology.

An evaluation of the LP published in 2019 (Byrne et al., 2019) found positive results for improvements in mother self-efficacy, parental stress, and parental sensitivity during playful interactions. The qualitative interviewing displayed some evidence of enhanced mentalizing capacity, suggesting encouraging evidence for improvement over time.

1.6 The current study The current empirical research project, run in collaboration with the Anna Freud National Centre for Children and Families (AFNCCF) and the LP, aims to address the following objectives:

- To describe how a single mother represents the child, during a MBT-group for high-risk parents.
- To explore the potential change in the mother's representations of the child throughout the MBT-programme

With regard to the operationalisation of the *mental representations of the child*, these will include a variety of attributes that a mother uses to describe *the child* in the course of a therapeutic intervention. *The child* will be considered as a broad category that will comprise the mother's attributes/references to: her own children, the other group members' children, and the children displayed in the videos that were used as tools to facilitate discussion and reflection amongst group members. Further details are outlined in the Method section (Paragraph 2.0).

As has been previously described, the link between childhood adversity and poor mentalizing, measured as low RF, can be accounted for by an avoidance of organising relationship representations and a focus on mental states, as a result of experiences of lack of care, or maltreatment or abuse (Fonagy & Luyten, 2009).

The lack of qualitative studies focusing on parental representations of the child in the course of a mentalizing programme positions this study within the privileged role of attempting to offer a clearer understanding of the subject. The journey of a high-risk mother in a MBT-group is presented by exploring her representations of the child, across the programme.

Specifically, the research question that this study aims to answer is:

How does a single mother represent and potentially transform her representations of the child in the course of the Lighthouse MBT-programme?

By attempting to answer the above question this project hypothesises changes in the way a single mother represents the child during the course of the intervention.

2.0 Method

2.1 Design

This study explores the development of a mother's representations of her child, in the course of the LP. The MBT-programme was developed to support parents at high risk of losing custody of their child, due to maltreatment. Parents of young children aged up to two years old took part in the group. For the purpose of the current research project, focus was given to one participant, a single mother.

The case was chosen by the researcher according to the clinical interest in the field of single mothers struggling in clearly representing and thinking about their children. In addition, the participant consistently attended the LP, enabling a thorough process of analysis.

The case-study approach to this research was chosen for its focus on an in-depth exploration of an occurrence over a period of time (Willig, 2008, p.75). The descriptive type of design adopted for this case study aimed to provide a detailed description of how a mother's representations of the child evolved during the MBT-group. In line with the purpose of descriptive studies and in contrast with the explanatory case studies aiming to generate explanations for their concerned occurrences (Willig, 2008, p.78), this study hopes to generate insights into and a better understanding of how a mother potentially changes in the way she represents the child over the course a MBT intervention.

The qualitative design of this single case study was employed for an in-depth exploration of the mother's narration of the child, across a 20-session time frame.

The transcripts were obtained from the video-recordings of the LP's 20 sessions. It was hoped that the decision to analyse the 20 sessions, coinciding with the entire duration of the group's programme, would provide a full and well-rounded picture of the range and depth of the participant's psychological journey, in relation to the child.

The videos were firstly screened according to their content and the parent's narratives of the child were identified and selected as material to transcribe, for the purpose of this research project. The excerpts in which the parent spoke about the child were transcribed and exclusively selected for the analysis. The comments/questions from any other group members, prior to and/or following the mother's narratives of the child, were also transcribed, however were excluded from the analysis; they were transcribed to provide the researcher with some context and guidance to navigate the data.

It is important to note that the mother's narratives might have been influenced by contextual elements, such as the emotional contagion between patients, the role of the group leader and its facilitators, and the MBT-manual that the programme followed.

In order to capture the sequential aspect of the mother's representations of the child, and their development throughout the programme, the sessions were divided into three phases: initial (sessions 1 to 7), middle (sessions 8 to 14) and final (sessions 15 to 20). More details of the division of the sessions in phases are presented in the subparagraph 2.3.1 (Planned analysis). These phases coincided respectively with the early, middle, and ending phases of the programme. This structure is often used in story-telling (Sarbin, 1986) and seemed appropriate and of benefit to the building and structuring of this research participant's narrative.

Each of these three phases was then analysed qualitatively by using the following methods:

1. Narrative Processes Coding System (NPCS) (Angus & Hardtke 1994; Angus, Hardtke, and Levitt, 1996; Angus, Levitt, and Hardtke,1999) was used flexibly to allow for a first analysis of the narratives into topic segments and subsequently for their corresponding narrative modes (i.e., external, internal, reflexive);
2. Thematic Analysis (TA) (Braun and Clarke, 2006) was adopted to further analyse the topic segments, through which superordinate and subordinate themes emerged.

Below is a more detailed description of these methods.

2.1.1 Narrative Processes Coding System

NPCS is a qualitative method of analysis that enables the researcher to categorise psycholinguistic dimensions of the therapeutic interaction and to unitise therapy transcripts, regardless of therapeutic methods (Angus, Levitt, & Hardtke, 1999). The application of NPCS entails reading through the transcripts first and finding shifts in focus during the development of a particular theme. The first reading identifies the individual topic segments. Topic segments are interactional units which may contain verbal interchanges between clients and therapists; they are defined as a description or overview of a specific content area or as a detailed elaboration of different facets of a specific content area. Topic segments are identified when a shift or change in subject (e.g., work, family, relationship with significant other) occurs during the therapy session discourse (Angus, Levitt, & Hardtke, 1999). Once the therapy session transcript has been unitised according to topic segments, each segment is further subdivided and coded in terms of shifts in narrative process type:

1. External description of events (i.e., external code)
2. Description of emotional experiencing (i.e., internal code)
3. Reflexive analysis of current, past and/or future events and emotional experiencing (i.e., reflexive code)

The resulting smaller units of text are coined narrative sequences. The types or modes of narrative sequences are described as External, Internal or Reflexive in accordance to their respective codes (i.e., External, Internal, Reflexive) giving rise to the emergence of narrative process codes.

Please see Appendix 2 for more details on the Narrative Processes Coding System as detailed in the NPCS Coding Assistance Manual (Angus, Hardtke, & Levitt, 1996).

For the scope of this research project, these modes were specifically identified in relation to the parent's narratives around the child:

1. the external code included the parent's description of events around the child.
2. the internal code corresponded to the parent's emotional experiencing in relation to the child/events around the child.
3. the reflexive code entailed a reflexive analysis of current, past and/or future events and emotional experiencing of the parent in relation to the child.

It was expected that some narratives of the child would contain reflexive elements related to the self, in response to the natural process of psychological development. However, for the purpose of this research project, these were not specifically analysed.

NPCS was adopted to look at the participant's communication about the child and her creation of meaning. Angus and Greenberg (2011) argue that the client's narrative expression is the cornerstone of the elaboration of emotional meaning-making; the expression of an emotional feeling is often a key indicator of the personal significance of a story, with unfolding action sequences. The reflexive processing and

symbolisation of clients' emotional experiences represent the vehicle for therapeutic change, to enable clients to meaningfully integrate their narrative and emotional lives (Angus & Greenberg, 2011).

2.1.2 Thematic Analysis

TA is a method for identifying, analysing and reporting patterns (themes) within data. Themes are identified in relation to the research question, capturing and revealing important information about the data. They represent some level of patterned response or meaning within the data set (Braun & Clarke, 2006).

For the purpose of this study, themes were identified in relation to the parent's representations of the child and how they potentially develop across the programme.

NPCS and TA were used in combination to analyse the mother's narratives about the child and extrapolate her representations of the child.

2.2 Participants

Eleven parents took part in the programme. The participants met in groups that ran weekly for 120-minute sessions cofacilitated by a psychotherapist and clinical psychologists. All families were under Social Services, who referred them to the LP.

2.2.1 The selected participant and a brief biography

The current study looked at one participant who took part in the MBT-group, specifically a single mother.

This parent was selected on the basis of the researcher's curiosity in clinical work with single mothers and interest in this mother's presentation across the entire duration of the group, as this emerged from the video-sessions. In fact, in the course of the researcher's iterative viewings, this mother appeared to have developed from an initially quiet and withdrawn stance to a vocal and more direct one; this drew the

researcher's interest in exploring her journey throughout the group, in relation to her view of the child.

The participant's real name was changed to Tash, for reasons of confidentiality. At the time of starting the MBT-intervention, Tash had two children, both toddler-aged, and her case was under Social Services and in care proceedings, due to physical and emotional abuse towards her children; she had been living with her children, in supervised care.

2.3 Analysis

This research project focuses on an in-depth analysis of the qualitative material that originated from Tash's narratives of the child. An analysis of Tash's references to the self and of her non-verbal communications went beyond the scope of this research project. Nonetheless, glimpses of Tash's references to the self and of her non-verbal communication (i.e., Tash's quiet stance in the beginning of the programme) were captured as they were considered to provide an additional and relevant observation to the interpretation and discussion of the findings[1].

2.3.1 Planned analysis

Initially, all the available video-sessions in which Tash had attended the group were watched by the researcher. Only the video-recording of session 1 was not available. Moreover, Tash did not attend session 6, 7 and 20.

All remaining 16 sessions were then screened in order to identify moments of Tash's interaction and communication in the group. These moments were then watched in depth, further screened, and chosen on the basis of Tash's specific references to *the child*, specifically Tash's own children, , group members' children, and children in the

[1] Please see paragraph '*4.1 Early phase: The external mode* and *the different child' for more details*

videos[2]. These three references to *the child* were chosen on the basis of Tash's explicit references to the child during the intervention. It was not excluded that Tash might have referred to her own child-self or that her own child-self might have been embedded in her view of *the child*. However, for the purpose of this research project, Tash's explicit references to the child were exclusively analysed. Being guided by the psychoanalytic concept of displacement[3], Tash's three references to *the child* were all considered to potentially add a greater understanding on how Tash ultimately represented the child, including her own children.

The sessions were divided into three parts: early phase (1-7), middle (8-14) phase, last phase (15-20). The choice of dividing the sessions in almost even parts represented a method of sectioning the programme in order to explore the phenomena in a more coherent way. It was noted that Tash did not attend several sessions, especially in the early phase, which would have possibly rendered unequal the amount of data available in each phase. The potential inequalities in the amount of data available in each session were considered to be a limitation of the study. However, in view of the qualitative nature of this study, focus was given to the overall journey that Tash embarked on through her representations of the child and how this potentially evolved throughout the group. As mentioned above, the division of the sessions in three phases was adopted to more coherently facilitate the exploration of Tash's representations of the child, rather than to provide an exact measure.

All moments in which Tash spoke about her own children, group members' children or the children in the videos were selected, transcribed and subsequently analysed as below.

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[2] Videos were often used throughout the programme as tools to facilitate reflection among the group members (e.g., the Strange Situation video).

[3] Displacement is 'the idea that feelings connected with a person or situation are displaced onto another person or object, which is safer than expressing the real conflict verbally or physically' (Senko and Harper, 2019, p.39).

The excerpts were coded using NPCS' and TA's respective coding systems, alongside the researcher's co-raters (i.e., research supervisor and fellow research colleagues). NPCS was adopted initially to identify topic segments. The topic segments coincided with the moments/excerpts in which Tash spoke about her own children, group members' children or the children in the videos, and were therefore categorised as:

- *Tash talking about her own children*
- *Tash talking about children in the videos*[4]
- *Tash talking about children in general* (e.g., group members' children, any other reference made by Tash in relation to children)

NPCS was then used to identify the following codes for each segments/excerpts: external, internal and reflexive code. The most frequent codes for each phase were reported and analysed.

Subsequently, the excerpts were analysed using TA in order to further explore and examine Tash's representations of the child, through the identification of patterns (themes).

In summary, language process modes and themes were both analysed to capture Tash's representations of the child as they emerged for each phase of the programme, and their development across the programme.

2.4 Ethics

Consent forms from participants were obtained prior to the start of the project. Participants were provided with information sheets detailing the recording of the group-therapy sessions for research purposes, which they consented to.

[4] Please refer to footnote n.3.

In order to protect confidentiality, all participants' names were anonymised, and all identifier components removed. The data, which included both the sessions' videos and the transcriptions, were securely kept on encrypted USB sticks and locked cabinets.

2.5 Credibility and trustworthiness

The researcher used a triangulation technique through group and one-to-one supervisions to ensure validity. According to Flick (1992), this technique utilises more than one perspective when analysing and interpreting data, in order to decrease chances of bias or high subjectivity. Willig (2009) suggests that triangulation is used to gain confirmation of findings through the merging of different perspectives. In consequence, a convergence of perspectives assures reality testing. Moreover, termly meetings with the LP creator to notify and discuss any progress achieved (e.g., transcriptions, coding, and analysis) also helped to assure transparency and reliability.

3.0 Results

Firstly, NPCS was employed to subdivide Tash's narratives according to their content. The following topic segments were identified:

- *Tash talking about her own children*
- *Tash talking about children in the videos*[5]
- *Tash talking about children in general* (e.g., group members' children, any other reference by Tash to children)

The most frequent topic segment was found to be *'Tash talking about her own children'*, for each of the programme's phases, reflecting how Tash's narratives mainly referred to her own children. However, for the purpose of this study, all the

[5] Please refer to footnote n.3.

aforementioned topic segments were included in the subsequent analysis, as it was considered relevant to comprehensively explore Tash's representations of the child. Tash was in fact also found to talk about the children described by other group members and the children in the videos.

Subsequently, NPCS and TA were adopted in combination to extract both narrative process modes and themes, in each of the three phases of the programme, to allow for Tash's representations of the child to be captured. Extracts from the transcripts will be presented in the following paragraphs to provide vivid examples of Tash's narratives from which the maternal representations of the child were extracted and explored.

Overlaps and interrelations between the categories provide for the fluidity and dynamicity of the psychological process.

The table below (Table 1) shows the most prevalent narrative process codes and the main themes, as emerged from NPCS and TA[6], respectively, for each phase of the LP. In order to complement the qualitative nature of this study, percentages were considered to be an appropriate tool to make some approximate quantitative comparisons across the programme. These numerical markers are, however, by no means statistically meaningful and merely used in order to help structure the narrative.

Table 1. NPCS & TA

Phase	**Narrative process codes**	**The main themes**
Early	***External (70%)*** *Internal (20%)* *Reflexive (10%)*	*The different child*

[6] NPCS and TA are described in the previous 2.0 Method paragraph. Further details on the narrative process modes are also elicited in Appendix 2.

Middle	***Reflexive (46%)*** *Descriptive (28%)* *Internal (26%)*	*The child as an individual*
Final	***External (45%)*** *Internal (32%)* *Reflexive (23%)*	*The interfering child* *(The child's place in my life* *and* *the hurting and hurt child)*

Percentages were calculated for each Narrative process code (i.e. external, internal, reflexive), in each phase (i.e., early, middle, final) via the number of extracts present for each code. Please see Appendix 3 for further information on the descriptive analysis of the data, including the number of NPCS codes and percentages per phase (table 1, Appendix 3).

Table 2 (below) shows the number of NPCS codes and excerpts per each session phase. It highlights the shorter number of codes/excerpts in the early phase, in comparison to the middle and final phase. It also shows that no data was available for the first session n.1 (no recording available) and the last two sessions (i.e., n.6, n.7) due to Tash's nonattendance. In the middle phase codes/excerpts were identified for each of the sessions and similarly to the final phase, with the exception of the last session (i.e., n.20) that Tash did not attend, hence no data was available.

Table 2. Number of NPCS codes and excerpts per session.

	Session	**Codes/ excerpts**
Early Phase	1	*No recording/ data available*
	2	*1*
	3	*1*
	4	*0*
	5	*8*

	Session	**Codes/ excerpts**
Mid Pha se	8	*3*
	9	*8*
	10	*5*
	11	*13*
	12	*8*

	Session	**Codes/ excerpts**
Final Phase	15	*4*
	16	*6*
	17	*2*
	18	*17*
	19	*2*

	6	*Not attended*		13	*1*		20	*Not attended*
	7	*Not attended*		14	*5*			

3.1 Early phase (sessions 1 to 7)

As shown in Table 1 above, during the programme's initial phase, using NPCS allowed the drawing-out of all three narrative process codes in Tash's narratives, namely the *external* code (70%), the *internal* code (20%), and the *reflexive* code (10%). However, as the percentages in brackets show, the *external* code dominated Tash's narratives of the child in this initial phase, as illustrated below:

> Tash: '*…my son doesn't get emotions, he doesn't understand them, sometimes (I ask) "how do you feel?" "I dunno" (he replies), cuz for him, mentally, he can't, he can't see the difference. It's just one thing for him, it's anger, it's all he has…*' Tash, Video-session n.3

The *external narrative mode* of the above extract shows that the child was being purely described. Specifically, Tash described the events around the child with no reference to emotions or to a mentalizing stance. The child was not reflected upon or mentalized with; rather the events around the child were described without related affect or reflection, at times in a blaming tone.

By looking at the content of the narratives of this beginning stage, TA allowed further exploration of Tash's representation of the child. *The different child* emerged as a strong theme, including the view of a child who is different from other children, in a derogatory sense, perceived to be incapacitated; a child who does not and cannot

understand. The extract above provides an example of both this theme and the *external* mode. Below is one more example.

> Tash: '…*my son doesn't react to shouting like a normal 3 yr…they would be scared…my son's so used to the shouting and the screaming, even if you're really to shout at him, nothing, he can scream back at you…not like a normal child...*' Tash, Video-session n.5

Similar to the previous excerpt, the *external* narrative process code of the above extract shows a purely descriptive delineation of the event and the absence of any elaboration of feelings or reflectivity, namely a child not reacting to shouting. The thematic layer of 'difference' adds to the external code characterising these early descriptions of the child. This contributes to evidence that the mother's representations of the child, in the initial part of the programme, were mainly characterised by negation, with the child described as different and lacking in capacities.

It is important to note the presence of a few *internal* and *reflexive* extracts in Tash's narratives of the child during this initial phase, as well as extracts whose content differs from the theme of *the different child.* However, as explained above, both the aforementioned external mode and theme prevailed. Furthermore, as the above Table 2 illustrates, Tash's low frequency scores regarding the number of codes/excerpts identified in this initial phase did not just reflect poorer initial attendance but that she was relatively quiet in this period.

3.2 Middle phase (sessions 8 to 14)

As the programme reached its middle phase, Tash appeared to grow more reflective. The three process codes of narrative were also identified in this phase through NPCS,

in various percentages: *reflexive* (46%), *external* (28%), and *internal* (26%). However, unlike the initial phase with its dominant external mode, the *reflexive* code prevailed in this stage.

The following excerpt illustrates an example of the reflexive code, in which Tash seemed to elaborate and reflect upon herself in relation to the child who appeared to be seen in a new light. Tash's shifting representation of the child, as emerges below and in this phase, appears to be closely intertwined to the evolving representation of herself.

> Tash: '*…that's why the whole wanting my son to be tough is like me projecting myself onto him...I don't want...I don't like it, it makes me uncomfortable when other people do it and I feel I'm saying this to my son?... am I trying to say to him "no don't cry don't look weak", I don't want to think that's what I'm doing…*' Tash, Video-session n.9

Tash started to reflect on her own projections on her child, showing her processing and curiosity in understanding feelings and events around herself and her child. As the sessions developed, Tash's identification with the daughter of another group member surfaced and her own tears emerged. Tash offered her comment on the meaning behind the screams in the turbulent mother–daughter relationship, as if the daughter was saying to her mother, '*I need you (mum) I need you, look at me!*' (Tash, video-session 11). Tash appeared to be mentalizing and the representations of the child possibly shifting alongside those of her mind.

Using TA allowed to further analyse Tash's narratives of the child by exploring their thematic content. *The child as an individual* emerged as the main theme of this stage; suggesting the idea of a child who emerges in the parent's mind as an individual in his

own right, whose sense of agency is beginning to be seen and recognised, as well as the child's own voice. It evokes the view of a child who is kept in mind and mentalized with, as illustrated below, by Tash's attempt to understand him.

> Tash: '*…as parent you think you know best…first ask the child, I think that's what people forget to do, they forget to say "are you happy?"…we think we know what's best for our children, but they have their own voice…*' Tash, Video-session n.13

The above extract shows a child brought to life in the parent's mind, seen as having choices, intentions, and preferences; a child who is more clearly seen as an individual, freer of the parent's projections.

This view also transpired from Tash's spontaneous comment about the LP, in which both *reflexive* code and the theme of *the child as an individual* emerged:

> Tash*: '…it [the group] helped with my son definitely, like when he's being a nightmare instead of saying "get out of my sight!" it stops me, like, hold on a minute, how he's going to feel when I tell him get out of my sight? I like asking him, instead of saying "go away"…so it does work and I think you don't realise it's working until you start doing it …oh hold on a minute the Lighthouse is on my mind…*' Tash, Video-session n.14

Tash's ability to recognise and reflect on her own responses to her child arose from the above excerpt. She compared her response to her child's 'nightmare behaviour' prior and during the group, and described it as shifting from an impulsive to a more pondering response. Tash's curiosity about her child's actions and feelings appeared

to develop in this extract and more generally in this middle phase, showing Tash's reformulation of past experiences and her richer representation of the child.

Both the *reflexive code* and the theme of *the child as an individual* prevailed in this phase. Nonetheless, similarly to the previous phase, Tash's narrative process codes and thematic contents varied on a few occasions.

3.3 Final phase (sessions 15 to 20)

During the ending of the programme, Tash's narratives of the child returned to be primarily *external* (45%) in process code. However, an *internal* code (32%) was also found to be particularly present, suggesting a fluctuating and possibly ambivalent psychological experience towards the child. A *reflexive* mode also emerged in the narratives of this phase, in minor part (23%).

The predominant *external* code of this phase shows that Tash was mainly describing the events around the child, avoiding a reflexive analysis of the emotional experience, as illustrated below.

> Tash: '…*I live in a five bedroom house…my kids are on the middle floor and I'm on the top floor, so since my kids were born I've never slept for the whole night, my whole life, not a single day…*' Tash, Video-session n.15

Tash's *external* mode (45%) of this phase often oscillated with an *internal* mode (32%), for example when Tash stated '*I hate I hate those places (soft-play)…I don't give a shit about those places…I would never like to put up with that crap with my kids*'(video-session n.16), in which she expressed her emotions and feelings in relation to bringing her children to parties or soft-plays. A few other times, a *reflexive* mode (23%) was also present in Tash's narratives, possibly reflecting Tash's shifting emotional experience:

Tash: '*….with the woman in the video with the baby, where she didn't react at all…it shouldn't be that way…she doesn't see that's harmful (for the baby)…*' Tash, video-session n.17

In the extract above, Tash referred to the woman in the Still-face experiment video[7]. When watching the video, Tash appeared to empathise with the baby's distress once the mother showed him a still-face, as instructed. Tash was able to notice the unresponsiveness of the woman to her baby and to think about the harmful effects on the baby, demonstrating some reflective capacities.

Regarding Tash's narratives in this last phase, TA revealed one superordinate theme, *the interfering child*, to be overarching, ahead of two subordinate themes, namely *the child's place in my life* and *the hurting and hurt child*.

These themes reflect a sense of intrusion and invasion that developed from Tash's account of the child. Simultaneously, a more liberated Tash emerged. In fact, while *the interfering child* seems to reflect a negative view of the child, the overall thematic content of this phase appears much richer than in the previous phases, and symbolic of Tash's emotional development. This will be further illustrated in the following paragraphs concerning the subordinate themes.

3.3.1 First subordinate theme: The child's place in my life

This subordinate theme concerns Tash thinking of the child in relation to herself and the impact of the child on her life.

The child appeared to be thought by Tash as interfering with her past and not fitting with her pre-birth life, demanding her attention and involvement at the cost of Tash's previous experiences and habits (e.g., sleeping). Simultaneously, Tash's increased

[7] The Still-face experiment (Tronick et al., 1978) was developed to portray the natural human process of attachment between a baby and mother, and then the effects of non-responsiveness on the part of the mother. It shows how an infant after a few minutes of interaction with a non-responsive and expressionless mother rapidly grows confused and frustrated, and begins to cry.

connection with herself and a sense of loss relating to missed and missing experiences were widespread at this stage:

> Tash: '*…it's just nice every now and again to just be like be yourself….I've got my children so young, like I was 19, so…you kind of lose that, like most 19 years old go to do whatever they're doing. I was, I had babies, I was living in my first house…*' Tash, video-session n.16

The child's place in my life suggests that the child represented by Tash in this phase was a child hampering her life by placing unfair and uncomfortable demands on her; a child not reflected upon, forgotten in terms of his thoughts and feelings, and largely seen in terms of his/her impact upon his mother's life. Despite the apparent regression in this ultimate stage of the programme, from a previous mentalized stance to a more negligent view of the child, Tash seemed to be gradually more in touch with herself, to be exploring her emotional life, and to be releasing difficult thoughts and feelings.

3.3.2 Second subordinate theme: *The hurting and hurt child*

This second subordinate theme of the programme's last phase conveys a physically and emotionally hurting child. Nonetheless, Tash's perception of a hurt and vulnerable child also comes to the fore, which allows a glimpse of Tash's increasing empathetic stance towards the child; a child experiencing pain, claiming and needing care and attention.

> Tash: '…*my son poked my other son off the sofa like …he smashed his face on the floor. I was sick, I was like "no, look, you're really hurting him now" and then, when I was soothing the little one who was crying, he then threw himself off the sofa – "I've done it too now*

mummy, I fell off the sofa too" (he said) – I was like "oh man"…' Tash, video-session n.18

In the above extract, Tash described the time one of her children harmed her other son, as if purposively attacking him. Equally, the same child was also described to be self-harming, in an attempt to claim Tash's nurturance.

In summary, in this last phase, the *external* mode and *the interfering child* represent the main language mode and theme respectively, resembling the initial phase of the programme with a more negative view of the child. However, Tash's narratives are much richer in their thematic content than in the earlier phases, and coloured by a variety of language modes; they provide a more rounded and more balanced portrayal of the child.

4.0 Discussion

This section will discuss and explore the narrative process codes and themes that emerged from the analysis of the participant's narratives of the child, for each of the three phases of the programme. It will reflect upon Tash's communication about the child in the attempt to extrapolate how she represents the child. It will relate the findings to literature, including current research and theoretical ideas. Furthermore, it will be guided by the aim of this research project(i.e., the exploration of how a high-risk mother in a MBT-group, represents the child and how her representations of the child evolve during the course of the group), and by its objectives: 1) to describe how a mother represents the child, during a MBT-group for high-risk parents; 2) to explore the potential changes in the mother's representations of the child throughout the MBT-programme. The structure of the previous section will be followed to reflect on the representations that emerge in these three phases (early, middle, late) and how they evolve throughout the intervention. The strengths and limitations of this study will be

considered before proceeding to highlight the implications and the suggestions for future research.

4.1 Early phase: The external mode and *the different child*

In this initial phase, Tash presented as mostly quiet and withdrawn. Possibly, Tash's observer role allowed her both to familiarise herself with and distance herself from the group, for fear of investing in it, consciously or unconsciously. Crittenden (1988) suggests that maltreating parents relate to others in a distrustful or withdrawn manner in an attempt to protect themselves from the pain of angry or unfulfilling relationships, as this is how they expect them to develop. In line with this, in this phase Tash's few and brief narratives of the child were mainly external descriptions, suggesting a detachment from a more emotional experience.

However, according to Angus (1999), the *external* mode is viewed primarily as a necessary starting point for the real work of accessing and articulating felt emotions (internal sequences) and elaborating new meanings (reflexive sequences). In consonance with this, in the initial part of the programme, Tash's narration of the child resulted predominantly in descriptions, leaving out any elaboration or analysis of emotional experiences and/or mental states. Looking at the functions of spoken narratives, Angus (1999) suggests that in the *external* sequences the narrator attempts to verbally show the therapist the scene, by means of descriptive and specific details. This constitutes a preconscious experiential and conceptual system that structures experiences and directs actions (Epstein, 1984). Furthermore, the group setting and the group members might have played an important role in Tash's initial and predominant use of the *external* mode; she might have felt inhibited by the other group members for fear of judgement and mistrust.

Nonetheless, the *external* mode differs from the internal and reflexive modes, which allow for the generation of new experiential and conceptual meanings (Angus, 1999), similar to the process of mentalization which seems to be lacking in this early part of the programme.

Moreover, the thematic content of Tash's external description of the child, in this initial phase, appeared to be negative. The theme of *the different child* arose via Tash depicting the child as incapacitated and lacking in abilities, a child who '*can't understand*' and '*doesn't get emotions*', as she stated, and at times blamed for his deficiencies. This is reflected in Crittenden (1988)'s statement regarding the children of abusing and neglecting mothers, described as living in the chaos of accusation and blame, in the absence of control or predictability.

Several empirical studies, following on from Fraiberg's and Bowlby's initial formulations, have supported the observation that certain attributions or attitudes, categorised as predominantly negative and distorted representations of the child, are significantly associated with hostile, intrusive, and non-protective maternal behaviour (Bugental & Happeney, 2004; Daggett, O'Brien, Zanolli, & Peyton, 2000) and a child exhibiting behavioural problems (Dix & Lochman, 1990; Nix et al., 1999). Schechter et al. (2005) reported that maternal interpersonal violence-associated PTSD severity is associated with distorted, negative, and poorly integrated maternal mental representations of her child. Consistently, Tash's external and negative view of the child is not surprising in the context of the reason for Social Services' referral to the LP (i.e., parental maltreatment) and its emergence in the initial phase of the MBT-group.

4.2 Middle phase: The reflexive mode and *the child as an individual*

During the middle part of the group, Tash's narratives moved onto a reflexive analysis of the child. Nye (1994) argues that the majority of the work of exploring and reconstructing the meaning of events or memories takes place in the reflective talk about the events that have occurred in the client's life. Similarly, Angus (1999) suggests that in the *reflexive* sequences the client attempts to make meaning of his/her experiences by exploring personal expectations, needs, motivations, anticipations, and beliefs of both the self and those individuals who play significant roles in the client's life. A new understanding or story is formed, which either supports or challenges the implicit beliefs about self and others.

Accordingly, in this phase Tash appeared to be questioning herself and her expectations of the child, moving on to the realm of mentalization, of 'striving' to see oneself and the other more clearly (Byrne, 2016, p.3). The theme of *the child as an individual* is representative of this shift. Tash's empathetic and reflective stance developed in this middle stage, in which she both connected with her child self and perceived the child more positively. Tash's identification with the daughter of a group member seemed to have allowed grief and tears to surface, for herself as a rejected child. This might have possibly reinforced Tash's mentalizing capacity, allowing her to perceive that behind a child's screams there was a cry for help, for wanting and needing to be seen by his mother. As Fraiberg (1975) hypothesised, 'when this mother's own cries are heard, she will hear her child's cries' (p.326).

Mentalizing has been defined as 'imaginatively perceiving and interpreting behaviour of oneself and others as conjoined with intentional mental states, shorthand for which is "holding mind in mind"' (Bateman et al., 2012, p.514). Tash described in this phase a child who is held in mind, who elicits curiosity for being known and understood. The

child appeared to be represented as an individual per se, freed from projections and misattributions, 'a child with a voice' as Tash herself described.

Adopting the Lighthouse language, *the illuminating beam* seems to clearly illustrate Tash's representation of the child at this stage of the programme. The image and metaphor of *the illuminating beam* refers to an attentive, curious, and imaginative parent watching his/her child closely or thinking about the child carefully, trying to see the world from his/her eyes, and wondering what feeling, thought, or belief might be behind the child's behaviour (Byrne, 2016).

4.3 Final phase: The external mode and *the interfering child*

In the final phase of the programme, the narrative process code returned to being primarily *external*. Tash's narratives of the child were primarily characterised by external descriptions, similar to the beginning phase. The reflective/mentalizing stance, which had stemmed in the middle phase, notoriously decreased in this last phase.

Similarly, from the point of view of the thematic content, Tash's representations of the child moved to be mainly characterised by negative descriptions, as transpires from the overarching theme of *the interfering child* and its subordinate themes of *the child's place in my life* and *the hurting and hurt child. The interfering child* suggests the view of a child making uncomfortable demands and causing physical and emotional pain. However, it also depicts a child who (in his mother's unconscious or conscious mind) is able to encourage the parent to undertake an emotionally draining journey, leading to some reflexivity and curiosity towards the child.

In fact, Tash's overall emotional development in this last phase of the intervention appeared to be richer. *The child's place in my life* shows Tash's thinking of the child in relation to herself and her previous life, which she felt had been invaded by the child.

Burgess and colleagues (1978) refer to abusing mothers as experiencing relationships, including those with their children, to be demanding and engendering feelings of anger and vulnerability. Similarly, Tash's resentment towards the child seemed to surface in this phase, in relation to her previous life and habits, which she felt had been lost and replaced by her child's birth. However, Tash appeared to be more in touch with herself, as a hint of melancholy transpired from her narratives and her feelings of rage and vulnerability came to the fore, possibly and gradually impacting on her emotional development.

In line with this, *the hurting and hurt child* conveys Tash's view of a child interfering with her life, both by actively causing pain and by turning into a vulnerable being requiring care and attention. Her frequent and emotionally charged narratives seem to hold the function of releasing her from difficult feelings. This contributes to Tash's more rounded representation of the child in this phase. A child that not only 'hurts' but is 'hurt', and therefore perhaps 'seen'.

Later on in the same session, Tash appeared at times to reflect on the reasons behind her child's behaviour and on what she possibly perceived as her guilt, what she called her 'bad parenting'. The external sequences of this final phase were counterbalanced by a few reflexive sequences and numerous internal segments, suggesting Tash's investment in the group and her emotional involvement. This denotes the flourishing of a new phase filled with potent expressed emotions and possibly with necessary and protective copying mechanisms. Tash's regression to think of the child in a more negative light (compared to the previous phase), might serve the purpose of protecting herself from the pain of an impending ending of the group in view of her possible attachment to it. The regression could be seen as the result of a defensive activity and a reversal to an earlier stage of development (A. Freud, 1965). Nonetheless, it could

represent part of the 'normal developmental process' (A. Freud, 1965), from a psychoanalytic standpoint, in terms of Tash's evolution within the MBT-group, and as a necessary process in order to progress (Winnicott, 1954).

In line with this, Angus (1999) refers to new experiential and conceptual meanings born out of the engagement in both internal and reflexive narrative process sequences, in the context of predominant external narratives. Despite the return to a predominant external mode, the presence of frequent internal and a few reflexive sequences suggests the emergence of a new phase that resembles the initial phase, yet nonetheless adds nuances to it: a new phase that encourages a more balanced view of the child and might represent the basis for the generation of new meanings of self and others (Pennebaker, 1995). Of note, following treatment completion, Tash's outcome was rated as 'good' in relation to her use of the MBT-group; she was discharged from Social Care and returned to have parental responsibility for her children[8].

These findings are similar to a few studies on change in caregiving representations (including the representations of the child) (e.g., Huber et al., 2015; Muzik, et al., 2015; Suchman et al., 2017). In a study by Huber et al. (2015) the efficacy of a 20-week circle-of-security attachment theory-based intervention was investigated. Regarding the caregiving representations, their results indicated more positive representations after the intervention; the caregivers made statements indicating more joy and less hostility in their relationships and spoke of showing more support for, and kindness towards, the child. Their results, quantitative in nature, hold some similarities with the qualitative findings of the current study, which hinted at a positive development in how

[8] This information became available to the researcher following completion of the analysis of the data of the current study, in order to avoid biases.

Tash represented the child during the LP. In contrast, Sleed et al. (2013) found no change in the self-report caregiver representations after an 8-week attachment-based group intervention designed specifically for mothers and babies in prison. The authors evaluated the outcomes of this intervention in a randomised controlled design, and participating mother–baby dyads were assessed at baseline, at the end of treatment (5 weeks later), and again two months later. Although type and duration of the intervention, sample characteristics, and differences in how representations were measured may all contribute to these different findings, the study by Sleede et al. (2013) contributes to raising questions with regard to the type of results that could emerge from the current study by including an analysis of follow-up measures.

To conclude, Tash's representations of the child during the group appears to resemble Anna Freud (1965)'s concept of a developmental path: a path characterised by both progressions and regressions, which promotes healthy development. In fact, in the programme's initial phase Tash's reflexive language was lacking in relation to the child; it grew significantly in the middle phase and then decreased during the last phase. TA enabled a further exploration into these three phases and into how the child was represented in each phase.In the initial phase, the child was primarily described in a negative light, as 'different'. It can be speculated that the lack of reflexivity during this phase might have obscured the mother's representations of the child. During the middle phase, coinciding with possibly increasing mentalization, the child emerged in a different light, as an individual who was mentalized with and being understood. As the programme developed and reached its ending, the content of Tash's narratives shifted once more towards a more inconvenient view of the child, such as that of a child interfering with his mother's life. However, as previously discussed, the more balanced presence of external, internal and reflexive codes in this stage also suggest

Tash's increasing trust in the group and her ability to share and to freed herself from difficult emotions. This mother's journey in the LP appears to have provided her with an enriching and fruitful psychological experience, through which her representations leaned towards the development and the strengthening of a more balanced and overall less negative view of the child, possibly freer from parental projections, and towards an increasing capacity to see *the child* in his/her true colours.

5.0 Strengths and limitations

This study has a series of strengths and limitations that need to be underlined. Firstly, being a single-case study, it provided an in-depth focus on a mother's psychological journey in a MBT-group, through her representations of the child. The choice to adopt a qualitative analysis, by using NPCS and TA, allowed the eliciting of some in-depth reflections from the mother's narratives on the child.

However, significant generalisations could not be drawn, principally due to this study being a single case study. Further, the 20 sessions were divided into 3 phases of unequal size, through an averaging of the number of sessions in each phase. Although this method of division was chosen to provide some coherency to the exploration of the phenomenon, it might have also levelled trends and/or disguised differences. Similarly, the poor quality of the recording of the video-sessions impacted on the amount of material that could be clearly heard and transcribed, limiting the exploration of further codes and themes that could have emerged, impacting on the validity of this research project. However, the inaudible material only included small sections (i.e., words and a few short sentences) of all sessions.

Moreover, this small study was limited in its scope. It aimed to explore a mother's representations of the child and their transformation across the programme by exclusively analysing the excerpts in which the mother spoke about her own children,

the group member's children and the children in the videos used throughout the programme. Her representations of the child and their development might have been influenced by contextual elements, such as the emotional contagion between patients, the role of the group leader and its facilitators, and the MBT-manual that the programme followed, the exploration of which went beyond the scope of this research. Examining the contextual elements could have added to the richness of the material explored and analysed, possibly impacting on the rigour and validity of this research project. In addition, the transformation in the mother's representations of the child may be coloured by the changes in her own representations of the self; the latter were not the focus of this project, nonetheless their exploration could have contributed to further enrich the current study's findings.

6.0 Implications and suggestions for further research

Despite its limitations, this study may be considered within the current context of growth in mentalization services and the lack of qualitative research in the area of representations. It attempts to provide a better understanding on how a high-risk parent's representations of the child change in the course of a MBT-group, and to strengthen the interventions that help iron out the struggles these parents face, especially in clearly seeing their child. Bearing in mind the centrality of balanced parental representations of the child in the wellbeing of the parent-child relationship, which transpired by this study's findings, studies exploring change in parents' representations of the child and the parents' experience of change through the use of qualitative approaches are recommended as valuable sources of information that can shape services' provision.

Further research could substantiate the results of this study by adopting a mixed-method (qualitative and quantitative) approach on a larger scale, improving the validity

of this empirical project; despite qualitative methods being highly valuable and recommended for research within vulnerable populations, the integration of quantitative measures (e.g., parental development interviews - PDIs, reflective functioning – RF, scales, the Working Model of the Child Interview - WMCI) could provide the study with an in-depth understanding and corroboration. This data would provide another window into the parental representations and add an element of credibility.

In addition to the maternal representations of the child, as defined in this study, subsequent studies could also focus on the maternal representations of the self to further explore changes in both representations of the child and of the self and related differences and similarities.

Another interesting addition to the present research would be an exploration of all the members of the LP, in order to capture how the entire group represents the child , through its various processes and dynamics, and potentially change their representations; this could be of further benefit to elicit possible mechanisms that could play a role in changing the parental representations of the child and in the establishment and/or enhancement of group interventions particularly invested in supporting high-risk parents.

7.0 Conclusion

The current research project aimed to explore the maternal representations of the child and how they evolved in the course of the LP for a parent involved with the child welfare system as a result of her children's maltreatment. The study aimed to qualitatively describe the maternal representations of the child, during a MBT-group for high-risk parents, and to explore the potential change in the mother's representations of the child throughout the MBT-programme. The findings were

obtained through the qualitative analysis of the narratives of a single mother member of the LP.

In the initial phase of the intervention, the maternal representations were mainly negative, in parallel with what appeared to be the mother's lack of mentalization. As the programme reached its middle phase, the child arose as an individual in the mother's narratives, in the sense of being seen and valued for who he was, perhaps less concealed by the mother's projections, coinciding with her developing reflective capacity. The ending phase was characterised by the mother's return to a more difficult view of the child; however, her overall representation of the child appeared more balanced, leaning towards a consolidation of a less negative, richer, and truer view of the child.

These findings are supportive of several MBT evaluations and studies (e.g., Rosenblum et al., 2018) that quantitatively demonstrated the enhancement of maternal sensitivity following treatment . The qualitative nature of the current study hopes to have added to the current lack of qualitative studies in this field and to have provided a better understanding of how a high-risk mother represents the child and transforms these representations in the course of a MBT-intervention.

Further research is recommended to substantiate the results of this study by adopting a larger sample size, and a mixed methodology.

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Part 3: Reflective Commentary

A story on how I integrated research and clinical elements in my journey towards becoming a Child and Adolescent Psychoanalytic Psychotherapy.

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1.0 Introduction

The current commentary aims to delineate my reflections on the process of undertaking a research project, my thoughts on its contributions to my development as a child psychotherapist and the relation between the research and the clinical elements of the training. It follows the structure of a story, with 'the initial phase', 'the middle phase' and 'the final phase', which resembles that of my empirical project, and in accordance with the idea that 'narratives provide the means by which people organise and relate the important experiences in their lives' (Russell et al., 1988, p. 19). *1.1 The initial phase*

1.1.1 Early challenges

The Clinical Doctorate in Child and Adolescent Psychoanalytic Psychotherapy combines clinical and research work, since its first year. I remember the integrated programme representing one of the reasons behind my choice to pursue this particular training. However, as I embarked on it, I was also faced with its challenging demands. In fact, during my first year I started to familiarise with my CAMHS work placement, a looked-after/edge-of-care/adoption team, which had just gone through a service transformation that had left a general feeling of discontent within the clinic. As part of the transformation, my team had abandoned its exclusive work with looked-after children to include an edge-of-care and adoption service. The development of a new team identity started to slowly crystallise; it continued to develop throughout my four-year placement, illustrating the powerful parallel with my own formation as a child and adolescent psychotherapist and clinical researcher.

The clinical audit represented one of the initial opportunities to concretely integrate my research and clinical work. Handling this assignment provided me with new skills and broadened my understanding of the topic I was auditing (i.e., the appropriateness of

referrals accepted in my team). Amongst the results of my audit, a more lucid representation of the population accessing our service emerged. With hindsight, I can see the mapping-out of my service population as representative of my team's evolving identity, and the audit work carried out within my CAMHS clinic as illustrative of my own development as a team member, as a researcher, and as a clinician.

Nonetheless, at the time, it was hard to attain these reflections. I remember feeling at times overwhelmed by the amount of clinical work I was undertaking, by hearing and feeling the poignant histories and deprived emotional experiences of the children I was working with, and by my own analysis[9].

The accomplishment of research and clinical work was an arduous task, further challenged in the context of my CAMHS team undergoing a relocation, just as I approached the end of the first year of the doctorate. This change resulted in a consistent amount of my mental space being occupied, and in my initial assumptions of having secured a four-year placement within the same physical site being unsettled. Upon reflection, I felt that the relocation provided me with an efficacious tool to better understand the experience of the children I was working with, with their multitude of foster placements, lack of consistency, and of familiarity within their lives where 'the facilitating environment' (Winnicott, 1965) was often compromised.

Gradually, I started to settle in the new building and I re-established a rhythm in my clinic. The arrival of the summer holidays provided further structure and containment, and I felt enthusiastic to begin my second academic year.

1.1.2 Choices

The beginning of the second year was marked by a significant choice to make with regard to the research element of the training, a choice concerning my research

[9] Child and adolescent psychotherapist trainees are required to be in intensive (four-times-a-week) analysis for the entire length of the four-year clinical doctorate

project. My fellow trainees and I were going to be split into two groups, each working on a different area of research, and were given the opportunity to express our preference for the two suggested subjects. One entailed adolescent depression and would draw on material gathered through the IMPACT (Improving Mood through Psychoanalytic and Cognitive Behavioural Therapy) study; the other topic concerned working on the data from the Lighthouse Project (LP), a mentalization-based intervention for parents of infants and young children, 'at risk' of harming their children. I recall finding both topics very interesting and relevant to my work. Nonetheless, my firm belief in the significance of early intervention in children's mental health and in the prevention of the development and intensification of difficulties in childhood had always been at the core of my clinical interests, and I remember myself leaning towards the LP, for its focus on therapeutic work with parents of young children. Moreover, having started offering long-term psychoanalytic psychotherapy to the children and the young people in my CAMHS clinic, I was intrigued by the opportunity of being exposed to a parenting intervention which could have amplified my understanding of parents' emotional world. I also remember being interested to explore a therapeutic intervention different in its theoretical background from pure psychoanalytic psychotherapy and I was curious as to how I was going to respond. In fact, I was myself just beginning to form as a psychoanalytic psychotherapist and at times I wondered whether I could open myself up to a different intervention.

These thoughts and feelings, amongst others, eventually led to my expressed choice of preference for the LP, which I was pleased to have subsequently been assigned to. I was excited at the idea of initiating my research project as I had pleasant memories linked to my previous research work, which partly contributed to these feelings. I drew especially on my then-most recent experience as an MSc student at the Anna Freud

Centre[10] (AFC) and I enjoyed the familiarity provided by the setting, by the staff, and certainly by my research supervisor who had also supervised my MSc research project. These feelings of familiarity and containment came to represent a 'secure base' from which I could navigate new and challenging routes.

Similarly, I came to experience the provision of research topics as a guidance and a basis from which to explore my research interest, to create my own project within the provided structure, especially in the context of all the demands from the doctoral training. Nevertheless, I also remember feeling initially constrained by the prescription administered and by the loss of agency I experienced. At times I was frustrated, feeling as if a lack of flexibility was reigning over me in and that I was being deprived of the freedom and creativity of devising my own research project. In retrospect, I wonder how the experiences of deprivation that I was becoming familiar with, through the children I was working with and often identifying with, played a role in this respect.

Gradually, I learned more about the LP, watched a few of the video recordings of the group sessions, and began to accustom myself to its manual. My interest in the parental representation of the child developed, which I understood as a means of understanding the parents' capacity to see their child. My research group became a central part in the shaping of my specific subject of interest. Although each of our projects were independent from each other, they all shared the same context of the LP. This provided me with the possibility to share thoughts, doubts, and reflections, within the avenue of a shared group experience.

1.1.3 Confusing thoughts

With our first research project assignment due just before Christmas, specifically the Research Proposal, the Winter workshop was set up as a mandatory activity to support

[10] The Anna Freud Centre underwent a relocation in 2019, following which it has been renamed the Anna Freud National Centre for Children and Families

us with the task ahead. I remember finding the workshop useful in helping to elucidate some of my confusing thoughts with regard to the content of my research. I had been thinking of focusing on the development of the parental representations of the child among high-risk parents attending a MBT-programme, gradually orientating myself towards an exploration of change in these representations.

I became increasingly clear, with the support of my supervisions, that my focus on 'change' needed further thoughts and clarification. Looking at 'change' leaned per se towards a more quantitative approach. Despite being drawn into qualitative research, I was curious to explore the option of a mixed methodology, which could include the Parent Development Interviews (PDI)[11] that I had learned were an option, and that increased my interest. In spite of this, I was wary of taking this route, especially in the context of the time constraints of the doctorate and the word limits of my dissertation. Despite my mixed feelings with regard to the use of a mixed methodology, I understood that this method felt too ambitious for me. I came to terms with the choice of focusing on a qualitative analysis, which I then greatly appreciated. I saw it as a gain, that of focusing on an in-depth qualitative analysis of the LP material, similar to my work as a clinician, attempting to profoundly understand the patients' narratives and emotional world.

Secondly, I was encouraged to think about the unique aspect of the LP, that of the use of metaphors, possibly altering my original focus on the parental representations of the child. I felt conflicted about this, as metaphors constituted a fascinating phenomenon to explore in relation to the parents' use, and were also highly significant for me in the context of working as a psychoanalytic psychotherapist, where

[11] The PDI is a quantitative tool intended to examine parents' representations of their children, themselves as parents, and their relationships with their children

metaphors and symbols are central to the framework. However, I was keen to keep the parental representations as a central part of my object of study, eager to understand whether these parents could be able to think and clearly ‘see’ their child, during the programme.
Further reflections resulted in a combination of my original idea about the parental representations of the child and the topic of metaphors, specifically that of the parents’ use of metaphors to think about and represent their child.

In the meantime, I had become interested in one more aspect of the LP, namely, that the majority of the parents attending the group presented with borderline personality disorder (BPD) traits. I did not know much about BPD, an aspect that gradually became more established in my mind and that I wanted to explore further.

In retrospect, I think that at this stage I was contending with too many interesting topics to fit within one study.

I remember finding it hard at this stage to ‘pause’ and search for the literature, before being able to access and analyse the Lighthouse data. I was aware that there were still many unknowns about my research project, such as the choice of which participants to focus on (one parent, a couple, the whole group?), or how many of the sessions. Certainly, I was still navigating ‘rough seas’, using the Lighthouse language, feeling a little lost with regard to my specific research focus while not being entirely aware of it.
Searching the literature, I was surprised to find numerous papers addressing the lack of reflecting functioning in adults with BPD and none looking at how metaphors were used within this population. A possibility opened up to further address this gap in my

next piece of research work, the empirical project, which took nevertheless a slightly different turn.

2.0 The middle phase

2.1 Towards clarity

Further supervision and meetings with the clinician and conceiver of the LP allowed for further thoughts and ideas. In the context of my research interest and of my developing identity as a child psychotherapist, I felt inspired when meeting the creator of the project, a psychotherapist with a keen interest in research who was integrating both clinical and research elements into his work.

With the help of my supervisor, I thought that metaphors were instrumental in the programme and a vehicle for much of the work. However, there seemed to be much more to be explored in the intervention that could have risked being lost by an exploration of metaphors alone. I felt both dissatisfied and apprehensive at the idea of revisiting once again my research focus, for fear of running behind. However, I also felt that these conversations enabled me to challenge my various research interests and reflect on some of their limitations.

With the help of my supervisor, I noticed that the array of topics involved in my literature review (i.e., symbols, metaphors, representations, BPD, MBT) could risk my empirical project becoming too dispersive. I thought that my literature review could still serve as a basis for my empirical project; however, it felt important to make adjustments.

I started to reflect on how I had begun my third year of the doctorate feeling, at times, like I was back in my previous year, at the beginning of this journey with its choice of

topic. This felt sometimes tedious and overwhelming; at others, like a moving forward, towards 'something' that I had been gradually and attentively growing.

I felt I was getting closer to knowing what my core research interest really was. I was interested to explore how a child who had been harmed by his/her parent had been 'seen' and could have been 'seen' by the same parent, in the course of a therapeutic intervention. Both my personal and clinical curiosity in this topic were behind this specific interest. At work, I started to familiarise myself with some parents' tendency to 'blame' the child and to want him/her to be 'fixed', as for the parents of my intensive case[12], who were seen in parallel by a colleague. In fact, in psychoanalytic psychotherapy, parents are often offered their own parent-work, in parallel with their child's therapy which takes place with a different clinician. In this way, parents are helped to reflect on their child and supported to see their children more clearly. I immensely valued this approach which in my view, as with the LP represented an opportunity to take the blame off the child.

With regard to both the layers of metaphors and of BPD patients, I thought they were interesting and fascinating subjects to examine; however, I also felt that each of these could have easily come to represent stand-alone research projects. Moreover, the time frame of my doctoral training, as well as my own resources and capacity in the context of working full time in the NHS and being a full-time student, functioned as important boundaries to keep in mind in the narrowing down of my research focus. My revisited interest and reflections were met with positivity in my supervisions and I felt keen and ready to access the material, firstly in order to identify my research participant/s.

[12] In accordance with the clinical requirements of the doctorate, the trainee works with three intensive (three-times-a week) cases and a minimum of five weekly cases, among others.

I was still uncertain about my choice of research participant/s. Again, it felt difficult to choose, especially as we had not yet had the opportunity to familiarise ourselves sufficiently with the video-sessions. My research group and I came to realise that the best use of some of our group supervisions would be to watch a few more extracts of the video-sessions, while waiting to gain remote access to the data, which we thought would be upcoming. Unfortunately, the entire process of gaining data access resulted in a much lengthier and frustrating experience than we all expected. Nevertheless, I was able to select the participant for my empirical project.

I decided to concentrate on Tash[13], a single mother of two toddlers. The reasons behind this choice, similar to my choice of research topic, were linked to both personal and professional curiosity. My initial conscious idea behind selecting Tash was related to how her presentation across some of the video-extracts had evolved during the course of the programme. In fact, she appeared introverted and withdrawn in some of the initial sessions, while vocal and expressive in the later sessions. A suspicious guise seemed to be constant in her facial and bodily expressions, which I interpreted as a mask, a defensive presentation that enabled me to empathise with this mother and to speculate on possible difficult experiences behind her protective shield. I knew that she had harmed her children both physically and emotionally, I did not know the details or any information on her background that was not part of the videos. I wondered how her 'seeing' her own children might have been hindered by her own history, and I hoped that the intervention could make a difference in this respect. I felt curious to know more about this mother's past life, to try to better understand her present, perhaps in an unconscious attempt to help her. At times, not knowing felt

[13] The participant's real name has been changed for reason of confidentiality.

frustrating. As a researcher, I knew that my role did not involve directly helping this mother, as I would have attempted to do in my clinical role. However, I thought about the possible implications of research into clinical practice, that of strengthening and improving therapeutic interventions and patient care, and it felt rewarding.

2.2 Further challenges

Having decided upon my research participant, I was able to redefine the focus of my research. I wanted to learn about this mother's view of the child during the group and I thought of transcribing the moments in which she talked about her own and other people's children. I felt particularly curious to follow Tash's narrative across the entire group, session by session, despite this choice requiring a lengthy process. I was suggested that I could also focus only on a few sessions, which would have still provided me with the opportunity to explore Tash's representations of the child in the course of the group, and would have helped with the time-constraints, especially in the context of the still unresolved problem of data access. However, I wanted to have a sense of her journey throughout the group and I was also interested to learn more about the intervention and the way it was run. I felt willing to watch all the 20 sessions of the therapeutic intervention and I was keen to embark on this process.

Despite some initial scepticism, I received my supervisor's approval to follow this path. I was ready to immerse myself in the data transcribing/coding when I was faced with a major obstacle. As my group and I finally gained remote access to the data, I was appalled to discover that the access to the material was still compromised. Due to some technical problems the quality of the videos was extremely poor, rendering data access still an unresolved issue. I felt powerless. I thought about the edge-of-care children, their feelings of powerlessness and helplessness, living in the uncertainty of going into care. I thought about their parents too with their own experience of anxiety,

stress and helplessness when going through care proceedings (Ward et al., 2011). A parent with whom I had been working in my clinic came to mind. I began to realise the powerful parallel between my research and clinical work. The experience of Tash, my research participant, of having her children at risk of care removal, strongly resembled that of a parent I had started to work with in my clinic.

This period was also characterised by the relocation of the AFC, the place where not only my research teachings and study had been taking place, but also where my journey towards the exploration of psychoanalysis initiated, during my previous MSc years. In retrospect, it felt significant how turbulent the period of data access felt in view of the centre's relocation. Perhaps the turbulence was also reminiscent of the difficulties linked to the losses and gains that the move brought forward, and foreshadowing of another upcoming ending: the end of my training.

We were approaching the summer term of the third year of the doctorate when the opportunity arose for us to use encrypted USB sticks in order to access the data remotely. After some further setbacks (e.g., requiring USB sticks with adequate storage capacity) we were able to finally gain access to the data. When we did, it felt like a triumph.

3.0 The ending phase

3.1'Making sense'

Perhaps this feeling of achievement, of overcoming obstacles following a lengthy, tedious, and often exasperating process, enabled me to progress with the work ahead relatively quickly. I immersed myself in the programme, watching the video-sessions relentlessly. I found watching Tash and the group to be an emotional and powerful experience. I felt that my clinical work and research work were highly aligned. In fact,

having been working in a LAC-EoC-Adoption team, I had some familiarity with the upsetting stories and histories brought by my patients and by their parents/carers. Nonetheless, it was a unique experience to be able to observe the strengths and the resourcefulness of Tash and the other parents of the LP, as well as their common struggles and 'ghosts in the nurseries' (Fraiberg, 1975), during the shared experience of the parenting group. I thought about the healing power of relationships and of a therapeutic group.

Focusing on Tash and following her journey through the entire programme felt like a privilege. Of course, there were the draining times of the transcription process, which at times challenged my patience, especially when the quality of the video-sound was compromised. However, allowing myself to be in touch with Tash's emotions made the entire process of data transcribing and analysis a rewarding and fascinating experience. I thought about the resonance with clinical work in general, with the importance of following the patient's pace and the material brought by the patient, without the therapist resorting to his/her desires (Freud, 1912). I thought that, similar to the clinician, the researcher keeps in check his/her wishes by letting the 'data speak'. I was hopeful that Tash could make use of the programme, that her view and representation of the child could shift positively by the end of the programme. With hindsight, I think that my parallel parent work, and the hopefulness I could see in this work, rendered my 'wish' for a positive shift in Tash more intense. Keeping my hopes in check, through personal analysis and supervision, was essential to respond faithfully to the research data.

As I approached the data analysis phase, I revised my choices of method of analysis. Initially, I considered Thematic Analysis (TA) to be an appropriate method to use, that could respond well to my research question. I was also familiar with it and I thought

that this could ease some pressure in the context of the time constraints. I was met with partial agreement from my supervisions and I was suggested a potential and alternative method of analysis, namely Narrative Process Coding System[14] (NPCS). I remember feeling intrigued about it, while equally apprehensive at the thought of needing to familiarise myself with a whole new method of analysis. However, I was reluctant to discard TA, as I felt that its use could prove insightful in finding patterns across the data. I also felt that NPCS could be extremely useful to analyse Tash's language mode in relation to her child.

With time, I arrived at the conclusion of combining both NPCS and TA, which proved to be fascinating. Of course, the analysis resulted in strenuous work at times, but it also felt motivating and enjoyable. Dividing the sessions into three main parts (beginning, middle, end), facilitated this process and enabled me to follow Tash in her 'representational journey' as if it were a story, one that resembled my own journey towards qualifying as a child psychotherapist. Tash's journey began with a more detached and negative view of the child, which shifted towards a more positive one in the middle stage of the programme, and then returned to be mainly negative, although tinged with much more reflexivity compared to the beginning. There was progress and then regression, as I certainly experienced in my own journey towards qualifying, where regression nevertheless represented a gain and was necessary for further progress (Anna Freud, 1965).

4.0 Conclusions

This journey has been demanding, inspiring, stressful, and rewarding. With my reflective account, I certainly wished to convey an important experience of my life, a

[14] Narrative Process Coding System is a qualitative method of analysis that enables the researcher to categorize psycholinguistic dimensions of the therapeutic interaction. It entails finding shifts in focus (i.e., external description of events, description of emotional experiencing, reflexive analysis of events and emotional experiencing) during the development of a particular theme.

narrative, to use Russell (1988)'s terms. A narrative of the experience of the whole process of research, of undertaking a clinical doctorate, and of establishing a child and adolescent psychotherapist identity. A non-linear process, a process of progressions and regressions, of revisiting and integrating.

I thought about how my data from the LP could have been interpreted perhaps differently without my clinical skills, and how my clinical skills are informed and integrated by research. 'Each form of knowledge can add something extra to the overall picture', Music (2016) cites. My reflective narrative ends here, with an acknowledgement of the myriad of learning experiences and challenges I encountered during my journey of conducting research as part of this clinical doctorate, all adding something extra and essential to the overall picture of growing into a child and adolescent psychotherapist.

5.0 Further reflections on the process of carrying changes to my thesis

More than a year has passed since the end of my clinical training and the start of what I would like to call a 're-adjustment phase'. This phase refers to my experience of consolidation and continuous development of my identity as a Child and Adolescent Psychotherapist, during my first year of post-qualifying life. It included carrying out changes to my thesis, with its symbolic meaning strongly associated with the changes in my own mental representations brought on by my role as a qualified Child and Adolescent Psychotherapist.

Looking back at the years of training, I remember nostalgically the shared learning experiences, the protective 'aura' surrounding therapy and research work from the often challenging and overwhelming demands of CAMHS, the stimulating and difficult

requirements of the training and my own personal analysis. My image or mental representations associated with the role of a Child and Adolescent Psychotherapist were in constant evolution, aligned with the new experiences I was facing and learning from. Most importantly, they were affiliated with the relationships and connections I was building throughout, such as those with my patients, my peer-group, my clinical supervisor, my research supervisor, my analyst and with the many other important people I encountered and who supported me during this journey.

The representations that I came to associate with the role of a Child and Adolescent Psychotherapist, were based on a theme of *connection*, such as that to oneself, to the children and families I worked with, to their narratives and stories, along with their silences. This sense of connection also related to piecing together our thoughts and feelings, stories and histories, linking past and present and envisaging future.

These representations continued to shift once I qualified.

Soon after qualifying, I got a job in a Generic CAMHS team within the same NHS Trust I worked for during my four years of training. I remember initially clinging on to the idea of working within the same Trust, though in a different team and in a different geographical area. It felt like I was trying to find a 'good enough balance' between the familiar and the unfamiliar that, in my mind, would have gradually eased me into my new qualified life as a Child and Adolescent Psychotherapist. I think I initially experienced the search for familiarity, for links, for *connections* even more ardently in view of the unfamiliar times of COVID-19 which further contributed to the experience of '*re-adjustment'*.

Starting to work in a new team when physical closeness and connection were compromised by the social distancing and lockdown measures, felt at times both alien

and alienating. I am certainly grateful to my colleagues who have made an invaluable contribution to my experience of feeling welcomed and relatively settled within the team, by finding together new ways of feeling *connected* and of *re-adjusting*. I also feel grateful to the children and the families I have been working with for the emotional experiences they are providing me with, and impressed by how they have been increasingly adapting to this new way of working and of connecting.

The process of *re-adjustment*, that I had been exposed to during my years of training in relation to the importance of adapting to different clinical scenarios while keeping hold of psychoanalytical principles in one's mind, became particularly salient as my training came to an end and my transition to post-qualifying life begun. The concrete and practical changes in the responsibilities that come with working as a qualified Child and Adolescent psychotherapist in a CAMHS setting, the new connections with colleagues and with the children and families I have been working with, all impacted and are impacting on the emotional experiencing and on the evolution of my mental representations associated with this role. Strangely, this transition to post-qualifying life and this phase of 're-adjustment' has coincided with a much broader and global re-working of our society's way of living, in view of the COVID-19 pandemic. This, I think, is having a major role in the way I am experiencing '*re-adjustment'* as one more salient theme in my mental representations of a Child and Adolescent psychotherapist role.

Time, experiences, the current climate, and new encounters, are certainly contributing to the development of these representations and to their *re-adjustment.* The process of undertaking revisions to my thesis has been and is being a major part of this re-adjustment phase. It has been a particularly challenging experience, nonetheless

powerfully enriching. I came to think of Tash's journey through the various phases of the programme and how, in part, echoed my own journey of undertaking revisions.

I felt I was initially navigating through some initial challenges, inundated by a primarily negative view of the process of revisions, where feelings of frustration were high. Gradually, the path led towards some clarity where further and more balanced reflections became possible. Nonetheless, I experienced further challenges, where at times I felt like 'giving up'. The encouragement and the communication with my supervisor and my fellow research students helped me keep going, until I reached the 'final phase', where the strengthening of more balanced reflections on this journey emerged, as well as the elaboration of what an enriching and fruitful psychological experience this has been. This phase was also tinged by feelings of hope and by a sense of gratitude for the feedback received by my examiners, that I believe resulted in a much-improved version of my thesis.

Here I am gradually continuing to develop a stronger sense of integration, in the sense of combining my experiences pre and post training within what I perceive to be particularly challenging contextual changes that we are all facing.

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Appendices

Appendix 1

The Lighthouse Project

The Lighthouse Project is a 20-session group mentalization-based programme for parents and babies, run in collaboration with the Anna Freud Centre. It is offered as a once-weekly 2-hour sessions and is usually run with three facilitators. It incorporates individual and group psychotherapy and video-interaction Guidance (VIG). Through

MBT, focus on attachment theory and the use of metaphors, this programme aims to improve outcomes for the most vulnerable children who have been identified as at high risk of maltreatment.

The programme has been written following the guidelines provided within the Quality Manual for MBT, in order to ensure treatment integrity (Perepletchikova and Kazdin, 2005) and has received permission by Anthony Bateman and Peter Fonagy, founders of the MBT approach. It incorporates the language and images of the Lighthouse Model; lighthouse, sea, sea-journeys and shore are some of the images and metaphors adopted to help parents grasp hold of key concepts in mentalizing, attachment and psychoanalysis. The metaphor of the Lighthouse, for example, represents the parent as a secure base for the child, a physical, psychological and emotional guide that enables the child to physically, psychologically and emotionally thrive. Parents are able to respond freely to the images and/or metaphors as well as to generate any spontaneous metaphors. According to the Lighthouse module, anchoring the patient's experience in lighthouse language using the metaphors, facilitate the process through which parents are able to mentalize self, child, past life experiences and current relationships.

The core principles of the Lighthouse MBT-Programme are: *Being seen is being believed; Wanting-to-know/-to-see clearly is more important than knowing/seeing clearly; Silhouette (*an impoverished representation of the child) *to 3D and 4D view of the child* (a fully rounded, full-colour, three-dimensional representation of the child)*; Bringing children and parents to life in our minds.* Through these principles, the programme aims for parents to develop a clearer sight of their child and a richer representation of themselves and their child. The relative liveliness of the parent and/or child in mind is one way in which the programme can measure and reflect back on the therapy.

(For more information on the Lighthouse programme, please visit: http://lighthouseparenting.net)

Appendix 2

NARRATIVE PROCESSES CODING SYSTEM From the **NARRATIVE PROCESSES CODING SYSTEM - Coding Assistance Manual** (Angus, Hardtke, & Levitt, 1996):

The Narrative Processes Coding System (NPCS) is a systematic method of unitising therapy transcripts, regardless of therapeutic modality. The NPCS is a two-step process which enables the researcher to: a) reliably subdivide therapy session transcripts into topic segments according to content shifts in verbal dialogue, and b) to further subdivide and characterise these topic segments in terms of one of three narrative process codes:

i. external description of events
ii. description of emotional experiencing
iii. reflexive analysis of current, past and/or future events and emotional experiencing..

The application of the NPCS entails the following: the researcher first reads the therapy session transcript through locating apparent shifts in themes or shifts in focus during the development of a particular theme. The first reading identifies the individual topic segments. Once identified, each topic segment is further subdivided and coded in terms of shifts in narrative process modes.

CHARACTERIZATION OF THE TOPIC SEGMENT BY NARRATIVE PROCESS CODE

Narrative Sequences

Once the therapy session transcript has been unitised according to topic segments, each segment is further subdivided and coded in terms of shifts in narrative process modes. The resulting units of text are termed narrative sequences.

Narrative Process Modes

i) External/Event Process Code

When the individual provides a descriptive elaboration of an event, the narrative sequence is coded as External/Event. Two distinctions are made within this process mode:

The individual may provide:

i) a general overview of an event or autobiographical memory narrative
ii) highlight a specific incident or event (past or present)
iii) provide information about external events

Example 1A

By referring to the topic segment illustrated in Example A, the following unit would be extracted and coded as External/Event:

(Topic Segment #1)
(beginning of narrative sequence/external)
THERAPIST: Good morning, how are you?

CLIENT: OK. It's been a pretty hectic week. My mother-in-law arrived in town. She'll be staying with us for two weeks. She's just taken over the house. She's cleaning everything. I mean, she even went out and bought Ajax and spent almost an hour scrubbing the kitchen sink. I mean it's not like the place was dirty. I made sure it was spotless before she arrived. The night before I even got up to check everything over so I could clean whatever was missed. She always does this.

TH: Okay, your mother-in-law arrived for a visit and what, the next day you walked into the kitchen and she was cleaning your sink?

CL: Yeah, she arrived Thursday afternoon. R__ picked her up from the airport. The next morning I dropped the kids off at school and when I got back there she was in the kitchen scrubbing the sink, you know with Ajax. So I just stood there with a dazed look on my face and said, you know, that she was on vacation and if the sink was dirty I would clean it. Well she said something like she knew I was busy and she was only trying to help.

TH: Hmm,mm

CL: Yeah and like she always does this. **(shift/end of narrative sequence/external)**

Example 1

The following further illustrates an example of a narrative sequence which would be coded External/Event:

TH: And you had a nervous tic.
CL: Yah.
TH: When was that?
CL: That started -
TH: Bad enough that your family doctor know about it?
CL: Yah. That started shortly after uh my father left. I developed a nervous tic and I developed migraine headaches. And the doctor just didn't do anything about it. I mean it just went away in time. But he felt things had to be calm for me and uh this was during the war and my sister became an Air raid warden and our home town became a center air raid home of our area. So that we could get a telephone. Because the doctor felt it was essential that I had to be able to communicate with somebody it I got too uptight or something. Used to have alot of nightmares, uh, I was a mess. (short pause)

External Code Cues

The following provide cues to help identify narrative sequences in the External process mode. The External sequences are:

- often presented as personal memories
- concrete examples to highlight issues raised in any of the three narrative process modes

ii) **Focus on the Internal**

When the individual provides a descriptive elaboration of experienced emotions or bodily felt sensations and/or feelings, the narrative sequence is coded as Internal. It is a description of how one feels in relation to one's self and/or to others.

Example 2A

By referring to the topic segment illustrated in Example A, the following unit would be extracted and coded as Internal:

TH: Hmm,mm

CL: Yeah and like she always does this.

TH: Hmm, mm. **(end of narrative sequence/external) (shift/beginning of narrative sequence/internal)**
So how does it make you feel when she acts like this?

CL: I feel like she's intruding. I mean she's the guest. I don't know I just want to scream I get so frustrated. She makes me feel hopeless, like a little kid. There is no point telling R__. He just sides with her. I just get really upset. I just feel like one of the kids when she's around.

TH: Hmm,mm. So when she visits you feel like she is the parent and you're the little kid?

CL: Yeah. Like when she cleans or says that I'm not dressing my kids right I feel like I've failed again. It is so aggravating. No matter how hard I try I can't please her. I think I'm starting to experience panic attacks when I know she's coming for a visit.

TH: Panic attacks?

CL: Like before she arrived I had a headache for a week. My stomach was in a knot and I could hardly eat. I just felt really tense and nervous. I just know that she will find something to criticize me about.

TH: Hmm,mm
(end of narrative sequence/internal)

Example 2

The following further illustrates an example of a narrative sequence which would be coded Internal:

CL: Um, I feel really good today and I feel very guilty about it. I just thought that I'd mention it because it's not typical of the way it should be. But I, I am conscious of the fact that I feel extremely guilty about feeling good. And I thought I should mention it, you know? I just feel happy, you know. Sort of bright, like sunny, like everything is okay.

Internal Code Cues

The following provide cues to help identify narrative sequences in the Internal process mode:
- the therapist asks directly how the client feels
- frequent use of words describing emotions (ex. sad, angry, frustrated)
- frequent and/or extended pauses

iii) **Focus on the Reflexive**

The individual focuses on the reflexive or interpretive analysis of event descriptions and/or descriptions of subjective experiences. The individual attempts to understand his/her own feelings regarding self, others or events.

Example 3A

By referring to the topic segment illustrated in Example A, the following unit would be extracted and coded as Reflexive:

TH: Panic attacks?

CL: Like before she arrived I had a headache for a week. My stomach was in a knot and I could hardly eat. I just felt really tense and nervous. I just know that she will find something to criticize me about.

TH: Hmm,mm **(end of narrative sequence/internal)**
(shift/beginning of narrative sequence/reflexive)
CL: And I don't know why I feel so obsessed with pleasing her anyways. She usually only comes to visit twice a year. I mean it's not like we're really close. I've talked to R__ who says I should just put up with her for 2 weeks, then forget about her. But I can't seem to do that. Maybe it's because I felt she never thought much of me. She was against R__ and I marrying. We were still in school. She's always given me the impression that she thought R__ would marry someone who would be more than a housewife. Why don't I have the guts to stand up to her? Why do I let her invade my home? I always let her take charge. I should stand up for myself and tell her what I think about all her cleaning. Maybe it I stood up to her she'd respect me more. Or at least she might shut up!

TH: Hmm,mm. **(end of narrative sequence/reflexive)**
(shift / end of Topic Segment #1 / beginning of Topic Segment #2) You mentioned last week that you had a job interview coming up. How did that go?

<u>Example 3</u>

The following further illustrates an example of a narrative sequence which would be coded Reflexive:

CL: Yes, it's true. I've put alot of effort into everything. Cause I like to see it completed or done well, to the best of my ability. And I know, generally I think I tried to the best of my ability with this and I'm finding it difficult to accept what I consider failure. It seems to me it's a failure, when two people head out together and spend so much time together, and put so much effort into it, having a family and all these things together, to build a life together and then all of a sudden it all falls apart. And I do see that as a failure. It's disappointing. I've given quite a bit of thought to the question you raised earlier about

have I lost battles before. And I do lose a lot of battles. We all do. And then I tend to retreat, battles at work and so on."

Reflexive Code Cues

The following provide cues to help identify narrative sequences in the Reflexive process mode. The Client:

- examines own behaviour in situations/relationships
- plans future behaviour alternatives
- examines own thinking in situations
- explores the meanings of expressed emotions in situations
- discusses patterns in own behaviour and/or that of others
- is self-questioning

	Early phase		**Middle phase**		**Final phase**	
NPCS Codes	Number	Percentages	Number	Percentages	Number	Percentages
Descriptive	7	70%	12	28%	14	45%
Internal	2	20%	11	26%	10	32%
Reflexive	1	10%	20	46%	7	23%
Tot.	10	100%	43	100%	31	100%

Appendix 3

Descriptive analysis of the data.

Table 1. Number of NPCS codes and percentages per phase.

Table 3. NPCS Codes and themes (via thematic analysis) per session.

	Session	**NPCS code**	**Themes**
	1	n/a	n/a
	2	External	the obsessed child
	3	External	difference and inability
	4	none	None

Early Phase	5	External	the child claiming the attention
		Internal	the child engendering interaction
		External	the child being held
		External	the crying child and the child being on his own
		External	normal vs not normal child
		External	the child’s taking in
		External	the aggressive/shouting child
		Internal	the child being impacted upon
	6	n/a	n/a
	7	n/a	n/a
Middle Phase	8	Internal	the clinging child
		Reflexive	the hopeful child
		Internal	the rejecting child
	9	Internal	the vulnerable child
		Internal	the child who needs to learn self-sufficiency
		External	the hurting child
		Internal	the ‘fine’ and upsetting child
		Reflexive	the child listened to vs the greedy child
		Reflexive	the projected upon child
		External	the child in need of consistency
		Reflexive	behind the child’s self-harm
	10	Reflexive	the child’s needs
		External	the child’s needs
		External	the ‘demon’ child
		Reflexive	the child impacted upon
		Reflexive	the child needing apologies and warmth
	11	External	the rebellious child
		Reflexive	the ‘pirate’ child
		Reflexive	the clingy child
		Internal	the panicked child
		Reflexive	the attached child
		Internal	the ‘frustrating’ child
		External	the child needing calming down
		Internal	the rejecting child
		External	the different-excluded child
		Internal	the child who needs you and wants to be seen
		Reflexive	the child who needs you and wants to be seen
		External	the volatile child
		Reflexive	the protective child
	12	Reflexive	the un-bothered child
		External	the affected child
		External	the deprived child
		Reflexive	the child’s needs
		Reflexive	the cut-off child
		Reflexive	the child being impacted upon
		Internal	the child not responded to

		Reflexive	behind the child's cries
	13	Reflexive	the child's voice
	14	External	the child's incident
		Reflexive	the child's intention
		External	children's difference
		Internal	the child's own mind
		Reflexive	the child being mentalized
Final Phase	15	External	the depriving child
		Internal	the child needing protection
		External	the child's impact on the parents' life
		Reflexive	'how the child sees me'
	16	Internal	the child's place in his/her mum's life, the interfering/depriving child
		Internal	the child's uncomfortable demands, mum's hating soft play
		External	the hateful child, hating 'mess', the hurtful child
		Internal	the child uncomfortably playing, mum hating mess and not coping
		Internal	the child's uncomfortable demands
		External	the child's demands
	17	Reflexive	harmful child rearing
		External	the controlled feed
	18	Internal	the pain of childbirth
		External	the hurting child
		Internal	the self-harming child
		External	the hurting and self-harming child
		Internal	the child's bad parented
		Reflexive	the child's in need of calm reaction
		External	the hurting child
		External	the child's self-harm to communicate
		Internal	the hurt and self-harming child
		Reflexive	behind a child's self-harm
		External	the child's doing something wrong
		External	the child told off
		Reflexive	behind the child's self-harm
		External	the child shouted at
		Reflexive	the child needing a calm response
		External	the child settling down
		Reflexive	behind the child's self-harm
	19	External	the child's challenging demands
		Internal	the child's demands
	20	n/a	n/a

Appendix 4

Qualitative data. Examples of analysis using NPCS and TA.

Glossary:

T: Tash

P: one of the group participants

F: facilitator

L: group leader

Colour Legend:

Topic segment's colours:

- *Tash talking about her own children*
- *Tash talking about children in the videos*
- *Tash talking about children in general* (e.g., group members' children, any other reference by Tash to children)

Early Phase.

Example from video session 2

One of the two facilitators explains the activity re pick up object reminding happy memory; the objects are placed onto a poster and participants are invited to go and grab one. They then come back to their seats and voluntarily choose their turn to share their memories.

T: I've picked a dinosaur as my two years old is obsessed with dinosaurs (giggles in the background) He can remember the names (she opens her arms and gazes at other participants while talking) of these dinosaurs that I could never ever remember at all. He remembers every one of them (-NPCS: External -TA: theme of 'the obsessed child')

F: And dinosaur names are not easy

T shakes her head simultaneously to the facilitator talking, as in agreement

T: it's just there in his head (points at her head), he is obsessed (-NPCS: External -TA: theme of 'the obsessed child')

Other participants carry on sharing

Tash remains quiet, observing the other participants while they speak.

Example from video session 3

T: the thing with my son is he doesn't understand how he feels because that's where they are different, my daughter she is good at express, my son doesn't get emotions, he doesn't understand them, sometimes how do you feel? 'I dunno' cuz for him mentally he can't he can't the difference, it's just one thing for him it's anger it's all he has, so trying to get my

son 'how you doing' he wouldn't be able to express 'oh I feel like this' so what do I then? (Laughing) ((NPCS: External -TA: theme of 'the different and not able child').
L: ok..the brilliant thing about bringing that right now your son, is that this week and next week I think some of the things we'll talk about will be helpful and as we are going to be meeting over the next 5 months still we can then test out whether that changed or not you can tell us actually this worked and he is more able to understand his feelings
T: it's because the condition he has, it's not because he cannot talk about it, actually he can't understand that's why (NPCS: External -TA: theme of 'the different and not able child')

L: but we can have a go and see whether some of the things we do practise here willl make a difference for him because it's, although that might be part of his condition, every day he starts with in that place where you don't…and they feel feelings very physically in their body..and over time we'll help understand feelings..and even Alvie in this state …he might not know what he is feeling and we can help him understand them …

Middle Phase
Example from video session 5
L: … Tash how are you feeling?
T: yeah like when you were talking about that …it made me think cuz my son he doesn't react to shouting..like a normal 3 yr…they would be scared…my son (makes a gesture of flat) because he is from..my partner..he is so used to the shouting and the screaming like…nothing (gestures with hands) like even if you were really to shout at him nothing he could can scream back at you..but at that same level..instead a normal child like if you were to scream like to a 2yrs old they it just made me think that he doesn't react now to that level of whatever cuz he was so it's kind of like filtered in like oh ok (NPCS: External, TA: Theme of 'a normal vs not normal child')

F: do you think that thing is just going that's too much shut down…
T: he got used to that like instead of …and it shouldn't be that way you shouldn't be used to hear that level of noise to then think that's ok like you said (looking at one parent) your little one you are not sure how much they take in he was about two when I left …and that (fingers on head)'s now in him it's such a young age but that's in his head like from that little (Npcs: reflexive, TA: Theme of 'a child's taking in')

L:..one of the things you could hope for a change is that he recovers some of that sensitivity…?
T: yeah yeah (rolling sleeves up)..like a normal child would feel afraid if it's not ok to hear shouting…
Parent: when you shout does then cry ..
T: he (inaudible) aggressive (NPCS: External, TA: Theme of 'the aggressive/shouting child')

Parent: yeah that's what I was wondering

T: he screams right at me (NPCS: External, TA: Theme of 'the aggressive/shouting child')

Parent:…and then probably you would get a few tears..
F: it sounds like..i don't know how you feel about it…
T: I feel like..cuz that's my fault..that's from me and him and that toxic environment that I for too long I feel …like he should have been taken out of there …and that's my fault and it's my fault (starts biting nails) (NPCS: internal, TA: Theme of 'the child being impacted upon')

F: so this is quite emotional (T smiles and rolls sleeves up)…

Final Phase
Example from video Session 16
T: …It's just nice every now and again to just be like be yourself. Because for that weekend I was not a mummy you know I was like no so it's nice you feel bad but I like I forget because I've got my children so young like I was 19 so it was like you kind of loose that like most 19 years old go to do whatever they r doing I was I had babies I was like living in my first house I was like dadada and I kind of miss that bit so it's nice sometimes just be like not to have to worry about doing things... (NPCS: Internal code, TA: Themes' the child's place in my life')

P: you shouldn't feel guilty about it
T: yeah
T:… Like you said and it reminds me of a soft like a soft play thing. When I see things like that that reminds me of soft play as well and I hate those places and I don't (inaudible) when I had this stuff going on with my kids like that's where my hesitation goes and I hate I hate those place so I see that and I'm like.. I don't give a shit I can't like I don't go to soft play with my kids anymore when people have parties then my sister takes them because I don't wanna go to those places because I hate those places I just all I say I would never like put up with that crap with my kids either like it's just it just makes me I don't see happy in these places I see (inaudible) (NPCS: Internal code, TA: Themes' the child's uncomfortable play)

F: but you can totally It sounds like you can see
T: for normal people would work for normal people ...some kind of fun
T: My kids hate me because they get toys out and I (inaudible) (NPCS: External code, TA: Themes' 'the hateful child')

P: my mum's house is spotless
T: It makes me feel if it's if it's not I don't feel relaxed I don't I don't feel nice and like I can't cope I can't sleep at night if I know that something is a mess
F: ..play with the toys
T: Yes yes. We have like four toybox so is there one is that one is there all organised like X's got one (inaudible) then with the soft toys my kids don't even play and just take the box out and then it'is just everywhere and my mum is like 'let them play' fine and it makes me I'm like this I'll be like this like OCD and I'll and it just drives me insane and if they play with

them I will be tidying up as they play like it's it's it's a nightmare (laughing) (NPCS: Internal code, TA: Themes' ideas of 'the child's uncomfortable demands/impact')

F: Is there a messy area like a messy corner where they can play
T: No no -giggling (people laughing in background)
Conversation continues
F: It's a real conflict isn't it between the parents who wants beautiful perfectly ordered .. and then the kid who wants to get messy get sandy who wants to play football Tash what do your kids play football?
T:...other than newborns that throw up all the time I would change my sons multiple times of the day any..clothes which will be all the time because that's what children do I will change them every single time (NPCS: External, TA: Themes' ideas of 'the child's demands')