Attachment, Trauma, and Parenting in Social Work Practice

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**Declaration of Authorship**

I ………………………… hereby declare that this thesis and the work presented in it is entirely my own. Where I have consulted the work of others, this is always clearly stated.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Abstract

This thesis seeks to examine qualitatively key influencing factors on the outcomes and experiences of parent-infant intervention. The participant group were selected based on their attachment trauma history and their involvement with children’s services. The intervention they received consisted of either a parent-infant foster placement, a residential assessment unit and/or parent-infant psychotherapy. Participants were interviewed on three separate occasions, once at the start of their placement, once during their placement and then after their placement had ended, when the outcome of their assessment was decided. In some cases, this outcome consisted of returning back into the community with their babies and for others, who had been unsuccessful in their assessments, the court granted social services removal of their baby.

The interviews were analysed thematically with the aim of exploring whether key patterns and themes emerged based on the outcomes of their assessment. In terms of the participants who were successful, the key themes that emerged from their interviews included four ‘change facilitators’: ‘*Acceptance*’, ‘*Determination*’, ‘*Mentalization*’ and ‘*Connection with past trauma’*. For the group whose babies were removed from their care, the key themes comprised three ‘change inhibitors’: ‘*Denial*’, ‘*Low Mentalization*’ and ‘*Disconnect with past trauma’*.

The ‘change facilitators and inhibitors’ could constitute a basis for practitioners to gauge progress in respect of all forms of help and support, not just psychosocial, in ways that do not rely solely on the behaviours of the parent and/or their infant, nor simply on the veridical account of the adult.
The findings also highlight the benefit of using an attachment and trauma lens when working with parents, particularly if they have a history of attachment based trauma. In addition, the need for access to therapeutic resources for families when there are child protection concerns is also discussed.

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**Introduction**

The human infant is born into the world incredibly vulnerable as, unlike other mammals, they lack the capacity to go to their caregiver to get their needs met. Instead they are reliant on their caregiver coming to them, and as such they are programmed to display certain behaviours, such as crying, in order to signal their needs to their caregiver. The extent to which the caregiver meets those needs determines the quality of what John Bowlby (1958) has termed the ‘attachment relationship’. It will be argued in this thesis that, when child maltreatment occurs, this is most likely due to a breakdown in essential attachment processes. Therefore, social workers can benefit from the use of attachment theory to determine why this has been the case, in order to formulate an appropriate plan for protection.

Bowlby’s (1958) theory of attachment, and the extensive work that has followed, offers a framework to understand human behaviour in the context of relationships. It provides insight into the infant’s needs and the potential behaviours that may occur if their needs are not met, which in turn may provide a better understanding of the infants/child’s likely experiences. Having an awareness of the influence that early relational experiences can have on behaviour, particularly in adulthood, can also provide an increased understanding of the parent’s behaviour. This level of insight into the infant/child’s world and the ‘caregiver’s state of mind’ (Corby *et al*. 2012) is likely to provide a more valuable detailed analysis of the parent-infant/child relationship.

Two key components that represent the ‘caregiver’s state of mind’ will be considered in detail throughout this thesis. These are ‘Unresolved Trauma’ and ‘Low Mentalizing Capacity’. There will also be an exploration of how children’s social care practitioners could use their understanding of these components to increase the quality of assessments and interventions, which in turn may improve the likelihood of some families being able to stay together.

Unresolved trauma within this context refers to significant incidences of childhood abuse and/or neglect that have not been processed effectively in the mind of the individual. During the past fifteen years, a growing body of research has emerged highlighting the detrimental effect unresolved trauma can have on an individual’s ability to offer sensitive care to their infant. Parents with unresolved trauma may have difficulties in accurately interpreting the affect state of their infant (Lyons-Ruth *et al*. 1999) and keeping them ‘in mind’ (Woodhead 2010). They may also struggle to respond appropriately when their infant is distressed because the child’s vulnerability can trigger the carer’s past feelings of fear and anger, from their childhood experiences, which may prevent them from being able to relieve the negative affect state in their infant (Cook *et al*. 2003, Walker 2007). Furthermore, they may respond to their infant in ways that are traumatizing (Jacobvitz & Hazan 1999, Main & Hesse 1990, Fonagy 2011, Lyengar *et al*. 2014, Tambelli *et al*. 2015, Jones 2016, Bartlett *et al.* 2017) and thus traumatizing attachment behaviours may transmit from one generation to the next.

Mentalization refers to a conscious awareness that other people have thoughts and feelings that may differ from one’s own, as well as connoting the ability to interpret accurately the thoughts and feelings of others (Allen & Fonagy 2006). Reflective function refers to mentalizaton within the *context of attachment relationships* (Fonagy *et al.* 1998) i.e. the parent’s ability to view their child as autonomous with a desire to correctly understand their mental states and subsequently offer a more synchronous response to their child’s individual needs. There is a considerable amount of empirical data evidencing the influence of parental reflective function on the attachment relationship and parental behaviour (Fonagy *et al*. 1994, Carlson & Sroufe 1995, Main 2000, Slade *et al.* 2005, Ensink *et al.* 2016, Shai & Belsy 2017, Weijers *et al.* 2018). Unresolved trauma may influence the extent to which a parent is able to mentalize (Fonagy & Target 1997, Fonagy *et al.* 2002a). This thesis will therefore argue the importance of considering both unresolved trauma *and* mentalizing capacity within the assessment and intervention process. Assessing both of these components may provide social workers with a clearer indication of the likelihood of significant maltreatment (Shemmings & Shemmings 2014, 2018).

Following the assessment process, many parents will require intervention to help them meet the objectives of the child protection plan. Intervention ideally should form part of the longer process of assessment as, arguably, only when parents are provided with the appropriate support to make changes is it possible to gain a clearer insight into the parent’s capacity to change. Therapeutic interventions that can help resolve traumatic incidences of childhood abuse have been shown to be effective (Shepherd *et al.* 2000, Bradley *et al.* 2005, Cohen & Mannarino 2008, Konanur *et al.* 2015, Reyes 2016), as well as parenting interventions designed to improve the parents capacity to mentalize (Cohen *et al.* 2002, Cicchetti *et al*. 2006, *Sadler et al*. 2013, Barlow *et al.* 2015, Grayton *et al.* 2017).

This thesis considers the connection between a parent’s exposure to traumatic experiences in childhood and their own parenting and the types of intervention that could be the most beneficial. Forrester (2016) notes that ‘we need urgently to address what can be done to reduce the need for care’. Current figures from the Department for Education’s (2017) national statistics paper reflects this need, as it states that from March 2017 there were 72,670 children in care, which was an increase of 3% compared to the previous year. Families being provided with adequate forms of intervention should therefore be a priority. Although the opportunities to provide intervention are restricted by government funding, this thesis will argue that providing the most effective and evidence-based approaches could save the local authority a large amount money in the long term. It will be proposed that the application of attachment theory and an understanding of the impact of attachment-based trauma provides a valuable framework for understanding the factors that can influence caregiving capacity, as well as what are likely to be the most useful methods of intervening.

This thesis seeks to make a positive contribution to the field of social work, and the findings may be beneficial to both practitioners and the families they work with. The theories, findings and concepts discussed and empirically examined aim to bridge the gap between social science and social care, or at the very least highlight the need for the construction and continuation of that bridge.

**Research Question**

**What factors affect the parental experience and outcomes of parent-infant intervention?**

**My own academic ‘journey’**

From a very young age, I have always enjoyed being around babies and children. Completing an A level in Psychology introduced me to the concept of attachment theory and I was fascinated and intrigued by it. My degree in Psychology and Education provided me with further insights, and I focused my dissertation on the impact that attachment experiences have on educational attainment and achievement. Whilst I had thought I may pursue a career within educational psychology, which was likely to consist of working with children who, in many cases have organic learning needs, what interested me more was the idea of working with children whose difficulties are attributable to their attachment experiences. I had wanted to train as a Child and Adolescent Psychotherapist and was advised that I needed some ‘life experience’ before embarking on such a career. This experience came in the form of a Family Support Worker role for children’s services.

I have been working within children’s services for eight years, during which my passion and interest to remain in this field has continued to increase. I am currently working independently as a Family Assessment Practitioner completing specific pieces of assessment and intervention work for families within child protection teams. My role over the past eight years has been varied and I believe it has taught me a good deal about the system, as well as the people who become part of it i.e. the professionals and the families. I have held cases within the ‘child in need’ team and have worked alongside social workers to complete assessments and interventions for cases held within ‘child protection’ teams. I also spent a year working in a mother and baby assessment unit in which I was responsible for providing the assessment and intervention to my allocated key families. It was physically and emotionally demanding, but it provided me with a unique opportunity to build professional relationships with parents and offer daily support and guidance that working for a local authority does not so easily lend itself to.

My role within the local authority and the assessment unit have contributed to the focus of this thesis as I have seen first-hand the impact that previous attachment-based trauma can have on someone’s ability to offer ‘good enough’ care to their child. I have also become increasingly aware of the significant lack of mainstream resources to provide parents with intervention that may increase their chances of becoming ‘good enough’. My roles have allowed me to apply theory directly into my practice and thus strengthened my practice, and my practice experience has strengthened my own personal contribution to theory.

I have attended a number of intensive training programmes during the last five years that have also influenced the focus of this thesis. I have been trained and accredited by Leiden University to provide Video-feedback Interaction to promote Positive Parenting (VIPP), which uses a mentalization-based approach to support parenting capacity. I have also completed a course at the Anna Freud Centre in order to become an accredited coder of Reflective Function using the Adult Attachment Interview (AAI-RF), which will be used within the methodology of this thesis. In addition, six years ago I attended a four day ARP (Attachment and Relationship Based Practice) training course. This was the first time I was taught about the significance of assessing the ‘carer’s state of mind’. This training programme has and will continue to shape my practice, as the tools and techniques that I was taught form an integral part of the parenting assessment and intervention work that I undertake.

Within the last few years, I have delivered Attachment and Relationship Based Practice training to social workers, contact supervisors and foster carers. I find it incredibly enjoyable and rewarding being able to work with delegates to use theoretical and research based knowledge, as well as practical examples from my own practice to aid them with theirs. I am also grateful for the opportunities I have had to be able to do this within my role as an honorary lecturer at the University of Kent, for their Centre for Child Protection. Training and lecturing has increased my awareness of the potential benefit of Psychology, in particular attachment theory, becoming more embedded within the core learning of social work qualifying courses. Discussions with students have also continued to provide me with insight and knowledge surrounding the experiences of many families within the child protection system.

**Structure of the Thesis**

This thesis consists of three parts. The first part is the literature review which comprises of four chapters. The first chapter introduces the concepts of attachment theory and the essential elements within the attachment relationship in order to consider these within the context of child maltreatment. The notion of intergenerational transmission of abuse is introduced with consideration given to genetic and environmental influences. The second chapter adds further to the exploration of intergenerational transmission of abuse by reviewing the literature on the impact that attachment-based trauma can have on the developing individual. Chapter Three focuses on the impact that unresolved attachment-based trauma has specifically on an individual’s parenting capacity and associated maltreating behaviours, as well as the way in which such behaviour can affect the child’s future prospects for offering appropriate care to their children, and therefore its role as a potential pathway for intergenerational maltreatment. The final chapter reviews the therapies and interventions that are likely to be most useful for parents with unresolved trauma who are at risk of displaying trauma-inducing behaviours towards their own children.

The second part features the research design and an explanation of why this research was deemed necessary, as well as discussion of the chosen methodology and methods used to answer the research question. The thesis findings and analysis are then discussed in the final section of part two.

The third and final part of the thesis discusses the findings within the context of existing theory and research, limitations of the findings, and suggestions for future research, as well as implications for social care policy and procedures. The chapter closes with final conclusions and reflections on completing the research.

**Chapter 1- Understanding the mechanisms of maltreatment**

The notion that the needs of an infant are far greater than simply a response to their physiological demands was first theorised by John Bowlby (1958). His earliest work drew on the principles discussed within Ethology, as he felt its concepts and methodology offered clearer insight into the ‘preverbal’ stage of development, of which he considered to be of great significance.

Bowlby was intrigued by the work of Lorenz (1937) on imprinting and other precocial birds (Bretherton 1992). This led to him theorising that an infant not only requires food in order for the formation of an appropriate bond but also requires comfort from, and close proximity to, its caregiver. This therefore challenged the psycho-sexual theory of Freud, as well as Kleinien dependency theory and secondary drive theory, which viewed the infant as in possession of purely physiological needs but not social needs (Bowlby 1958). Bowlby’s theory was operationalized by the innovative work of Harlow and Zimmerman (1958) demonstrating the impact of maternal deprivation on Rhesus monkeys and their innate desire for close physical contact.

Bowlby’s earliest work on ‘separation’ with children removed from their homes during the Second World War, or institutionalized, provided one of the first insights into the trauma of separation and loss (Laschinger 2008). In Bowlby’s (1960) paper ‘separation anxiety’ he made clear his belief that traditional theory did not adequately explain the intensity of the attachment relationship and the implications of separation (Bretherton 1992). The burgeoning of attachment literature and findings that followed Bowlby’s original work in the late 1950’s added further insight into the extent to which the quality of care the infant receives, and the subsequent attachment relationship, has a long lasting impact on the child’s psychological well-being, capacity for love, and the development of close and intimate adult relationships (Mayes 2010).

Another key concept developed by Bowlby was the implication of parental mental representations, also termed ‘Internal Working Models’, on attachment relationships and functioning. For many decades since its formation, this concept has continued to be applied in the assessment of the quality of the parent-infant relationship. Consideration is given to the mother’s view of the baby, of herself as a mother, and their relationship, as well as past and present significant attachment figures (Sleed & Fonagy 2010).

Mary Ainsworth is regarded as an additional highly influential figure in the expansion and application of Attachment theory. Her development of the attachment classification system was born out of her original observations of interaction between mothers and infants in the home, which was followed by the construction of a laboratory experiment referred to as ‘The Strange Situation’ (Ainsworth & Wittig 1969). During this experiment the child, aged between 12 and 18 months, is exposed to a brief period of separation from the mother and left alone in a room. They also spend time alone with a stranger, before being reunited with the mother. Ainsworth had particular interest in the balance of attachment and exploratory behaviours when the child is placed in a stress inducing environment, which this experiment artificially created (Bretherton 1992). This work added considerable strength to Bowlby’s theoretical framework, in particular the necessity of the caregiver to act as a ‘*secure base*’ and ‘*safe haven*’ for the infant. It has been fundamental in distinguishing variations in observable attachment behaviour patterns, classifying infants into one of three categories, Type A- Insecure Avoidant, Type B- Secure, and Type C- Insecure Anxious/Ambivalent.

This work was further added to by Main and Solomon (1990) as limitations of the original classification system had emerged. Observable behaviours of some children were difficult to classify into the three attachment categories established by Ainsworth. These were all children with known histories of abuse who demonstrated an absence of an organized strategy to cope with the stresses experienced in ‘The Strange Situation’, scenario (Bakermans-Kranenburg *et al*. 2005). Based on the presentation and histories of these children, the category of ‘disorganized’ was established. Rather than existing as a standalone category of attachment style, it presents as fleeting behaviours that occur under specific circumstances in which the child is experiencing ‘fright without solution’ (Hesse & Main 2000). Therefore, the child will also be classified as either insecure avoidant or insecure ambivalent with ‘disorganized’ attachment behaviour. This attachment style, and its impact, as well as the parental mechanisms associated with disorganized attachment behaviour will be explored in further detail in Chapter Three.

The Dynamic Maturational Model of Attachment offers an alternative view to that of Mary Main and was produced by Patricia Crittenden who, similarly to Mary Main, was a graduate student of Mary Ainsworth. The model views attachment patterns as ‘self-protective strategies’. Crittenden proposed that these ‘strategies’ develop as a result of the type of care experienced from their caregiver. The individual’s processing of their caregiving experience facilitates the development of ‘dispositional representations’ that are then used to produce the ‘self-protective behavioural strategies’ (Shah *et al*. 2010). Crittenden (2016) has also produced a model of patterns of attachment in adulthood, which is based on the individual’s extent of information processing distortion. It uses Ainsworth’s ABC patterns of attachment organized dimensionally, instead of categorically.

Main and Crittenden’s models do share some similarities in that they both use the ABC styles of attachment classification. Both paradigms acknowledge the impact that fear can have on the attachment behaviour of the infant. However, their viewpoints of what the infant does when experiencing fear induced by the caregiver differs greatly. As previously stated, Main developed the category of ‘disorganized’ attachment to describe the behaviour of the infant who experiences a breakdown of an ‘organized strategy’ when placed in an irresolvable fearful situation. Crittenden, however, argues that the fearful infant will behave in an ‘organized’ way and certain behaviours that Main believed to be dimensions of disorganization, such as disorientation, Crittenden believed to be strategic as they allow the child more time for ‘information gathering or processing’ (Crittenden, 1992). This disparity is best understood when considering their stance on what they believe to be the goal of the attachment system. Main viewed physical proximity to the caregiver to be the primary goal (Landa & Duchinsky 2013). Therefore, the infant experiences internal conflicts when approaching the caregiver, who they fear, which results in a state of ‘disorganization’. For Crittenden, the goal of the attachment system is the availability of the caregiver (Landa & Duchinsky 2013), hence why she believes the infant will act strategically to make their caregiver more available to them, rather than the view that they are experiencing a behavioural breakdown and disorganization. There are a very small number of comparison studies of these models, of which none of them have looked at application within infancy and no independent evaluations of the DMM model have been published to date. Mary Main’s work on ‘disorganization’ has, however, been empirically investigated and evaluated with a growing number of researchers and clinicians continuing to contribute to her original findings and working within the framework of infant disorganization.

Mary Main was also influential in the development of the Adult Attachment Interview. Main and her colleague Goldwyn (1994**)** devised the scoring system for this structured interview with Adults, in which they explore in detail the participant’s childhood experiences with their primary attachment figures and their mental representations in relation to these attachment relationships and experiences. After the interview, the participant’s answers are reviewed and coded, providing them with an adult attachment style in one of three categories: (i) Secure/Autonomous (ii) Insecure/Dismissing (iii) Insecure/Preoccupied. The Adult Attachment Interview is also able to identify specific parental variables that can directly impact on attachment relationships with their own children. These are unresolved loss and trauma, as well as low reflective function. The Adult Attachment Interview and The Strange Situation experiment have often been used in conjunction within the same studies to produce important findings on inter-generational attachment patterns. This will be explored later in this chapter.

From the initial findings established by its founders, attachment theory has continued to grow and develop. Its many components offer explanations for human behaviour, and its proven versatility has enabled it to be added to by various fields of social science, biological and neuro-developmental researchers (Howe 2005). This has led to attachment theory remaining a prominent force in understanding development, behaviour, and relationships ‘from the cradle to the grave’ (Bowlby 1979 p.129). Therefore, it does appear to be an appropriate framework to use when attempting to understand child maltreatment.

Attachment theory, with its emphasis on the importance of the mother-infant bond, has provided a platform from which to explore and seek further explanation around the impact on infants of receiving inadequate care from their parental figures. During the 1970s and 80s, there was an increased awareness around the numbers of children suffering from severe abuse. Consequently, attachment researchers were able to develop further insight into the trauma experienced during this abuse (Laschinger 2008).

There is a wealth of research documenting the destructive nature of significant childhood abuse and the detrimental, and potential long lasting, effects it can have on all aspects of human functioning (Neumann *et al*. 1996, DeOliveira *et al.* 2004, Cook *et al.* 2005, Boxer & Terranova 2008, Fonagy *et al.* 2007, Treisman 2017, van der Kolk 2017, Cook *et al*. 2017). This will be explored further in Chapter Two, specifically the impact of the trauma induced by severe childhood abuse and how this trauma can manifest itself in the mind and the body of an infant and then throughout an individual’s lifetime.

Research regarding the complexities of child abuse is an area that continues to grow and develop. Its relevance and necessity is attributable to its known impact, longevity, and the enormity of the challenge faced in our desire to eradicate it. The field has seen a transition from identifying attachment behaviour and categorising this, to looking at the impact and outcomes of abuse, and then a further desire to understand why this abuse has occurred and, therefore, why instinctual processes of caring for an infant have not developed. This shift has facilitated the more recent exploration of the necessary parenting behaviours that may not be present or are lacking within these abusive attachment relationships and the reasoning behind this.

Consideration will now be given to the literature and findings on specific parental capabilities that are deemed fundamental to the formation of attachment relationships and are thus identifiable as potential variables when examining parental difficulties. The first one to consider is mentalization.

The concept of mentalization derives from the work of French psychoanalysts and their findings within psychosomatics during the 1970s. They identified that a number of people with somatic illness had difficulties with mental representations (Hawkes 2011). They struggled in assuming an ‘intentional stance’ in relation to understanding the minds of others (Dennett 1989). During the late 90s and the decade that followed, Peter Fonagy, a psychoanalyst and clinical psychologist, and his colleagues explored the concept of mentalization further in their clinical work with patients with borderline personality disorder.

Allen and Fonagy (2006) have defined mentalization as ‘attending to states of mind in oneself and others…holding mind in mind’ (p.3). They have offered an additional definition that ‘Mentalization is simply about recognising what’s going on in our own heads and what might be going on in other peoples’ (Allen *et al*. 2008 p.203). The awareness of other’s mental states has important implications for our interpersonal relationships (Coates 2006). The ability to mentalize is therefore considered to be a crucial factor in parental behaviour and thus the formation of our attachment relationships. Other terms used within the literature to capture this ability include ‘Mind-mindedness’ (Meins 2015), ‘Insightfulness’, (Oppenheim & Koren-Karie 2002) and ‘Reflective Function’ (Slade 2005). Reflective Function is a concept developed by Howard and Miriam Steele, and it refers to mentalization within the context of the attachment relationship. Capturing the extent to which the parent is able to accurately consider what the child could be thinking and feeling and their ability to comprehend that their child’s experiences are different from their own.

The ability to mentalize varies within all individuals and can diminish under situations of severe stress (Fonagy 1999, Hawkes 2011), in particular, attachment related stress (Nolte *et al.* 2010, 2013). Fonagy and colleagues have evidenced that one’s capacity for reflective function is dependent on emotional rather than cognitive abilities (Fonagy *et al*. 2002a). Findings from Truman *et al.* (2002) support this work indicating that reflective function was poorer in a high-risk sample and that variations of reflective function within this group were attributable to other aspects aside from intelligence. However, Slade *et al.* (2005) note from their work using mentalization based therapy that being able to hold an idea or state in one’s mind and demonstrating flexibility when it comes to reflecting on this is associated with executive processing that is closely linked with a higher level of cortical functioning.

Possession of a ‘theory of mind’, as termed by Premack and Woodruff (1978), is considered to be ‘the hallmark of the intentional stance’ (Fonagy 1999), and what enables us to mentalize. Given the fact that mentalization refers to the ability to enter the mental world of another and respond appropriately to their thoughts, feelings and subsequent needs, it is not surprising that its presence is regarded by many as highly influential in the formation of our attachment relationships. A child who experiences a caregiver who is available to them, with the capacity to be reflective about their mental state, is more likely to have a secure attachment relationship (Fonagy *et al.* 2002a, McQuaid *et al.* 2008, Shai & Belsky 2017, Zeegers *et al.* 2017, Camoirano 2017). The strength of the attachment relationship is dependent on the caregiver’s ability to meet the child’s physical and social needs. The parent’s capacity for reflective function enables them to identify these needs and ensure they are responded to appropriately. Ainsworth (1969) noted the importance of the parent having to view their baby as an ‘autonomous’ person and, if not, then ‘her baby continues to be a narcissistic extension of herself’ (Bernier & Dozier (2003 p.360). Bernier and Dozier (2003) have commented that the ‘non-autonomous’ mother struggles to see their infant as separate from themselves. This therefore increases the likelihood of the parent failing to meet their infant’s needs sufficiently.

Fonagy (1991) and his colleagues used the Adult Attachment interview with parents to assess whether their mental representations of self and others were predictive of attachment security. He found that reflective function capabilities could reliably predict at the pre-natal stage the behaviour of the child during the strange situation procedure. Mothers and fathers who received high scoring for reflective function were three or four times more likely to have children classified as ‘secure’, than those parents with a low score, thus instrumentally evidencing the significance of reflective function within the attachment relationship.

Elizabeth Mein’s research has focused on parental assessment of reflective function, which she terms ‘mind-mindedness’. Her definition of this concept centres on the parent’s ability to see their child as an individual in possession of an independent mind of its own. In order to interpret their child’s cues correctly, she feels the parent needs to understand the mental state of their child during this time (Meins 1997). Mein’s findings have demonstrated that parent’s reflections on their child’s behaviour when watching their child through a video and during free play were predictive of attachment security, theory of mind and stream of consciousness performance, and these results have remained valid years after the original observations were made (Meins & Fernyhough 1999, Meins *et al.* 2001, 2002, 2003). Furthermore, her work has continued to evidence the influence of mind-mindedness on attachment patterns and caregiving dynamics (Meins *et al.* 2012, Meins *et al.* 2014, Meins 2015, Meins *et al.* 2016, Meins *et al.* 2017).

The philosopher Hegel (1807) believed ‘It is only through getting to know the mind of the other that the child develops full appreciation of the nature of mental states’ (Fonagy 2011p.27). The parent’s capacity for reflective function not only impacts on attachment security but also the child’s own development of being able to accurately understand and predict the thoughts and feelings of others (Fonagy & Bateman 2016), as well as knowing that other people’s minds consist of thoughts, feelings, and intentions that differ from their own. This is thought to be facilitated by the caregiver through ‘complex linguistic and quasi-linguistic processes’ (Fonagy, 2006 p.77). The inter-subjectivity of this process is that the child’s ability to understand the caregiver’s mind is reliant on the caregivers desire to understand and offer containment of the child’s mental states (Fonagy *et al.* 2002a). Fonagy’s (1995**)** longitudinal study of 92 children produced some of the first findings in support of this, reporting that children with a secure attachment classification were twice as likely to pass a ‘false belief task’ and the parent’s own reflective function capacity was also positively associated with the pass rate. Meins *et al.* (1998, 2014) have reported similar findings, noting the association between attachment patterns, mind-mindedness, and ‘theory of mind’ task performance. Research has also connected mentalization in adolescents with maternal mentalization (Rosso *et al.* 2015), and the vulnerability for later developing a personality disorder (Fonagy *et al.* 2018).

The child whose parent has low reflective abilities is also vulnerable to experiencing negative intentionality towards them. This consists of the parent misinterpreting their child’s behavioural signals and attributing them to deliberate negative intentions towards them or others (Lieberman *et al.* 2005), many of which may be beyond the child’s cognitive capability. Meins *et al.* (2001) evidenced the influence of this, reporting that it was the appropriateness of the maternal references to the child’s state of mind that was most influential on attachment security, rather than the number of maternal references that are made.

Having discussed the concept of mentalization and reflective function a second parental capability to consider within the context of social work and maltreatment, due to its impact on attachment relationships, is emotion regulation, also referred to as affect regulation. Attachment has been defined as ‘the dyadic regulation of emotion’ (Sroufe 1996). Fonagy *et al.* (2002a) described the attachment system as ‘an open bio-social homeostatic regulatory system’. The infant is highly dependent on the parent’s regulation of their negative affect. If not, their emotional states become extremely overwhelming to them (Joyce 2010). Emotion regulation is, therefore, regarded within the literature as a key component within the formation of positive attachment relationships.

The process of emotion regulation is closely intertwined with one’s ability to demonstrate reflective function, as it is reliant on the parent accurately identifying the emotional need of the child and responding in such a way that negative emotions are removed, and the child is able to return to a state of ‘emotional equilibrium’ (Schore 2010). The child therefore learns that when the caregiver is present their emotional arousal will not bring about a state of ‘disorganization’ that is beyond their coping capacity (Fonagy 1999).

A number of attachment theorists and researchers have referred to the need for the caregiver to act as a ‘mirror’ in relation to their response to the infant’s emotional states (Winnicott 1957, Fonagy 1999, Fonagy *et al.* 2002a, Sharp & Fonagy 2008, Tronick 2009, Pederson 2014). Winnicott (1957) wrote, ‘What does the infant see when he looks at his mother? He sees himself’ (p.131). The caregiver is required to mirror the child’s emotional state but also ‘marks it’ with an additional facial expression that is not compatible with the child’s. Therefore, demonstrating that they themselves have internalized the negative affect of the infant and are thus able to cope with it (Fonagy 1999, Fonagy *et al.* 2002a). This has been referred to as ‘representational mapping’ and provides the child with valuable information regarding their own internal states (Fonagy, 1999). A caregiver who is unable to accurately mirror the infant’s emotional state may project an image onto the infant that does not accurately depict their state or it is an exaggerated version. The infant may then internalize this inaccuracy as part of the self (Sharp & Fonagy 2008), as well as remaining in a state of emotional dysregulation.

Infants who regularly experience emotional dysregulation are likely to be vulnerable to the negative effect this can have on their development and functioning. If the infant does not receive an adequate response when in a state of distress, then they are forced to use ‘all their regulatory resources’ (Schore 2001), in a bid to relieve the stress for themselves. However, this is at the detriment of their cognitive engagement with their surrounding environment, as in doing so they are unable to engage in anything else (Tronick & Weinberg 1997p.56). This process may have developmental implications causing potential difficulties; in particular in ‘socio-emotional learning,’ (Schore 2001).

A caregiver who is appropriately attentive to the emotional needs of their infant should in turn facilitate the development of self-regulation. Schore (2010) states that ‘If attachment is the regulation of interactive synchrony, then attachment stress is an asynchrony of psychobiological attunement’ (p.21). The ‘affect synchrony’ within the attachment relationship provides the necessary emotional repair to support the process of self-regulation (Schore 2010). The capacity to self-regulate enables the individual to cope with negative emotional states as they are able to find solutions and strategies within themselves to deal with this, and eventually relieve themselves of the dysregulation. Individuals who are lacking in this capacity are believed to rely on external support, on whom they can project their negative experiences (Hawkes 2011). The impact of insufficient self-regulatory capacities is explored further in Chapter Two.

Thus far in this chapter, there has been an exploration of attachment theory and parental capabilities that are highly influential in the formation of the attachment relationship and the development of the individual. The remainder of this chapter will consider the literature in relation to the intergenerational transmission of abuse in order to explore further the underlying mechanisms that may contribute to maltreatment.

The intergenerational transmission of abuse appears to be a contentious area of research. This is largely due to varying psycho-social perspectives on how we acquire abusive behaviours and the assumptions that have often been made in relation to the statistical rate of transmission, as well as the complexity of providing empirical evidence that is methodologically sound. The social learning perspective proposes that there are three developmental processes a child will go through when acquiring maltreating patterns of behaviour. These are (i) observational learning (ii) modelling and (iii) reinforcement (Maccoby *et al.* 2005). In this sense, the theory asserts that witnessing abusive behaviour within the home exposes the child to its existence as well as its appropriateness (Widom 1989) and subsequent acceptance. The attachment perspective offers the viewpoint that transmission of abuse is due to our construction of internal working models for ourselves and others, which we acquire from our early relational experiences. In children who have been abused, the transmission of abuse can therefore occur due to the development of negative internal working models of themselves and/or others. This in turn can increase the chance of them suffering with relational and behavioural difficulties in their future social and attachment relationships (Milner *et al.* 2010, Riggs 2010, Hawkins & Haskitt 2013). Attachment scholars propose that it is this cognitive internal working model of the parent-child relationship that passes through generations and not the maltreating behaviour. However, the model does, of course, influence these behaviours (Maccoby *et al.* 2005).

There appears to be an assumption outside of the academic literature that children who have been maltreated are highly likely to go on to abuse children of their own. Garmezy (1974) referred to this viewpoint as an ‘etiological error’. In Widom’s (1989p.24) literature review, she concluded her paper by discussing her desire to avert the ‘intergenerational transmission of misinformation’. In addition, she discusses the fact that research in the 70s and 80s did bring into question the accuracy of a ‘violence breeds violence’ hypothesis. She notes that Steele and Pollack (1968) were amongst the first to discuss observations of intergenerational transmission of abuse. Despite their acknowledgement of the limitations of their work and their forewarning that they should not be considered tangible findings, their study during the late 90s was regarded as one of the most commonly cited in strength of intergenerational transmission.

 Past research into the transmission of abuse rate has provided statistical findings ranging from 18-40% (Hunter & Kilstrom 1979, Kaufman & Zigler 1987, Egeland, Jacobvitz, & Paptola, 1989 Oliver 1993, Pears & Capaldi 2001). Of those who provided an estimated rate of 30%, they have stated that approximately one third of those abused will go on to become abusive towards their own offspring. However, there does appear to be some conflict in relation to what happens to the other two thirds. Oliver (1993) stated that one third will go on to abuse, one third will not and the others will remain vulnerable to abusive behaviour. However, Kaufman and Zigler (1987) assert that the other two thirds will not go on to repeat these patterns of behaviour.

It is a widely conceived notion within the literature that being maltreated as a child increases your risk of maltreating your own children. However, the path one follows to get from one to the other is deemed ‘far from direct or inevitable’ (Kaufman & Zigler, 1987). Current researchers and findings suggest that a great deal more needs to be done in terms of replication of studies that have looked at the mechanisms and mediating pathways of the transmission of abuse (Bernier & Dozier 2003, Maccoby *et al*. 2005, Berlin *et al*. 2011, Oliveria *et al*. 2012, Bartlett *et al.* 2017).

The validity of much of the research has been criticized due to its methodological limitations. Firstly, the majority of findings have derived from studies that have used a retrospective design causing accuracy of information to be considered, in some cases, weak and questionable, therefore potentially leading to an inflated rate of transmission. There is also a likelihood of bias self-reporting given that data is often based on personal accounts (Pears & Capaldi 2001, Simons *et al*. 1991, Widom 1989). In addition, participants in possession of insecure attachment styles are believed to be more likely to have limited self-awareness and insight into their levels of insecurity, which could also influence their narratives (Read & Gumley 2010).

A range of definitions relating to maltreatment subtypes and thresholds of abuse that have changed over time has impacted on frequency and replication of findings (Pears & Capaldi 2001, Newcomb & Locke 2001, Widom 1989). In addition, Berlin (2011) discusses the need for separating the categories of physical abuse and neglect due to the fact that individuals may possess more explicit memories of physical abuse than neglect. Given the nature of these studies, in that participants are often reporting on their past parenting experiences as well as their own present parenting behaviour, findings are susceptible to the bias associated with using the same person’s account for both the independent and dependant variables (Simons 1991 Pears & Capaldi 2001).

Widom’s (1989) review commented on weak sampling techniques that consisted of opportunity and convenience samples, but it would appear from more recent reviews that sampling techniques have not been as heavily brought into question. However, Widom also raised the issue of a lack of comparison and control group matches on factors such as social economic status, and this appears to remain a limitation within the more recent research. Her recent 30 year follow up study included matched comparisons, and highlights the potential influence of detection and surveillance bias on transmission findings (Widom *et al.* 2015). Ertem *et al*. (2000) reviewed studies published between 1965 and 2000 and found that only ten studies provided data on abuse within two generations and used control groups. Regardless of the issues raised in relation to the methodology used when researching the intergenerational transmission of abuse, this work has generated theories and findings that have been widely accepted and developed upon.

Examining the idea that a parent who suffered abuse by a parental figure may carry those memories and experiences from their past into the present and how this can influence their relationship with their own child, is a concept that Selma Fraiberg (1975) famously termed ‘Ghosts in the nursery’. This phrase has since been used by theorists and practitioners when further exploring the mechanisms behind transmission of abuse. Predating this concept, Freud’s (1920) psychodynamic principle of ‘repetition compulsion’ has also been considered to be useful in understanding transference of behaviour. Originally based on his work on patient analyst transference, this facilitated the development of identifying parental transference within the parent-infant relationship and the necessary therapeutic interventions that could follow (Jones 2010).

Similarly to the concept of ‘Ghosts in the nursery’ the psychoanalyst Fairbairn (1951) was of the viewpoint that it is not that the parent is compulsively repeating negative attachment behaviours, but rather they are being ‘haunted by bad objects’ (p.166) and have no defence mechanism of which to prevent their return. Lieberman (2005) however, refers to parents ‘grimly’ re-enacting their experiences of childhood relational trauma with their own children. Both viewpoints, although offering differing ideas in relation to the mechanism by which it occurs, describe how negative past parental relationships can influence the present attachment relationships.

The ‘Ghosts in the nursery’ are believed to have a detrimental impact on the parenting capacity of the parent. This may take the form of a parent unknowingly projecting repressed thoughts, feelings and emotions on their infant during interaction (Jones 2010). In addition, there may be cases whereby the child represents a figure of attachment of which the parent carries significant feelings of hate and rage towards (Lieberman 2005). Closely linked with the concept of mentalization, the parent fails to view the child as an individual who has a separate mind and intentions and instead the child’s existence and behaviour merges with the parent’s past negative relational memories (Fonagy, Target, Steele, & Steele, 1997, Ensink 2014). When this occurs the infant can be frightened by the parental response to them, which can appear out of context in relation to their own internal state. It is this lack of synchrony, as described earlier in this chapter, which can lead to dysregulation and later self-regulating difficulties.

The notion of ‘Ghosts in the nursery’, whilst discussed amongst theorists and practitioners, appears to be somewhat poetic in nature and therefore one must look at empirical ways of measuring and testing this concept. This has predominantly been done through the assessment of attachment styles using the ‘Strange Situation’ and the ‘Adult Attachment Interview’ to measure attachment within the two generations. Both of these assessment tools have been described in detail at the beginning of this chapter.

Central to the empirical testing of the transmission of attachment styles is the way in which The Adult Attachment Interview (AAI) measures parent’s mental representations of their childhood attachment experiences. Main *et al.* (1985) discussed how as researchers, their re-conceptualization of individual differences in attachment organization, as individual differences in the mental representation of the self, allows for further exploration of attachment in older children and adults, not just infants, with an additional focus on representations and language. During the mid-1990s this led to a central hypothesis emerging that parent’s mental representations of their own attachment experiences greatly impacted on the quality of their child’s attachment to them (van IJzendoorm 1995).

Mary Main’s work in the mid-1980s identified a match of 75% in relation to the blind coding of the AAI interviews and strange situation coding of secure versus insecure attachment styles (Main *et al.* 1985). Main highlighted similarities in behaviours across generations, noting that infants who were avoidant of interaction with their mother during the reunion period correlated with having a mother who persistently struggled to recall childhood memories. This avoidance was still prominent when the child was tested again at age five. The findings from van IJzendoorn’s (1995) pertinent meta-analysis have often been described within the transmission literature as they demonstrate the strength of the influence of the parent’s adult attachment style on their child. In addition, this influence has also been confirmed when adult attachment was tested prior to the birth of their baby (Fonagy 1999). There is also evidence to suggest that it is not just the child’s own attachment experiences that can lead to maltreatment within their own families but also their observation of the interaction of their parent with their siblings (Crittenden 1984).

The specific classifications coded within the Adult Attachment Interview (AAI) are Autonomous, Preoccupied, Dismissing and Unresolved. Empirical findings based on using the AAI with the parent and the strange situation experiment with the child has shown that autonomous individuals are likely to have infants who are classified as secure, preoccupied individuals are likely to have infants who are ambivalent, and dismissing individuals are more likely to have avoidant infants (Bernier & Dozier 2003). Similarly to the ‘disorganised’ attachment category, the ‘unresolved’ adult attachment category is assigned in conjunction with one of the three primary attachment classifications just described. This is due to the fact that, similar to disorganised attachment behaviour, the ‘unresolved’ state only occurs under specific circumstances in which the individual experiences a disorganized mental state when relaying traumatic experiences to the interviewer (Riggs & Jacobvitz 2002).

Van IJzendoorn (1995) theorised that autonomous adults respond more appropriately to their infant’s attachment signals than preoccupied or dismissing adults. In contrast to this, dismissing parents may fail to respond appropriately as the emotional expression in the child may trigger memories of their own negative attachment experiences. These parents are likely to be rejecting in response to their child’s need to be close to them, which in turn facilitates the development of an insecure avoidant attachment style. He discussed how preoccupied parents may struggle to respond to their child’s signals in a way that is predictable due to their preoccupation of thoughts with their own attachment experiences. These parents have been found to be more likely to suffer with suicidal ideation than the other adult attachment categories (Riggs & Jacobvitz 2002).

It is believed that unresolved parents are likely to behave in one of two ways towards their infants. Either they will appear physically fearful of them, or they will behave in a way that is frightening towards them (Hesse & Main (1990). Findings from clinical populations have linked unresolved states of mind with emotional and psychological difficulties. This has included psychiatric hospitalization and criminal behaviour (Allen *et al.* 1996), as well as borderline personality disorder (Fonagy 2000). The parental behaviours associated with an unresolved state of mind in relation to trauma and the impact of this on the child will be explored further in Chapter Three.

It is therefore apparent within the literature that the parent’s own attachment style is likely to have a significant role in the transmission of negative parental behaviour. Research has recently started to look beyond the rather broad concept of transmission of attachment patterns and has examined the impact that specific parental mechanisms, such as mentalization (reflective function) have on this intergenerational cycle of negative parental behaviour. These capabilities have provided a more specific focus on mechanisms behind parenting behaviours rather than the use of the broader term of ‘parental sensitivity’. Van IJzendoorn’s (1995) landmark meta-analysis found that parental sensitivity offered an inadequate explanation of the transmission of attachment classifications. In fact it was noted that sensitivity accounted for only 23% of the association between infant security and subsequent adult state of mind.

The ability for a parent to demonstrate reflective function has been regarded as a key component in the intergenerational transmission of attachment patterns (Fonagy & Target 2005, Slade *et al*. 2005, Berthelot *et al.* 2015). Fonagy, with his colleagues, has demonstrated a link between a mother’s capacity for reflective function and her own adult attachment classification, her child’s attachment classification and the child’s own capacity to reflect on the thoughts and feelings of others. Bernier & Dozier (2003) reported ‘striking’ findings in their research, which examined the extent to which mind-mindedness (reflective function) could account for the relationship between adult attachment state of mind and infant attachment security. They note that ‘mind-mindedness accounted for the totality of the predictive power of state of mind on infant attachment’. Meins and colleagues (2012) have continued to document that mind mindedness is a better predictor of attachment security than maternal sensitivity for the majority of parent-infant dyads. These findings therefore imply that a low capacity for reflective function has the potential to create negative intergenerational attachment patterns.

The capacity to offer sufficient emotional regulation to the infant when in a state of high arousal is also considered a mechanism by which maltreating behaviour may pass through generations (Mayes 2010). As previously mentioned in this chapter, it is commonly noted within the literature that a child who remains in a dysregulated state may struggle to develop the capacity to self-regulate (Schore 2010). The lack of such a capacity can lead to a number of negative behaviours during childhood (Cook *et al*. 2003). These could include impulsivity, irritability and aggressiveness, which are hallmark behaviours for an anti-social personality disorder, and parents with these characteristics could be more likely to demonstrate harsh or abusive parental behaviours (Pears & Capaldi 2001). In addition, in adolescence these individuals who may have deficits in their capacity for self-regulation may develop a dependency on the use of drugs and alcohol as a way of self-soothing negative emotional states (Suh *et al.* 2008, Fletcher 2015, van der Kolk 2016). Such behavioural difficulties and potential dependencies are likely to impact on the individual’s parenting capacity and subsequent response to their own infant’s emotional demands and thus a transmission of negative behavioural and parental traits may pass from one generation to the next.

There are also findings that suggest that where intergenerational abuse occurs, this can be attributable to a combination of factors. Research that has focused on the causes of sexually abusive behaviour has found that although being sexually abused was considered a risk factor for becoming a perpetrator of sexual abuse, being exposed to a set of highly stressful interlinked abusive experiences, without the existence of appropriate protective factors resulted in negative outcomes (Bentovim 2002). Past and present life stressors have been found to elevate the risk of negative parenting behaviours (Widom, 1989). Individuals who have experienced abuse may be more likely to experience family and environmental stressors and social dynamics such as unemployment, social isolation and poor housing that may increase the risk of child maltreatment (Newcomb & Locke 2001).

The final element to consider when examining the transmission of abuse is the role of genetics. With a shared genetic makeup of 50% between parents and their infants, the role of genetics should be given consideration when exploring the transmission of abuse. Certain genetic elements may have a contribution to make in bridging the ‘transmission gap’ (Bakermans-Kranenburg & van IJzendoorn 2007), given their impact on parental functioning and therefore the subsequent functioning of their offspring.

Research has tended to include the examination of environmental factors as well as genetics in order to gain insight into the influence that both may have on each other. Two hypotheses have been formulated; the first is that an individual has a genetic ‘differential susceptibility’ (Belsky, 1997, Boyce & Ellis 2005) and may be more susceptible to negative or positive parental care and therefore may experience the negative or positive associated outcomes of this. The second hypothesis is ‘genetic vulnerability’ (Paris 2000, Rutter 2006), which postulates that the child possesses a genetic susceptibility if they receive negative parental care and therefore experience the associated negative outcomes. The concept of genetic vulnerability may offer insight into the resilience that some children exhibit having experienced particularly anomalous parenting (Madigan *et al.* 2006).

One of the first molecular genetic studies relating to attachment was conducted by Lakatos and her colleagues (2000). Previous studies had found an association between the DRD4 gene polymorphism and pathological impulsive behaviour, as well as substance abuse in adults. In addition, an association has also been found between this gene and children developing ADHD (Bakermans-Kranenburg & van IJzendoorn 2007). Lakatos *et al.* (2000) used the ‘strange situation procedure’ together with genetic testing and their findings evidenced an association between the dopamine D4 receptor, DRD4 7-repeat allele and disorganized attachment behaviour. A second study with the same participants was also conducted by Lakatos and colleagues (2002), which included the analysis of the functional -521 C/T single nucleotide polymorphism. They found that the association between disorganised attachment behaviour and the DRD4 7-repeat allele was stronger when the -521 T variant was present. The chance of being classified as disorganized increased tenfold in those children who were in possession of both the DRD4 7-repeat allele and the -521 C/T genotype within the upstream regulatory region of the DRD4 gene. Therefore, this implies that genetic combinations as well as the presence of single genes could impact on the outcomes for the individual.

Bakermans-Kranenburg and van IJzendoorn’s (2007) research review on genetics and attachment commented that Lakatos’ (2000) findings needed replication due to the fact that multiple gene effects are the result of a high number of statistical tests, which are susceptible to false positive results. They expressed the need for replication, rigorous testing and meta-analysis, as the link between DRD4-7 and disorganized attachment when tested in six samples with a combined sample size of 542 dyads showed no significant effect. They conclude that a combined gene and environment explanation may provide more sufficient empirical evidence rather than a sole focus on genetic factors.

A further widely referenced study that also supports the need for gene and environment investigation was a longitudinal cohort conducted by Caspi and colleagues (2002), which investigated the association between maltreatment, monoamine oxidase-A (MAOA) gene activity and anti-social behaviour. Their findings indicated that those males with low MAOA activity who were also maltreated in childhood had higher anti-social scores. Males with high MAOA did not score highly on anti-social behaviour despite having experienced childhood maltreatment. This study therefore highlights the importance of examining environmental factors alongside genetic. This notion is also supported by research that has indicated genetics alone cannot account for the transmission gap (O’Connor & Croft 2001, Dozier *et al*. 2001).

Environmental factors that have been tested alongside genetics have included specific parental behaviours such as maternal sensitivity. Findings from Bakermans-Kranenburg & van IJzendoorn (2006) study examining maternal insensitivity indicated support for a gene-environment interaction as they found children with the DRD4 7- repeat allele and a mother who scored as ‘insensitive’ displayed more externalising behaviours, such as aggression and oppositional behaviour, than children without this genetic polymorphism. Maternal insensitivity alone without the presence of the DRD4-7 repeat polymorphism was not associated with increased externalising behaviour. Those children with the DRD4 7-repeat allele and a sensitive mother received the lowest scoring of externalising behaviour, thus demonstrating the significance of combined genetic and environmental factors. When examining the influence of unresolved loss and trauma van IJzendoorn & Bakermans- Kranenburg (2006) also found an association between the DRD4 7-repeat allele and disorganised attachment when the mother was experiencing unresolved loss and trauma. There is also evidence to suggest parental genetic factors alone may influence maternal sensitivity with the first study conducted by Bakermans-Kranenburg & van IJzendoorn (2008) demonstrating that parents with potentially less efficient variants of the serotonergic (5-HTT) and oxytonergic (AA/AG) system genes showed lower levels of sensitive responsiveness to their toddlers.

The concept of Epigenetics may offer further explanation of generational cycles of maltreatment as it examines how environmental influences can cause changes in gene expression that are inherently passed between family members. These epigenetic changes can occur during mitosis and meiosis and can continue across four generations (Anyway *et al.* 2005). Thus, in some cases, despite removal of the original environmental stimulus the behaviours associated with particular genetic alterations can still occur (Pretorius 2010).

Animal studies, specifically involving rat pups were the first to produce the most significant findings in this area, most likely due to the fact they removed the interference of a large number of confounding variables (Maccoby *et al.* (2005). Meaney’s (2001) findings demonstrated that differing levels of maternal care (pup licking/grooming) altered DNA structure at a glucocorticoid receptor gene promoter in the hippocampus of the rat pup, such changes influence stress regulatory capacity and can therefore impact on future care giving of their offspring. Weaver *et al.* (2004) offered further support for this finding, in that their study, which also used rat pups, found that in those rats that had received a higher level of maternal care the glucocorticoid receptor gene gradually ‘demethylates’ causing it to become more active. This increase in activity was associated with rats that developed to be calmer in temperament, whilst those who had not gone through this genetic alteration were more anxious and prone to disease.

Research that has used human samples includes the work of Bygren *et al.* (2014) who traced ancestry from the 19th century to demonstrate the epigenetic influence of the Swedish famine. In addition, Cecil *et al.* (2016) identified patterns of epigenetic changes linked with adolescents who had been maltreated. Moore *et al.* (2017) have conducted the first epigenetic investigation on living parent-child dyads. They assessed the influence of maternal contact with infants on the epigenetic signatures later on when the children were 4-5 years old. Although there were no candidate gene DNA methylation sites significantly associated with maternal contact, when DNA methylation was explored across the genome differences were detected between the groups who had received high and low contact.

 O’McGowan *et al.* (2009) findings have added further insight in relation to the influence of the glucocrticoid receptor gene. They examined the differences in glucocorticoid receptor (NR3C1) via post-mortem analysis of the hippocampus of suicide victims who had a history of childhood abuse, against suicide victims with no history of abuse. Those individuals with a past history of abuse had lower levels of the glucocorticoid receptor gene, which was associated with higher levels of DNA methylation in the same glucocorticoid promoter region. It is not possible to understand whether the abuse was responsible for the potential epigenetic change, but it highlights the necessity for more research that can add further clarity to be conducted.

The past decade has seen the emergence of empirical evidence that highlights the links between genetics, maladaptive behaviour and the potential intergenerational transmission of abuse. However, there does appear a need for more research to be done, as well as replication and meta- analysis of existing findings. Regardless of this, it is perhaps more likely the case that there is an intertwining of genetic and environmental factors rather than one versus the other when it comes to examining the role of genetics. These findings seem to have important implications in terms of the necessity for appropriate intervention in order to halt the transmission of maladaptive functioning caused by attachment trauma, which may then impact on the genetic composition of future generations.

This chapter has discussed the formation of attachment theory and the various measures that have been created to explore it empirically. Two important aspects of parenting capacity have been introduced, which are mentalization and emotion regulation. The widely acknowledged influence of both of these on the developing attachment relationship means that associated theories and research findings concerning them will continue to feature within all chapters of this literature review. The influence of parental unresolved trauma on parenting capacity has not been covered in detail within the discussion of transmission of maltreatment in this chapter, but is the focus of Chapter Three. Chapter Two will now examine the impact of relational childhood trauma on the individual, in order to provide the context for later examination in Chapter Three of the impact this can have on the individual when they become a parent, and potential intergenerational cycles of abusive and/or neglectful behaviour.

**Chapter 2- The Impact of Attachment Trauma**

Attachment based trauma can consist of varying types, severity and longevity of abuse, and there is a substantial amount of research documenting the multitude of ways this can influence development. No child is likely to have experienced exactly the same traumatic incidences with an entirely similar outcome. However, with more awareness of the prevalence of significant maltreatment, as well as advances in neuroscience within the last two decades, there has been an increase in research relating to the impact of attachment based trauma. Given that children’s social care is primarily a service that deals with cases of abuse and/or neglect, this extensive knowledge base is likely to be particularly relevant and will be explored throughout this chapter.

The human mind and body has the capacity to overcome moderate levels of event based trauma such as accidents, car crashes, involvement in natural disasters. Medical intervention enables our bodies to heal and in most cases our minds will process these events as one off accidents or occurrences and the normality of life that resumes helps to make this possible. In some cases, individuals may suffer with post-traumatic stress disorder (PTSD) and will need to seek further therapeutic intervention. Although symptoms relating to this condition may place a strain on the individual’s relationships, their ability to function appropriately within close relationships is not likely to continue to be affected in the long term. However, if the trauma they endured has been relational in nature, with a potential attachment figure, then the impact on relational and psychological functioning is likely to be far greater.

This premise is supported by the research of Sagi-Schwatz *et al*. (2003) who investigated whether the traumatic experiences of the Holocaust survivors impacted on their attachment relationships and the generation that followed. They found that the survivors themselves showed more ‘unresolved loss’ on the Adult Attachment Interview and scored higher on measures of stress and anxiety. However, there was no significant difference between the daughters of the survivors and the control group in relation to attachment representations, anxiety, traumatic stress reactions and maternal behaviour towards their own infants. They concluded that the survivor’s attachment relationships with their own children were not impacted by this trauma due to the fact that the traumatic experiences were not inflicted by their parental figures, and prior to the trauma of the holocaust they had experienced ‘normal’ relational experiences.

Kulka *et al.* (1990) analysis of data from the Vietnam’s war veteran’s readjustment study, however, demonstrates the influence of previous attachment trauma when combined with event based trauma. They concluded that veterans who had an unstable family environment, childhood anti-social behaviour and prior trauma history were at a significantly higher risk of developing PTSD. Therefore, for those veterans who had experienced attachment based trauma this impacted heavily on their resilience and coping strategy when faced with later additional event based trauma. Bessel van der Kolk (2014), an expert trauma therapist and researcher, discussed how the patients he saw following the Vietnam War helped him to formulate his ideas and establish his well-respected concepts within the psychodynamic field of the impact that attachment based trauma can have on the mind and body.

This chapter will explore the ways in which attachment based trauma has the potential to be significantly destructive and detrimental to an individual’s development and functioning. Attachment trauma refers to significant incidences of abuse and/or neglect whereby the perpetrator of such abuse is someone whom the child considers to be a caregiver. This type of trauma is thought to conjure up feelings of terror and helplessness in the child, as well as fear of abandonment and disintegration, which can threaten their sense of ‘psychic survival far beyond the moment of actual threat’ (Benamer &White 2008 p.2).

Attachment theorists have devised two categories for discussion of attachment based trauma. ‘Big T’ trauma, which relates to sexual abuse, rape, death and physical abuse and ‘Small T’ trauma, which includes neglect or a depressed or chronically mis-attuned carer (Neborsky 2003). The effects of ‘Small T trauma’ are deemed to be just as detrimental on the developing child as ‘Big T Trauma’ as it is often characterised by sustained and repetitive incidences of emotional abuse (Walker 2007).

In terms of the assessment of attachment trauma, there are certain factors that have been identified for consideration when assessing the impact of these experiences. Trauma caused by someone whom the child views as a direct caregiver can be more destructive, as well as the younger the child was at the time of the abuse, the length and severity (Cozolino, 2002, Brewin 2003). In addition, the previous care that the child may have received prior to the incidences of maltreatment and the availability of alternative care and support, during and after these events, can affect the outcomes for the trauma victim (Bentovim *et al.* 2009). Cook *et al*. (2005) emphasise the importance of ensuring that assessments of trauma are ‘forensically sound and clinically rigorous’ by reviewing the full extent of complex trauma exposure and post traumatic outcomes.

‘The Complex Trauma taskforce’ within the National Child Traumatic Stress Network, which consists of a number of leading experts within the field, are campaigning for a formal diagnosis for children who have suffered significant attachment related traumas. At present there is no diagnostic term that accurately captures the wide ranging effects of traumatic abuse on the development and functioning of the child. The Complex Trauma taskforce set out a proposal for the diagnosis of ‘Developmental Trauma Disorder’ (van der Kolk *et al.* 2009). They did not feel that the diagnosis of post-traumatic stress disorder covers the severity and complexity of symptoms experienced by children who have been traumatized by maltreatment. The diagnosis of post-traumatic stress disorder was designed for adults. Therefore, diagnosing it in children is challenging due to the subjectivity of symptoms and the reliance on verbal discussions with the patient (Shmid *et al.* 2013). Less than 25% of the children receiving treatment for trauma induced psychopathology under the National Child Traumatic Stress Network meet the criteria for PTSD (D’Andrea 2012). This therefore demonstrates the inadequacy of PTSD being the only available diagnosis for these patients.

Van der Kolk *et al.* (2009) state that the diagnosis of ‘Developmental Trauma Disorder’ would consist of three additional criteria inclusive of the symptoms of post-traumatic stress disorder. These criteria include symptoms of emotional and physiological dysregulation/dissociation, problems with conduct and attention regulation and difficulties with self-esteem regulation and managing social connections. The establishment of such a diagnosis could be beneficial in educating professionals and the members of the public on the impact of severe maltreatment and subsequent traumatisation in childhood. It may also impact on legislation and practice within child protection (Schmid *et al.* 2013) by providing clearer guidelines on effective prevention and intervention (van der Kolk 2008).

At present, there are professionals and researchers who do not support such a proposal as it is thought it will impact negatively on the use of current diagnostic manuals such as DSM-IV-TR and ICD-10, which are based on identifying symptoms and diagnoses rather than focusing on the cause (Schmid *et al.* 2013). However, others are of the view that a diagnosis based on childhood victimization could in fact reduce diagnostic confusion and provide a more focused treatment approach relating directly to the impact of biopsychosocial dysregulation (D’Andrea *et al*. 2012).

Despite the proposal being supported by a large portion of data findings, as well the members of the National Association of State Mental Health (that serves 6.1 million people annually), The American Psychiatric Association has rejected it. They did so on the grounds that there was too little evidence to support DTD featuring in DSM-5. They felt that the connection between early childhood adverse experiences and developmental disruptions were based more on ‘clinical intuition’ than ‘research based fact’ (van der Kolk 2017). Van der Kolk (2017) has responded by stating that this explanation is a ‘blatant lie’, which aims to ignore the ‘devastating effects of childhood trauma’.

Chapter One outlined the infants’ need for the mother to provide regulation of their emotional states during times of high arousal. In cases whereby the child is subjected to traumatic experiences within the attachment relationship, this process does not occur as the parent is in fact the source of emotional dysregulation. The child’s inability to regulate their own emotional state is considered to be one of the most significant effects of traumatic stress (van der Kolk 2008). When the distressing state induced by the caregiver is relentless, the child is thought to have difficulty processing thoughts and emotions, and as direct result of this they can’t effectively comprehend what is occurring, resulting in an inability to formulate effective plans to remove themselves from the situation (van der Kolk & Fisler 1995, van der Kolk 2017).

Behaviours of traumatized children are thought to be best understood in the context of attempts to regulate their distress and reduce potential threat (Pynoos *et al.* 1987, Cook *et al.* 2005, van der Kolk 2016). These children may respond to emotional stimuli at a much more rapid pace and may display more extreme behaviour during tantrums, thus requiring a longer period of time than other children to calm down after emotional episodes (Schmid *et al*. 2013). This behaviour also places them in a more vulnerable position in terms of the development of peer relations, as well overall socio-emotional development (Maughan & Cicchetti 2002, van der kolk 2014, Treisman 2017, De Thierry 2017).

Individuals who have difficulties in their ability to regulate their emotions may display some behaviour that could mislead professionals into thinking the child may meet the criteria for an autistic spectrum disorder. This includes behaviours such as difficulties in awareness of emotional states, disorganization when transitioning from one action to another and over or under reactivity to touch and sounds (Schmid *et al.* 2013). In addition, maltreated children under experimental conditions have been found to show difficulties in understanding and expressing emotions (Pollack *et al.* 2000). When these behaviours are present coupled with rigid behaviour patterns and resistance to changes in routine (Cook *et al.* 2003), then the chances of a possible misdiagnosis of an autistic spectrum disorder increase further. Treisman (2017) notes that many children who have experienced relational and developmental trauma can present with an ‘alphabet soup’ of potential diagnoses. Misdiagnosis of disorders for traumatised children such as ADHD, ADD, and ODD may also occur given that these children can display symptoms such as poor impulse control, self-destructive behaviour, difficulty understanding and complying with rules and oppositional behaviour (Cook *et al.* 2003, Cook *et al*. 2017)

Closely linked with the difficulties traumatized children experience in relation to emotion regulation is a potential immaturity in the child’s sensory and perceptual systems leading to difficulty in attending to emotional cues (Pollack, Cicchetti & Klorman 1998, Dvir *et al.* 2014). A number of researchers have focused specifically on maltreated children’s responses to angry cues within an experimental setting. For those children who have experienced a significant level of physical abuse, images of anger are likely to be associated with imminent threat thus requiring a higher proportion of the child’s attentional resources (Pollack & Tolley-Schell 2003). A large number of empirical studies have produced findings that support this (Pollak *et al.* 2000, Pollak & Kirstler, 2002, Pollak & Sinha 2002, Pollack & Tolley-Schell 2003 & Cicchetti & Curtiss 2005, Masten *et al.* 2008). More recently McCrory *et al.* (2011, 2013) evidenced that maltreated children had increased activation in the amygdala and interior insula when processing angry faces.

In addition to increased fearful responses to anger, traumatized children can interpret neutral behaviours as negative and hostile (Schmid *et al.* 2013). Thus a hyper-vigilance within the traumatized child can lead to increased emotional and physical responses to negative and neutral stimuli and these are the children who may also have the most difficulty in self-regulating and returning to a state of ‘emotional equilibrium’.

When difficulties with emotion regulation persist, with a lack of stable and consistent relationships, both externalizing and internalizing behaviour may occur. Externalizing behaviours are inclusive of anti-social behaviour and extreme levels of anger and/or suicide attempts. Internalizing behaviours are chronic depressive disorders and suicidal ideation (De Bellis 2001). A number of studies have demonstrated that traumatized children can have difficulties with management of aggression, impulse control and oppositional defiant behaviour (Ford *et al.* 2009, Cook *et al.* 2005, Cook *et al.* 2017). Fonagy and Target (1999) attribute these behaviours to complex defence mechanisms developed within a traumatic attachment relationship. Bentovim (1995) made reference to a ‘Trauma organised system’, which refers to the individual ‘creating an aura of violence’ with the use of aggression and threat and in doing so they project their own sense of victimisation onto another individual (Bentovim 2011). They can also project parts of themselves that they wish to disown on to another individual, which creates strong feelings of hate towards them in order to displace it from the self (Crabtree 2010).

The previous experience of trauma in which the child felt extreme helplessness may also lead to displays of aggression in a bid to control and dominate another individual. Traumatized children may have grave difficulty linking their behaviour with their feelings and relating this to what has happened to them in the past (van der Kolk 2008). Therefore, trying to reduce high levels of aggression within these individuals is a challenging task both for the individuals themselves and any professionals whom they may be working with.

Chapter One introduced the concept of mentalization. One key aspect of this is being able to accurately understand the thoughts and feelings of others. Attachment based trauma can limit the extent to which this ability develops within the child. When the attachment relationship is characterized by abuse and hostility, the child may use an adaptive defensive strategy of deactivating their capacity to mentalize (Fonagy 2011). During this process, the child can intentionally disregard contemplating the content of the mind of the abuser due to the callous nature of the intentions of harm towards them (Fonagy *et al.* 2002a). This will inevitably have developmental implications in terms of the child’s own capacity to mentalize and their desire to want to understand the mental states of others. This is also likely to lead to deficits in their ability to empathise, which requires one to be able to accurately understand the feelings of another, leading to further difficulties within social and intimate relationships.

Both children and adults with an inability to mentalize are likely to function in one of three ways. The first is termed ‘Psychic equivalence’ whereby the individual processes information in a very literal way with extremely limited opportunities for alternatives ‘how it seems is how it is’ (Fonagy 1999). The second is ‘pretend mode’ in which the person experiences feelings and ideas as representational or symbolic, with no implication for the outside world. The last is that of ‘teleological mode’ in which the validity of thoughts and feelings is reliant on observable actions (Allen *et al.* 2008). The developing child who acquires the ability to mentalize will move through each of these stages and provided they receive appropriate mentalized responses from the caregiver they will then transition to a ‘mentalistic intentional viewpoint’ (Fonagy 1999). Fonagy proposed that the pre-school child with a history of disorganized attachment behaviour experiencing fear of their caregiver, and who is controlling and inflexible in thought patterns and behaviour, is likely to have failed to transition beyond the stage of ‘psychic equivalence’. Therefore, often thoughts and feelings are experienced with a similar level of intensity felt during particular traumatic incidents causing their behaviour to often appear out of context within the present situation.

In the case of abusive attachment relationships, the child is likely to have experienced a caregiver with a poor capacity to mentalize for them who misinterprets their actions and minimizes their thoughts and feelings. They also experience trauma and hostility that is unpredictable and illogical, which results in confusion for the child, in terms of trying to understand and make sense of the thoughts and feelings of their caregiver. This can lead them to internalize that such a process is ineffective therefore not worth pursuing (Shemmings & Shemmings 2011). The result of this is likely to be an individual who not only lacks interest in the thoughts and feelings of others but also greatly struggles to differentiate between their experiences and those of others, potentially impacting significantly on their behaviour and social functioning. The extent to which this impacts on their parenting capacity when they become a parent later in life is explored in Chapter Three.

Peer relationships are also likely to be jeopardised when taking into account the symptoms expressed by traumatized children such as the potential displays of violence and aggression and difficulties reading social and emotional cues. Bolger *et al.* (1998) noted that the maltreating parents in their study had fewer peer relationships, therefore they may not offer appropriate role modelling in respect of the positive dynamics of friendships.

Children who have experienced interpersonal trauma often suffer with low self-esteem (Cook *et al.* 2003, &, Cook *et al*. 2005, Kim & Cicchetti 2006, Passanisi *et al.* 2015) low self-efficacy (D’Andrea 2012) and low self-worth (Burack *et al.* 2006). All of which can be risk factors for the development of later adolescent psychopathology (Daigneault *et al.* 2006, Cook *et al.* 2017).

In relation to the development of ‘the self’, Winnicott (1984) introduced the concept of the ‘false self’, which he believed develops in children whose needs are insufficiently met, coupled with emotional neglect. He believed the constant misattunement experienced by the child prevents them from forming a clear concept of themselves and instead a ‘false self’ is formed. Sleed and Fonagy (2010) discuss how in a neglectful environment ‘the material for constructing an image of oneself is oneself alone’. Children who experience significant maltreatment consequently may develop a fixed sense of self that does not accurately reflect their nature. In order to try and make sense of the abusive behaviour, the child may internalize that they are unlovable and deserving of this abuse (Lieberman & Amaya-Jackson 2005). Continual abuse reinforces this thought process further as the child learns that the most predictable pattern of thought is ‘I’m unlovable’ (Shemmings & Shemmings 2018).

The child’s belief in their inherent badness is believed to provide a sense of control as it provides an explanation for the abuse (De Zulueta 2011). In addition, believing themselves to be ‘bad’ allows the child to view his attachment figures as ‘good’ (Fairbairn 1952), which is thought to sit far more comfortably in the mind of the child. In addition, it also offers the child a sense that if the abuse is attributable to them then they can have some control over what happens to them in the future (Fairbairn 1952 p.65-67). Fairbairn termed this concept ‘moral defence’ and stated that without this process of thought the child would experience extreme levels of anxiety that would sever their attachment relationship with their parent (Crabtree 2010), therefore leaving them more vulnerable.

The potential rigidity of the complex defence mechanisms used by traumatized children means they may suffer from a lack of flexibility in patterns of thought. Making clear distinctions between thoughts and feelings and the reality of what they are experiencing is likely to be a struggle (Fonagy 2006). Van der kolk (2008) states that these children have no ‘internal map’ with which to guide themselves, therefore they react to situations rather than making plans for how to respond. He also discusses how they often demonstrate their needs through behaviour rather than entering into discussions about their feelings, due to difficulty in describing feelings and internal experiences (van der Kolk 2014) as well as problems with the processes of acknowledging and describing internal states (Cook *et al.* 2017). These defence mechanisms and subsequent difficulties may understandably lead to problematic situations within school environments and if the child has been removed by the local authority are also likely to impact significantly on interactions within foster care or residential settings.

The following section will examine the contribution that the field of neuroscience has made in increasing our understanding of the impact of attachment based trauma.

The attachment relationship has been referred to as a ‘major organizer’ in the development of vital neurobiological structures and functioning within the infant brain (Fonagy & Target 2005, p.304). Schore (2001) asserts that trauma induced by a perceived caregiver is qualitatively and quantitatively more likely to have a psycho-pathogenic outcome on the individual than any other form of social and physical stressor. He makes reference to the ‘vulnerability matrix’, which surrounds the child who experiences early interpersonal trauma in relation to child and adult mental health difficulties. McCrory *et al.* (2017) similarly make reference to the ‘latent vulnerability’ of the child exposed to maltreatment.

Luu & Tucker (1996 p.297) refer to the child’s brain as being ‘mutable’ and therefore its organization reflects the ‘history of the organism’. The vulnerability of the infant’s developing brain means exposure to traumatic attachment experiences may have a more detrimental effect than if experienced later in their lifetime. These effects are believed to span across multiple domains of functioning impacting on physical, cognitive, emotional and behavioural development. McCrory *et al.* (2017) note that neuroscience has the potential to improve our understanding of these effects, which is important for the progression from treating psychopathology to formulating effective preventions to reduce the chance of certain disorders developing.

Findings from animal studies were amongst the first to offer evidence on the impact of maltreatment on neurodevelopment. Within the last two decades, this work has been greatly strengthened through the use of medical technological advancements in neuroimaging. This has enabled researchers to use human participants to generate far more valid and applicable data. However, due to the nature of the participant group when studying previous incidences of traumatic maltreatment, there will continue to be limitations to such research in terms of difficulties obtaining large sample sizes, as well as gaining samples whereby the abuse and neglect that they have suffered is controlled and thoroughly documented (Brown & Ward 2013). Regardless of this, there is still a plethora of insightful and potentially influential neurodevelopmental findings to be discussed.

There is evidence to suggest that trauma impacts on the integration and functioning of the right and left brain hemispheres. In the case of a normally developing child, a natural shift occurs between right hemisphere dominance, which is responsible for our senses and emotions, to a more prominent use of the left hemisphere, which is responsible for language, reasoning and longer term planning (Cook *et al.* 2003). Greater left hemisphere activity has been found amongst children classified as more resilient (Curtis & Cicchetti (2007). However, the brains of traumatized children may not go through this transitional process and trauma experts within the National Traumatic Stress Network believe that this can account for ‘irrational’ behaviour when exposed to stressful stimuli. They state that under stress these children are therefore unable to use the necessary left brain hemisphere functions to process what is happening to them and in fact these capacities disintegrate leaving them in a disorganized and often highly emotional state (Cook *et al.* 2003).

Schore (2001) suggests that early trauma interferes with the development of the right brain hemisphere, which is central to the processing of attachment behaviours, and is where the ‘internal working model’ of attachment relationships is stored. He states that impairments in the right hemisphere are reflected in the behaviour of infants categorized as ‘disorganized’ can significantly impact on an individual’s capacity to cope with stressors, which can increase their vulnerability to the development of Post-Traumatic Stress Disorder (PTSD) and interpersonal violence. Therefore, it would appear that development of the right hemisphere can be compromised in children who experience early trauma within their attachment relationships, and yet, as discussed above, these individuals are more prone to right hemisphere dominance. This could result in the child struggling to effectively process environmental stimuli and respond appropriately.

The literature detailing the impact of maltreatment on the size of the developing infant’s brain has been the subject of some debate and criticism. Specific critics will be discussed at the end of this section. However, there are empirical findings that do appear to offer some insight into how brain mass and the volume of certain structures within the brain can be affected by traumatic maltreatment (De Bellis *et al.* 1999, Carrion *et al.* 2001, De Bellis *et al.* 2002). Teicher and Samson’s (2016) review does, however, note that in some cases when data was corrected for differences in intracranial volume the maltreatment related alterations in grey and white matter volume disappeared. Therefore, further research is needed to offer more conclusive evidence.

The body’s response to stress activates a number of biological mechanisms within the neuroendocrine system. Documented within the field is evidence to suggest that severe trauma in childhood compromises the functioning of the neuroendocrine system due to the subsequent dysregulation of the parasympathetic and sympathetic nervous systems. When exposed to stressors, the sympathetic nervous system provides the individual with the commonly termed ‘fight or flight’ response. A state of ‘hyperarousal’ is associated with the ‘fight’ response, conversely a state of ‘hypo-arousal’ is associated with a ‘freeze’ response. At times of hyperarousal, increased levels of adrenaline and noradrenaline have been found to be released (McCrory 2010) leading to cardiac acceleration and an increase in blood pressure and respiration levels (Schore 2010).

Under the extreme stress of maltreatment, the infants elevated level of arousal can formulate a pattern of response that will be repeatedly triggered regardless of the actual level of threat. This has been referred to as the infants ‘embedded response pattern’ and due to the fact that it occurs on an involuntary and subconscious level, this pattern of response can be difficult to change (Moroz 2005 p.6). These individuals can find themselves in a continued state of hyperarousal, which has been linked to compromised brain development (DeGregorio 2012). This can also result in hypersensitivity causing children and adolescents to demonstrate reactive behaviour even to incidents of low level stress (Brown & Ward 2013). This is most likely due to the fact that the brain regions that demonstrate ‘hypersensitivity’ to stress cues are also associated with emotion regulation (Elsey *et al.* 2015).

Two key areas of the brain located within the limbic system that are widely documented as being vulnerable to alterations from exposure to stress and trauma are the hippocampus and the amygdala. Their neurological role would appear to increase the likelihood that functional changes could occur when a child is exposed to maltreatment. The hippocampus is a key part of the limbic area of the brain responsible for forming, encoding and retrieving memories (Teicher *et al.* 2003, Nadel, Campbell, & Ryan 2007). Trauma is believed to impair the integrational function of the hippocampus (Sigel 2017a).

The amygdala is thought to be fundamental in processing threat and fear. Its central role in the detection of dangerous stimuli (McCrory 2017) has led to it being referred to as ‘the smoke detector’ of the brain (van der Kolk 2017). In addition, Louis Cozolino (2017) refers to this area of the brain as being ‘the elephant who never forgets’ because when traumatic incidences occur these are often not forgotten. The role of the amygdala in responding and processing trauma is widely acknowledged within the psychotherapeutic field.

A reduction in size of the hippocampus has been reported in adults who were maltreated as children (Vythilingam *et al*. 2002, Teicher *et al*. 2003, Vermetten *et al.* 2006, Danlowski *et al*. 2012). However, as McCory *et al.* (2010) highlighted in their review, this has not been reported within studies that have used children and adolescents, leading them to suggest that reduction in hippocampus size may be the result of prolonged suffering of PTSD in adulthood rather than a direct link to maltreatment. Teicher and Samson’s (2016) review of the neurological findings connected with maltreatment identified 30 papers that documented significant differences in hippocampal size for adults who had experienced maltreatment. However, they reported findings that suggest that females may be less affected. Similarly to McCroy *et al.* (2010) review they also noted that the association was less established in studies that used children and adolescent samples. This fits with the hypothesis that there may be a ‘silent period’ between exposure to maltreatment and subsequent observable neurological differences (Andersen & Teicher, 2004).

In relation to the amygdala, the data on potential alterations in volume and functioning is varied. Woon and Hedges (2008) meta-analysis reported no significant differences in amygdala volume between children diagnosed with child maltreatment related PTSD or controls. However, Teicher & Samson’s (2016) review reported increased volumes, predominantly in those who were exposed early to emotional and or physical neglect, whilst others have documented significant reductions in studies using adult or adolescent samples who had experienced multiple types of maltreatment during their development. In addition, they note that increased volume of the amygdala has been associated with neglect and reductions being more closely connected with abuse.

 Whittle *et al.’s* (2013) finding suggest that the timing of the maltreatment may be the cause of this difference as they reported that early experiences of maltreatment could increase volume whilst later experiences could cause a decrease. Interestingly, Kuo *et al.’s* (2012) study with combat veterans showed that amygdala volume was reduced after service but only in those who had a previous history of child maltreatment. These findings imply that early experiences of abuse could cause the amygdala to be more vulnerable to changes later in life during periods of intense stress or threat.

Mixed findings have also been documented in studies that have focused on brain activity in maltreated samples. Puetz *et al.* (2016) reported reduced activity in the amygdala in children who had been maltreated. They felt this was attributable to a ‘hypo-aroused’ state in response to socially threatening stimuli. Hypo-arousal and dissociation will be discussed in more detail later in this chapter. White *et al.’s* (2012) findings on amygdala activity add further to the combined genetic and environmental debate discussed in the previous chapter as they reported increased amygdala activity in adolescents who had experienced neglect but only those who had the FK506-binding protein 5 (FKBP5) gene.

 Although the findings relating to the amygdala appear to vary, potentially based on age, hypo or hyper aroused responses and genetics, the evidence to date suggests that exposure to attachment based trauma can cause alterations in its size and functionality. Both functional and structural abnormalities in the amygdala have also been linked to a number of psychiatric disorders (Teicher & Samson 2016).

The Hypothalamus Pituitary Adrenal (HPA) axis is another key response system during exposure to stress. Stressors trigger the HPA axis to release the corticotrophin releasing hormone (CRH), this binds to receptors, which then stimulates the secretion of adreno-cortico-trophic hormone (ACTH), which in turn binds to receptors within the anterior pituitary stimulating the release of glucocorticoid hormones such as cortisol (McCrory 2010). The manipulation of the postnatal handling of rats has proven to be one of the strongest models of investigating the development of stress responses (Francis & Meaney 1999). Associations have been reported between minimal handling and higher levels of anxiety with a less productive HPA stress response (McCrory 2010). Anisman *et al.* (1998) discussed findings for protracted early maternal separation of rats, demonstrating that rats that had experienced 24 hours of separation had an enhanced ACTH and corticosterone response to a stressor, as well as a reduction in CRH binding sites. Despite the fact that these findings have occurred with a sample of rodents they do offer some insight into the potential biochemical impact of neglect.

Coplan *et al.’s* (2001) findings have added further to this work by demonstrating the long lasting effect that a brief period of early exposure to stressors can have on the functioning of the HPA axis. During their first study in (1996) they manipulated the availability of food that the primate mother could forage for the duration of 12 weeks. By placing her in this highly stressful situation, she responded less well to the needs of her young, resulting in her young primates experiencing elevated levels of cerebrospinal fluid (CSF) and concentrations of corticotrophin releasing factor (CRF). Their follow up (2001) study revealed that as adult primates these rats continued to have elevated levels of (CSF) and (CRF).

Increased cortisol levels are thought to impair the connecting neural pathways from the prefrontal cortex to the amygdala resulting in less inhibition by the prefrontal cortex of activity within the amygdala. The impact of this is believed to be an increased reactivity to even mild stressors (Brown & Ward 2013). The literature in relation to the extent to which exposure to the stressors of child maltreatment impacts on secretion levels of stress related hormones such as CRH, ACTH and cortisol has provided varied findings. Putnam *et al.* (1991) reported increased morning cortisol levels in girls who had been sexually abused. Cicchetti and Rogosh (2001) found that maltreated children with internalizing and externalizing problems had elevated cortisol levels. In addition, Weems and Carrion (2007) found an association between increased cortisol secretion and childhood interpersonal trauma could predict the reduction in size of the hippocampus.

Conversely there are findings that have documented reduced or blunted concentrations of cortisol, CRH and/or ACTH in maltreated children (Hart *et al.* 1995, De Bellis *et al.* 1994, Murray-Close *et al*. 2008,). Tarullo & Gunnar (2006) attribute the variation in findings to the fact that elevated levels will only be present when there is the presence of coexisting affective disorder. This accounts for Kaufmans (1997) findings of increased ACTH response amongst those maltreated children regarded as ‘depressed’ who remained within the stressful environment. In addition, similar findings have been noted in relation to cortisol levels of those who had been maltreated and had an additional diagnosis of depression showing elevated cortisol measures (McCrory *et al.* 2010). Hawes (2009) meta-analysis identifies additional factors that could impact on cortisol levels such as comorbidity of disorders, internalizing and externalizing behaviour, and the intensity of early environmental stress experienced. Rachel Yehuda’s (2017) work has been influential in highlighting the lower levels of cortisol found in adults diagnosed with PTSD and therefore developing the theory that the function of cortisol is in fact to signal to the body that things are ok. In this sense, it has been referred to as an ‘anti stress hormone’ (van der Kolk 2017). It would appear that further exploration of hormonal stress responses is required.

The majority of neurodevelopmental studies have focused on structural brain regions and levels of activity with significantly less findings relating to cognitive functioning (McCrory *et al.* 2010). During episodes of inter-relational trauma, the child’s resources that would usually be assigned to promoting development and functionality instead are believed to be used to process danger and threat (Cook *et al.* 2003), thus cognitive development may be in some way compromised.

Findings have suggested that abuse can impact on activity in the middle front and medial frontal areas of the brain (Carrion *et al.* 2008). Attention bias away from threatening stimuli (Pine *et al.* 2005), deficits in attention and concentration (Porter *et al.* 2005) and in visual-motor integration, auditory attention, problem solving, abstraction and planning (Nolin & Ethier 2007) have all been evidenced. In addition, Ayoub *et al.* (2006) reported that the severity of interpersonal trauma predicted the extent of problem solving deficits in maltreated children. Finally, Dillon *et al.* (2009) reported an association between blunted responses to reward predicting cues and deficits in learning from rewards as well as motivation. However, McCrory *et al.’s* (2017) review of the neurological findings relating to child maltreatment reported that the current data on cognitive function should be viewed with caution, as it may not be reflective of ‘cognitive processes’ but rather ‘cognitive vulnerabilities’ that could have been present regardless of exposure to maltreatment.

In order to strengthen the connection between attachment based trauma and neurodevelopment, there is a need to look at the impact of specific parental behaviour. Allan Schore has been particularly influential in relation to this area of research, as he has integrated both psychological and biological models in order to offer important theoretical insight into social and emotional development.

Schore (2001) discusses how the traumatic interaction the infant experiences from an abusive and/or neglectful caregiver induces severe negative affect states. He notes this type of caregiver is not viewed as accessible or available to the infant and their response to the emotional expressions and demands of the infant are often minimal, rejecting, and/or unpredictable. This caregiver behaviour is believed to distort their infant’s level of arousal. Schore (2001) states that a physically and emotionally abusive caregiver induces high levels of stimulation and arousal, whereas a neglectful caregiver induces extremely low levels. Schore (2001) asserts that both of these extreme levels of arousal are usually long lasting and can cause significant alterations in relation to the biochemistry of the infant’s brain, particularly to structural areas associated with the development of the child’s resilience and coping strategies.

The limbic system, particularly the amygdala, is primarily responsible for the processing of emotions and is believed to be associated with the development of attachment related behaviours. Schore (2001, 2010) discusses how during infancy there is a crucial period of growth of the limbic system and periods of early dysregulation lead to ‘chaotic alterations’ and ‘imprinting’ within this system, which subsequently leads to emotion regulation difficulties. ‘Limbic irritability’ has been reported by Teicher and his colleagues (2016) as the symptom most strongly associated with childhood maltreatment (Teicher *et al*. 2006, Teicher *et al.* 2010, Teicher & Vitaliano 2011, Teicher & Parigger, 2015).

 A neglectful caregiver, who does not offer their infant the necessary interactive repair when they are in a stress induced state of emotional dysregulation, can expose the infant’s limbic connections to increased levels of excitotoxic neurotransmitters, such as cortisol and glutamate (Schore 2001). Increased levels of glucocorticoids (steroid hormones) have been reported to induce ‘neuronal cell death’ within the limbic circuits during the postnatal period (Schore 2001). This may therefore compromise a number of aspects of neurological development and functioning and could account for some of the findings discussed previously.

The application of neurodevelopmental findings within the field of social work has led to vehement debate amongst a number of academics. Sue White has documented her position through a number of papers and conference presentations. Wastell & White (2012) argue that the application of neuroscientific research that is influencing social policy is receiving limited criticism and as such is being used as ‘powerful trump cards’ within social care legal proceedings. In addition, the notion that there is a ‘window of opportunity’ for parental input in order to assist in essential neurodevelopmental growth and functioning is one area of contention amongst White and fellow academics. In Eileen Munro’s (2011) review of child protection, it details findings that state that the most severe neurological impairments occur during the first eighteen months of a child’s life.

Bruce Perry, a clinical psychiatrist, with expertise within the field of childhood trauma, has coined the phrase ‘use it or lose it’ when referring to this time sensitive period of neurological development (Perry 2002). His study that produced neuro images of the brains labelled ‘normal’ and ‘extreme neglect’ were featured on the front page of Graham Allen’s (2011) government paper on ‘Early Intervention’. Perry has, however, voiced his concern that neurological findings can be overstated and misunderstood leading to potential ‘bad polices’ (Lewis and Boseley 2010).

Brown and Ward (2013) in their paper titled ‘Decision making within a child’s timeframe’ discuss the developmental implications if infants do not receive appropriate care and stimulation within a ‘pre-determined timeframe’ preventing them from progressing appropriately through their developmental milestones. They draw on neurodevelopmental findings of Perry and others in support of the stance that environmental input during the first three years determines whether synapses function appropriately or are subsequently lost.

 Significant opposition to this notion has been documented by a number of academics. Bruer (1999) published ‘The myth of the first three years’, which criticises the use of research relating to children’s timeframes as not robust enough to influence social policy in the way that it has done. White continues to be in agreement with this stance and offers fierce opposition in relation to the existence of a time limited window of opportunity for neurodevelopment and writes that such a concept threatens ‘real debate’ (Wastell & White 2012). Macvarish (2015) is a further critic who objects to the use of ‘neuro determinist arguments’, which she feels are being used to increase state funding of interventions. Many of the academics who oppose the application of neuroscience within social work intervention believe that such an approach is neglecting to consider the influence of wider social issues on family functioning such as, poverty, unemployment and housing concerns.

White asserts that a focus on time limited opportunities for intervention is instigating the removal of young children from their families from a very young age in order to prevent long lasting damage, when in fact the plasticity of young infant’s brain reduces the chance of such effects. Brown & Ward (2013) are, however, also in agreement with the concept of ‘plasticity’. For now, it appears that the continuing increase in neurodevelopmental research and the presence of individuals who wish to apply this growing knowledge base to the understanding of maltreatment, specifically intervention, is likely to ensure the debate will continue for many years to come.

Neuroplasticity is still a relatively new but important discovery as it suggests that under certain conditions the brain can ‘rewire’ or ‘recalibrate’ itself. Sonuga-Barke (2017) notes that the scope, limits and clinical significance of this phenomenon remains unclear given the limited clinical evidence from human studies. There are, however, some empirical findings that have demonstrated how damaged neural pathways due to childhood trauma can be corrected with specific methods of therapeutic intervention (Hosier 2013). Meditation and mindfulness are being explored as methods to bring about positive alterations in neuro activity (Davidson 2008, Teicher & Samson 2016).

To conclude this section on neurodevelopment, it would appear that a large number of neurological findings suggest that traumatic childhood maltreatment and neglect can compromise neurodevelopmental processes and subsequent functioning. However, this relationship is ‘complex’ given that a number of alterations are present in both those suffering with difficulties and those regarded as ‘resilient’ (Teicher & Samson 2016) Therefore, the mechanisms that foster resilience are believed to be an important area for future research (McCrory *et al.* 2017).

This field of neuroscience is making progress to overcome some of the criticisms made during the past few years, namely that the tolerance levels for the acceptance of statistically significant results need to be far higher than normal due to the effects of ‘noise in the machine’. This ‘noise’ was evidenced by Craig Bennett’s (2009) work with a ‘Dead Atlantic Salmon’ that was placed in an fMRI scanner and yet demonstrated some neuro activity. This light hearted experiment highlighted the potential for false positives to emerge and therefore the need for statistical significance to be much higher. Belsky and de Haan (2011) cautiously note that neuroscientific research remains in the ‘embryonic stage’ of its development. McCrory *et al*.’s (2017) review asserts that the field must learn from the limitations that are present in many of the studies to date in order to improve the levels of confidence in its findings. It is therefore clear that in order to move from the ‘embryonic’ to the ‘foetal’ stage further replication, increased statistical significance, larger sample sizes, and longitudinal analysis would be beneficial.

Mental Health is an area of study that in many cases is believed to be closely linked with the individual’s early interpersonal experiences. Mental Health conditions and diagnoses associated with attachment trauma will now be explored.

The stress response of the infant who experiences traumatic maltreatment was explored earlier in this chapter. The psychobiological mechanisms associated with the process of ‘hyperarousal’ were previously discussed. However, a different response pattern can be to enter a state of ‘hypo-arousal’. Bowlby (1973) captured this contrasting state by expressing that maltreated children respond to the world ‘by shrinking from it or by doing battle with it’ (p.242).

Dissociation is believed to be another mechanism the body can use to manage the stress of traumatic experiences (Cook *et al*. 2003). The mind can enter a state of altered consciousness when placed in a situation that is psychologically traumatizing (Loewenstein 1996). Described as a ‘hole in the mind’ (Bentovim 2011), the individual will enter a ‘trance-like state’ with the additional loss of a sense of time and spatial surroundings (Schmid *et al*. 2013). It is believed to be a passive defensive survival strategy (Schore 2010), that can continue into adulthood. It is also thought to be an adaptive strategy as if this process did not take place then the individual may experience a significant mental breakdown (Shemmings & Shemmings 2011).

Exposure to the trauma of experiencing significant maltreatment by an attachment figure is believed to significantly increase the likelihood of entering into dissociative states of mind (Schmid *et al.* 2013, Moroz 2005, Briere 2002, Berthelot *et al*. 2012, van der Kolk 2014). This derives from feeling as if there is ‘nowhere to run and no one to turn to’ (Mollon 2001 p.218). Interpersonal trauma can begin from the start of a baby’s life and as such dissociation has been observed in young babies, also referred to as ‘petit mal seizures’ (Joyce 2010), whereby the infant withdraws from interaction and appears blank and expressionless (Schore 2010). At the point at which this withdrawal takes place, the mind of the infant can no longer tolerate the unpredictability of the care that they are receiving (Joyce 2010).

Dissociation compromises the child’s ability to develop self-regulatory behaviours (Cook *et al*. 2005), as well the capacity to mentalize (Fonagy 2011, Allen 2012). A child who experiences continual trauma can become dependent on dissociation as their main coping strategy, the consequence of which can be problematic behaviour management and difficulties with the formulation of their own self-concept (Cook *et al*. 2017) and coherency of their sense of self (Cook *et al*. 2003). The dissociative state that a traumatized individual assumes could be the result of chronic trauma. However, it can progress into a significant mental health disorder in its own right requiring clinical and therapeutic intervention (Schore 2001, Cook *et al*. 2003). One potential diagnostic outcome is the development of Dissociative Identity Disorder (DID). Steele (2011) states individuals with this diagnosis are thought to have felt ‘chronically unloved’ due to the fact that the care they received alternated between abuse and neglect, this in turn can manipulate and mutilate the developing personality. In an attempt at survival, multiple personalities are formed within the dissociative state (Steele 2011).

Dissociation is prevalent amongst individuals with a diagnosis of Post-Traumatic Stress Disorder (PTSD), (De Zulueta 2011). The literature relating to PTSD remains influential and indicates a significant association between childhood interpersonal trauma and PTSD in adults (Widom 1999, Famularo *et al*. 1994, Mayes 2010, De Zulueta 2011). Children and adolescents who consequently suffer PTSD as a result of their abuse are considered to be the ones most severely affected by it and it is believed that it is the interpersonal nature of such abuse that significantly heightens the risk of developing PTSD (De Bellis 2001).

PTSD symptoms are inclusive of, but not limited to, intrusive thoughts (that sometimes include hearing the voice of the abuser), flashbacks, dissociative episodes, and psychological distress when exposed to triggers that remind the individual of the traumatic event (De Bellis 2001). De Bellis (2001) states that PTSD responses are best understood in terms of dimensions rather than a categorical diagnosis. However, the majority of clinical studies define PTSD categorically with an ‘all or none outcome’. De Bellis (2001) reviewed the literature on rates of PSTD diagnosis for victims of significant childhood abuse. He reported that rates of PTSD resulting from sexual abuse ranged from 42-90%, and 50% in the case of physical abuse. Sullivan *et al*. (2006) found links between development of PTSD after emotional and sexual abuse but not with other types of abuse including neglect. Associations between neglect and PTSD have however been documented (Thompson *et al*. 2000, De Belllis *et al*. 2009, Nikulina *et al*. 2010).

A number of links have been found in relation to PSTD and cortisol levels. Yehuda *et al*. (1997) reported that survivors of road traffic accidents who went on to develop PTSD had lower level cortisol responses following the incident. Similar findings have been recorded in relation to women who had been historically sexually abused showing lower levels of cortisol when receiving emergency medical treatment and a subsequent increased chance of developing PTSD (Resnick *et al*. 1995). These findings link in with Yehuda’s (2017) theory discussed earlier that the function of cortisol is to aid in the process of overcoming the traumatic event, therefore lower levels could contribute to increased PTSD symptoms.

Van der Kolk (2017) proposes that trauma leaves a ‘sensory imprint’ and although the mind may not always remember ‘the body keeps the score’. There are number of general health implications that have been linked to significant attachment based trauma. These include high blood pressure, diabetes and heart disease (Schmid *et al*. 2013), as well as sleep disorders and eating disorders (Cook *et al*. 2005). Unsurprisingly these individuals are at increased risk for substance misuse (De Bellis 2001, Cook *et al*. 2005, Cook *et al*. 2003, Cook *et al.* 2017) and subsequent comorbid disorders that can follow. In addition, childhood trauma can also significantly increase the chance of developing depression in adolescence and adulthood (Nanni *et al*. 2012, Mayes 2010, Cook *et al*. 2017). It may also increase the chances of obesity and fibromyalgia (Cichetti 2016). The epigenetic research findings also highlight the ways in which attachment based trauma can alter the length of telomeres, which can then impact on genetic material remaining intact (Ridout *et al.* 2017). Reduction in the length of telomeres has been found to be associated with an increased chance of developing inflammatory diseases such as diabetes, cancer and Alzheimer’s (Siegel 2017a).

Schmid *et al*. (2013) state that self-harming and suicidal thoughts and behaviour are amongst the most likely symptoms for victims of childhood trauma. When investigating the origins of self-destructive behaviour, van der Kolk *et al*. (1991) reported that 80% of participants who had a history of self-injury reported early traumatic experiences of sexual and/or physical abuse. Schmid *et al*. (2013) hypothesise that self-harming behaviour helps alleviate emotional dysregulation and prevents the onset of dissociative states.

The nature of interpersonal trauma can lend itself to potential difficulties in developing close interpersonal relationships. In Chapter One, there was some discussion on ‘internal working models’ and how their formation is believed to be influenced by early caregiving experiences. Early adverse relational experiences are likely to cause an individual to develop a negative and distorted viewpoint of the self (as discussed early in this chapter). They are therefore most in need of a ‘corrective influence’ on those thought processes via positive peer relationships (Read & Gumley 2010). However, managing close relationships may continue be a struggle. De Bellis (2001) draws upon a computer analogy to describe the impact that childhood trauma can have on the ability to act appropriately in close relationships. He states that whilst the ‘hardwiring is present’ it has been traumatized resulting in ‘the software’ being programmed to be fearful and distrusting. Trauma victims may be unable to progress in terms of their cognitive and emotional development past the stage at which they experienced the trauma (Moroz 2005). As well as experiencing the emotion regulation difficulties, discussed earlier in this chapter, they may also suffer with Alexithymia (Moroz 2005, van der Kolk 2014). This refers to the inability to use words to describe emotions and feelings. Both of these elements may compromise communication and connectedness within close relationships.

 In addition, close and intimate relationships increase the chances that ‘archaic’ emotions will surface combined with ‘primitive defences’ (Solomon, 2003), the interplay of which would be arduous for any relationship. Therefore, when combined, all of these elements may lead to a limited capacity for those who have suffered childhood trauma to maintain functional interpersonal relationships (Schore 2001).

Significant abuse and neglect during childhood is believed to significantly increase the chances of developing a personality disorder (Skodal *et al*. 2002 Baron-Cohen 2012, Fonagy *et al.* 2018). It appears that the link between childhood abuse and neglect and Borderline Personality Disorder (BPD), in particular is strong (Baron-Cohen 2012). Between 40-70% of borderline patients within clinics report experiencing sexual abuse (Zanarini 2000). Bryer *et al*. (1997) discussed findings of between 60-80% of borderline patients reporting historical experiences of physical abuse or traumatic separation from their caregiver due to emotional neglect and rejection.

There has been some discussion around renaming BPD as ‘emotional dysregulation disorder or ‘emotionally impulsive personality disorder’ (Baron-Cohen 2012 p.39). Baron-Cohen (2012) describes the behaviour of BPD patients as alternating between raging with hate and full of love within close relationships. He states that they will attribute their impulsive behaviours such as substance misuse, self-harming, sexual promiscuity and suicide attempts, to the need to gain relief from an all-consuming feeling of ‘emptiness’. It is also important to remember that Peter Fonagy’s contribution to the literature on low mentalization is mainly based on his work with patients with BPD. As discussed in Chapter One, linked closely with the concept of low mentalization, is the ability to show empathy for others. Baron-Cohen (2012) has coined the phrase ‘Zero degrees of empathy’ when referring to individuals who lack the capacity to empathise and he includes those with BPD within this category. Drawing on neurological studies he concludes that ‘Zero degrees of empathy’ in BPD patients is the result of abnormalities within the empathy circuit of the brain.

Significant findings have linked childhood abuse with the development of psychotic disorders (Read *et al*. 2005, Janssen *et al*. 2004, Compton *et al*. 2004, Kaufman 2012, Dvir 2014), as well as the expression of symptoms in patients suffering with psychosis and schizophrenia, such as paranoid delusions and hallucinations (Hammersley *et al*. 2003, Bebbington *et al*. 2004, Read & Hammersley 2006, Murphy *et al*. 2007). Using a non-clinical sample, Berry *et al*. (2006) reported a significant relationship between both insecure avoidant and insecure ambivalent attachment styles and symptoms of paranoia and hallucinations. Pickering *et al*. (2008) reported an association between insecure attachment styles and symptoms of paranoia but not hallucinations. Once again, further research is needed to be confident of a robust causality.

Similarly to the development of BPD, it has been argued that psychotic disorders are also the result of affect dysregulation (Read & Gumley 2010, Dvir 2014). Specific functioning in the brains of patients with schizophrenia that is associated with affect dysregulation and oversensitivity has also been found in the brains of children who have been traumatized (Read *et al*. 2001).

A number of mental health disorders and associated symptoms might be best understood when considered within the context of early attachment experiences. However, it is also worth noting that reviews of neurological studies of child maltreatment have stated that functional differences in neurocognitive functioning does not always lead to a diagnosable psychiatric disorder (Teicher & Samson 2016, McCrory *et al*. 2017). Cicchetti’s (2016) review of the existing research states that additional longitudinal studies are required in order to strengthen causality.

Schore (2001) made reference to the need to integrate current research from the fields of attachment, neuroscience and psychiatry to produce more complex models of ‘psycho-pathogenesis’. However, over a decade later and McCrory *et al*. (2010), in their review of the literature regarding the neurobiology of maltreatment, conclude that there still remains a large gap between the neuro-scientific findings and application within clinical practice. D’ Andrea *et al*. (2012) concluded that there is still a need for the construction of a ‘conceptual paradigm’, which more effectively combines the neurodevelopment literature, findings and research with that of adult behaviour. They imply that these two fields of study remain on the whole quite isolated from one another, with the work of neuro-developmental researchers tending not to include the study of complex behaviours and those researching complex behaviours are not necessarily producing findings firmly linking with neuroscience. Van der Kolk (2017) recently highlighted the continued lack of cohesion between neurodevelopmental findings and actual clinical practice, stating how he believes they remain ‘tragically’ removed from one another.

This chapter sought to examine the multi-faceted ways in which childhood trauma can affect neurological, social and emotional development and functioning throughout an individual’s lifetime. Teicher *et al*. (2016) express that the neurological changes that have been associated with maltreatment are best understood as ‘adaptive responses to facilitate survival’. They assert that childhood maltreatment causes the brain to develop alternate pathways due to the stress induced environment and that this may result in psychopathology due to the ‘mismatch’ between the environment the brain was developing in and the current environment it exists within.

Moroz (2005p.12) notes the importance of clinicians using a ‘trauma lens’ when attempting to understand the behaviours and difficulties trauma victims’ face due to the fact they may ‘organise much of their lives around repetitive patterns of reliving and warding off traumatic memories’. Lieberman and Jackson (2005) have added to this concept stating professionals working with traumatised individuals must use both a ‘trauma lens’ and an ‘attachment lens’.

The existing literature clearly evidences the behavioural and social difficulties that children and adults who are exposed to early interpersonal trauma can experience and these findings are particularly relevant to the social work field. Social work practitioners may benefit from understanding parental maltreatment through the use of a trauma and attachment lens when assessing families and offering intervention. A more in depth attachment and trauma knowledge base is also likely to be beneficial for fostering services in terms of provision and support within placements. In addition, this knowledge may also be useful in increasing practitioners’ understanding of parental behaviour in cases where the parents themselves were previously maltreated. The next chapter will examine the precise ways in which outcomes of childhood trauma can impact on parental behaviour and the following generation’s attachment relationship.

**Chapter 3 - The Impact of Unresolved Trauma on Parenting Capacity and the Attachment Relationship**

Attachment based trauma is more likely to impact on the individual’s capacity to function appropriately in their relationships with their own children when their traumatic memories of the past are ‘unresolved’ (Main & Hesse 1990, Moroz 2005, Abrams 2006, Walker 2007, Fonagy 2011, Shemmings & Shemmings 2018). It is not simply the exposure to traumatic experiences that is believed to be responsible for later parental difficulties, but the extent to which the individual has been able to effectively come to terms with and make sense of what has happened to them (Walker 2007).

Developments in neuroscience suggest that, in order to achieve ‘resolution’ there needs to be cognitive integration of these past memories into their ‘original context’, which enables the individual to make sense of them when contemplated in the present (Shemmings & Shemmings 2011 , Siegel 2017a). If not, then these memories remain fragmented, disjointed and disconnected as if they are ‘unlocked’ in the individual’s mind, but inaccessibly stored in a ‘hidden file for which there is little language, only image and feeling’ (Walker 2007 p.81). Traumatic memories are believed to be stored in complex associative networks whereby ‘stimulus features’ are closely linked with ‘response features’ (McClough & Cloitre 2006). Therefore, certain sights, smells and sounds can trigger fearful physiological responses. Similar symptoms may therefore be displayed in those with unresolved attachment based trauma and those with a broader diagnosis of PTSD. Re-experiencing symptoms in such a way is thought to be an adaptive strategy for integrating the trauma into the correct context (Foa & Hearst-Ikeda 1996). For individuals who do not experience such flashbacks and associated triggers, they could be more prone to entering a dissociative state (as discussed in Chapter Two), which can influence their ability to effectively process these memories as it can often remove them from conscious thought (Main & Morgan, 1996, Cook *et al.* 2003).

Past trauma that remains unresolved in the mind of the parent can weaken their ability to monitor and respond to their child’s distress (Lyons-Ruth *et al.* 1999, Jones 2016, Bartlett 2017). The parents’ mind can become ‘suffused and saturated’ by unprocessed feelings (Baradon 2010), and the baby is then subsequently lost from their mind (Woodhead 2010). One of the most detrimental ways unresolved attachment trauma can impact negatively on parental behaviour is when the infant acts as a sensory or physiological trigger of traumatic memories. When the child’s attachment system is activated under normal circumstances this should in turn activate the parent’s care giving system (Walker 2007). However, in the case of caregivers with unresolved attachment trauma the vulnerability, emotional expression and demand of the infant can trigger previous feelings of fear, distress, anger, rejection and abuse (Walker 2007, Cook *et al*. 2003, Daum 2017). The result of which is a caregiver who can be so consumed by their own psychological state that they fail to respond to their infant’s needs at the precise moment in time when a nurturing response is most needed (West & George 1999).

Persistent difficulty meeting the attachment needs of the infant can therefore interfere significantly with fundamental processes required within their attachment relationship. The unpredictability of their response and potential anomalous parental behaviour may induce fear, confusion and a state of disorientation for the infant. It may also lead to a repetition of the neglectful and/or abusive behaviour they experienced during their own childhood. Bentovim (2009 p.67) refers to this as ‘self-reinforcing cycles’, potentially occurring within generations of family members. This mechanism could therefore be responsible for intergenerational patterns of maltreating behaviour.

The Adult Attachment Interview (AAI) (Main & Hesse 1990) is the most common assessment tool for identifying whether an individual has unresolved trauma. This is identifiable by the display of lapses in metacognitive monitoring, contradictory beliefs, or sudden exposure to visual images (Out *et al*. 2009). Difficulty distinguishing between thoughts and feelings and a low capacity for reflective function (Liotti 2004), also feature as potential indicators. Hesse and Main (2006) attribute such lapses in monitoring to the absorption of a dissociative state. Walker (2007) discussed the importance of the exploration of unresolved trauma within the field of social work due to its implications in the assessment of risk and identification of required therapeutic intervention. The AAI is not a tool that social care practitioners are qualified to use and therefore they are unable to measure unresolved trauma in parents in any real quantifiable way. Regardless of this, the findings that have emerged through research using the AAI could potentially improve the understanding of the impact that unresolved trauma can have on an individual’s behaviour and parenting capacity.

A strong association has been established between parents classified as ‘unresolved’ and displays of frightening behaviour towards their child (Schuengel *et al*. 1999, Jacobvitz & Hazan 1999, Abrams *et al*. 2006 Lyengar *et al*. 2014, Tambelli *et al*. 2015). In addition to behaving in a way that is frightening towards their child, these parents may also act as if they themselves are frightened by their child, both of which are equally distressing to the child (Main & Hesse 1990, Fonagy 2011). Main and Hesse (1998) were the first to develop a coding system for both frightening and frightened behaviour (referred to within the literature as FR behaviour). This included categories of frightening, frightened, dissociated, deferential, sexualized and disorganized parental behaviour. Hesse and Main (2006) assert that these FR behaviours are attributed to being in a dissociative state. However, Out *et al*. (2009) highlight various studies that have failed to demonstrate a significant association between FR behaviour and dissociation and feel that replication of studies that do not rely on self- report measures is required.

True *et al. (*2001) have evidenced that this type of frightening behaviour can occur independently of measures of maternal sensitivity. However, this study did take place in West Africa and therefore results could be culturally sensitive. In line with such evidence, Out *et al*. (2009) developed the Disconnected and Extremely Insensitive Parenting (DIP) coding system, which consists of two separate dimensions for behaviours they believe could be present in parents with ‘unresolved’ attachment based trauma. The first is the ‘disconnected’ dimension, which uses most of the behaviours featured in Main and Hesse’s (1998) coding of FR behaviours with some alterations to ensure behaviours are disconnected and appear out of context and are thus unpredictable rather than insensitive. It details frightening behaviours such as facial expressions, voice alterations and attack postures. In contrast, parents may display frightened behaviour themselves in relation to their facial expression, posture and movement to create distance from themselves and the child. In addition, they believe parents may display dissociative freezing behaviour, deferential and romantic/sexualized behaviours as well as disorganized and disoriented behaviours, again through facial expressions and alterations in their tone of voice. The impact of potential parental dissociative behaviour on the infant is discussed in more detail later in this chapter.

The second dimension of the DIP coding system is ‘extremely insensitive’ parental behaviour and includes items from the Atypical Maternal Behaviour Instrument for Assessment and Classification (AMBIANCE) (Bronfman *et al.* 2004), such as parental withdrawal, neglect and/or aggressive, negative and intrusive behaviour towards the child. Out *et al*. (2009) suggest that exposure to disconnected behaviours induces a higher level of fear in the child and the unpredictability of such behaviour can mean alterations in their own behaviour will have no effect in limiting its occurrence. However, in the case of extreme insensitivity the parent is thought likely to consistently display insensitive behaviours. Therefore, the child may have a better chance of predicting and preparing for these in a more ‘organized’ manner.

Chapters One and Two have discussed the parental process of ‘emotion regulation’ and its importance within the attachment relationship as well as the impact if it does not occur. Parents who experience unresolved childhood traumas can experience difficulty in regulating their infant’s negative affect states and therefore these infants are at risk of ‘emotional derailment’ (Broughton 2010). These parents often may avoid thinking about and discussing their own emotions and therefore struggle to respond appropriately when faced with a wide array of emotions in their children (Cook *et al*. 2003). They may become overwhelmed and as such they may be unable to offer the necessary emotional containment their infant needs (De Oliveira *et al.* 2004). Instead, the infant might be exposed to unpredictable responses and behaviour from their parent, which can threaten their psychological well-being and induce defensive dissociative states (Woodhead 2010).

Jones (2010) discusses how the lack of attunement that can occur in mothers who are traumatized induces emotional dysregulation within the infant due to the fact she might project her own negative affect states onto the infant. This can produce emotions within the infant that are actually those of the parent. Therefore, the infant processes the mother’s traumatized affect state as their own (Fonagy *et al.* 2002a) and does not receive the necessary interactive repair from their mother in order to relieve this, thus they remain in a highly dysregulated state (Schore 2010). The mother may then perceive this dysregulated state as the infant deliberately not wanting to be soothed by her and thereby rejecting her. The infant is subsequently traumatized by the experience of a caregiver who is unable to comfort them and feelings of anger and hostility can start to manifest in the mind of the mother (Tomas-Merrills & Chakraborty 2010, Jones 2015, Jones 2016), causing difficulties for what might already be a potentially fragile attachment relationship.

Attachment researchers have demonstrated that exposure to traumatic relational experiences in childhood can disrupt the development of mentalization, which can then have a detrimental impact on the individual’s parenting capacity (Fonagy & Target 1997, Fonagy *et al.* 2002a Fonagy & Bateman 2016). Therefore, as discussed in Chapter One, low mentalization has been viewed as a potential mediator for intergenerational transmission of abuse. The ability to mentalize enables the parent to accurately understand and interpret the cues of the infant as there is a full appreciation for the fact that the infant has separate thoughts and feelings to those of the parent. Fonagy has identified the attributes of the parent who fails to mentalize as demonstrating affective communication errors (e.g. laughing when the infant is crying), role and boundary confusions (e.g., demanding a show of affection), fearful behaviour (e.g., as evident in a squeaky voice), intrusive behaviour (e.g., pulling the infant by the wrist), and withdrawal (e.g., not acknowledging the infant after a separation) (Allen *et al*. 2008). These parents are thought to have been the victims of abusive and rejecting behaviour, and this can greatly impact not only on their mentalizing capacity but also, as discussed in Chapter Two, their mental representation of the self and others (Slade 2005). The parent’s distorted representation of themselves can cause confusion for the infant and unpredictability in relation to the parent’s behaviour. They may then be left unsure of whether they will experience safety or danger and they may then struggle to develop effective coping strategies when these negative parental behaviours occur (Baradon & Brofman 2010).

Ensink *et al.’s* (2014) study provided further insight into the link between unresolved trauma and the capacity to mentalize. They were the first to assess mentalization (measured as RF) in pregnant women with a history of child abuse and/or neglect across two separate domains, the first relating to RF in the context of attachment relationships and the second when discussing their traumatic experiences. The majority of women in the study had difficulties with the use of mental state language that was specific to discussion of trauma rather than more general attachment relationships, which has been the only measure taken in previous studies. Low mentalization in the context of their experiences of trauma was associated with struggling to feel invested in their pregnancy and diminished positive feelings regarding the baby and becoming a mother, as well as difficulties within close relationships. This finding suggests struggling to mentalize specifically in relation to past trauma is more likely to effect the parent’s state of mind and the developing attachment relationship.

Berthelot *et al.* (2015) have contributed further to this finding by examining the extent that trauma specific RF could impact on attachment styles. They reported that 83% of mothers who had histories of abuse and neglect had a child with an insecure attachment, 44% manifested attachment disorganization. Unresolved trauma as well as trauma specific reflective function contributed significantly to the variance in infant disorganization. Therefore, their work has also highlighted the significance of trauma specific (RF) mentalization. Both unresolved trauma and trauma-speciﬁc reﬂective function made signiﬁcant contributions to explaining variance in infant attachment disorganization.

Chapter Two detailed the impact that maltreatment and abuse can have on neurological development. Researchers have used these findings to demonstrate the ways in which neurological damage or failure of growth in certain regions of the brain during infancy and/or childhood due to traumatic neglect and/or maltreatment can directly impact on the individual’s response to their own infant. The Orbital Frontal Cortex (OFC) is associated with positive responses to touch. Impairments within this region have been linked with difficulties in experiencing positive emotions associated with the infant, as well as offering socially appropriate responses (De Gregorio 2012). Cognitive demand can impact on the functioning of the OFC, therefore individuals with deficits in this area may be likely to struggle with the multiple demands of an infant, such as making a bottle or changing an infant, whilst also offering verbal reassurance (De Gregorio 2012).

Laurent and Ablow (2012) used the strange situation procedure and conducted an MRI scan of mothers whilst exposed to the sound of their own infant crying and another infant. The neural responses of mothers to their own infant’s cry were associated with attachment security and behaviours of the infant. Mothers of secure infant’s showed greater activity in the left para-hippocampal and amygdala areas when hearing their infant cry. Mothers of infants that displayed avoidant behaviours during the strange situation demonstrated a decreased response in the left prefrontal, parietal and cerebella areas that are associated with attention processing. Mothers of infants that displayed disorganized attachment behaviour showed reduced responses in bilateral, temporal and subcallosal regions associated with emotion regulation and social cognition.

The anterior cingulated cortex (ACC) is believed to play a key role in decision making and emotion regulation. Findings have demonstrated an increase in parent’s awareness of emotional states and detection of infant cues when this area within the brain is active (Lane *et al*. 1998, Lane *et al.* 2008). A number of studies have documented a link between AAC functioning and previous childhood maltreatment (Davidson, Putnam & Larson, 2000, McCrory 2017). As discussed in Chapter Two, the amygdala is central in processing threat and conditioning fear responses. Deficits in the development of this area can therefore impact on the parent’s ability to respond to a fearful infant, thus increasing the likelihood of potentially leaving the infant in a prolonged negative and traumatizing state (DeGregorio 2012).

A number of studies have discovered associations between activity in additional brain regions of mothers such as the anterior and posterior cingulated cortices, medial thalamic nuclei, bilateral mesial prefrontal cortex, dorsomedial prefrontal cortex, the medial frontal gyrus, superior frontal gyrus, angular gyrus, posterior gyrus, fusiform gyryus and the medial temporal gyrus in response to listening to or watching videos of their infants (Loberbaum *et al.* 2002, Noriuchi, Kikuchi, & Senoo 2008, Kim *et al.* 2010). Therefore, given the ‘latent vulnerability’ for neurological alterations due to maltreatment, as evidenced in the previous chapter, it is understandable that parental behaviours could be compromised for individuals with a past history of attachment based trauma.

Neurological researchers have also produced findings evidencing a connection between childhood maltreatment and the functioning of areas of the brain associated with reward processing in both children (Mehta *et al*.2010, Takiguchi *et al.* 2015) and adults (Dillon *et al.* 2009, Boecker *et al.* 2014). An interesting direction for future research may be to observe parent-infant dyads where attachment related difficulties have been identified and investigate whether links can be established between parental history, present difficulties and the functioning of areas of the brain associated with reward processing. The purpose of this would be to ensure appropriate methods of intervention were being provided, as well as potentially highlighting effectiveness.

Chapter Two detailed how traumatic childhood parental experiences can cause individuals to develop dissociative tendencies as a defence mechanism. They may enter a dissociative state involuntarily when traumatic experiences occur and also when traumatic memories may become triggered. Parental dissociation was briefly discussed earlier in this chapter introduced within Out *et al.’s* (2009)Disconnected and Extremely Insensitive Parenting (DIP) coding system. Dissociating parents are likely to behave in avoidant ways with their infant in a bid to avoid the activation of distressing associations (Broughton 2010), triggered by the infant’s vulnerability. A parent who enters a dissociative state can be so consumed by this they may become entirely unaware of their surrounding environment and the behaviour of their infant, leaving the infant in an alarmed and fearful state (Hesse & Main 2006). Unsurprisingly, such dissociative parental behaviour is thought to disrupt the development of organized attachment processes between the parent and child and instead can contribute to significant parental neglect (Schore 2001, Jones 2016).

Research that has used the Adult Attachment Interview with the parent in conjunction with the strange situation procedure with the parent and child has evidenced that exposure to a parent who is in a dissociative state can induce high levels of fear resulting in the loss of a ‘coherent attachment strategy’ (Broughton 2010). Attachment theorists have proposed that this can cause a disintegration of emotional and behavioural states and therefore a state of ‘disorganization’ can manifest. As discussed in Chapter One the category of ‘disorganized’ was first established by Mary Main and her colleagues during the 1980s whilst closely examining behaviours that had previously been perceived as ‘unclassifiable’. The term ‘disorganized’ was chosen due to the belief that these infants were lacking in goal-directed attachment behaviour (Green & Goldwyn 2002).

Main and Hesse (1990) were the first to establish a significant association between ‘unresolved’ trauma in parents and disorganized attachment behaviour in their infants. This finding has been replicated a number of times and been established meta-analytically (van IJzendoorn 1995, van IJzendoorn *et al.* 1999, Goldwyn, Green, Stanley & Smith 2000, Fonagy 2011). However, despite these findings, Sleed and Fonagy (2010) discuss how there is still a large number of parents who are not classified as ‘unresolved’ yet their infants have been described as exhibiting disorganized attachment behaviour (DAB). The fact that the classification of the parent’s unresolved state of mind is reliant on their disclosure of past traumatic events has been considered to be a possible cause of such discrepancy (Lyons-Ruth *et al*. 2005). Alternative causes for disorganised attachment (DA) classifications will be explored later in this chapter.

It has been consistently evidenced that 48-80% of children who have been significantly maltreated may demonstrate disorganized attachment behaviour (DAB) (Carlson *et al*. 1989, Cicchetti & Barnett 1991, van IJzendoorn 1999, Moroz 2005, Brown & Ward 2013). There is evidence to suggest that DA behaviour even occurs in 15% of low-risk samples (Liotti 2004), regarded by Leckman (2005) as a ‘sobering’ statistic. Secure attachment relationships appear to correlate in a ‘non- specific way’ with most positive factors that impact on development, whereas attachment disorganization has the potential to be regarded as a ‘nonspecific’ indicator for negative and high risk factors (Green & Goldwyn 2002). Main and Solomon’s (1986) discovery of DA behaviour and subsequent findings have contributed significantly to the field of psychology, in particular the domains of clinical and social intervention (Duschinsky 2015). The past two decades have seen a productive increase in relation to research that has sought to strengthen understanding of DA behaviour (Liotti 2004). Solomon and George (2011) have stated that the development of the concept of infant disorganization has resulted in a ‘paradigm shift’ within the study of attachment and it is now also being applied within clinical areas such as parental infant mental health.

Evidence suggests that parental behaviours that can lead to infant disorganization are inclusive of the frightening and dissociative behaviour discussed earlier in this chapter (Hesse & Main 2006). Lyons-Ruth, Bronfman, & Atwood (1999) produced a model for the type of parental behaviour that can predict DA behaviour. Similar to Out *et al.*’s (2009) Disconnected and Extremely Insensitive Parenting (DIP) coding system this detailed restrictive and intrusive behaviours, as well as withdrawing from interaction and failing to respond appropriately to the needs of the child. Beebe *et al.* (2013) documented maternal behaviour towards infant’s at four months that they felt predicted a disorganized attachment classification at twelve months. Some of these behaviours included extensive periods of time gazing away from their infant, less touch, extensive looming, denial of infant distress and withdrawal.

The parent’s capacity to mentalize (measured as Reflective Function, RF) has been found to impact on disorganized attachment behaviour, with RF measures accounting for the difference in scores of parent-infant affective communication between organized and disorganized attachment groups (Slade *et al*. 2005, Kelly *et al*. 2005). Fonagy and Target (2005) argue that the parent’s ability to demonstrate RF determines the extent to which the parents ‘unresolved state of mind’ will lead to insensitive and/or frightening behaviour.

The literature discussed in Chapter One highlighted the ways that the capacity to mentalize and the maternal process of emotion regulation are closely interlinked. A parent who is unable to effectively understand and interpret the thoughts, feelings and behaviours of the infant is likely to struggle to offer appropriate emotion regulation, as this relies heavily on their ability to accurately interpret their infant’s behavioural cues. An infant who experiences a distinct lack of parental regulatory responses and who is subsequently often left in an emotionally dysregulated state is believed to be more likely to become disorganized. (Maunder & Hunter 2001, Read & Gumley 2010, Brown & Ward 2013). The state of disorganization can occur due to a break down in a consistent strategy for regulating emotions and these children therefore can be the least able to cope with negative emotions (van IJzendoorn *et al.* 1999), and yet, if being maltreated, are the most likely to experience them. When the parent is maltreating and frightening the infant, then they are not only the source of fear, but also the only source of regulation of that fear, the very nature of which is thought to be highly disorganizing for the infant (Cook *et al*. 2003, Sleed & Fonagy 2010).

Parental insensitivity is thought to relate more to ‘organized’ attachment styles than DA behaviour (Wolff & van IJzendoorn 1997, Bakermans-Kranenburg *et al*. 2005). However, van IJzendoorns (1999) meta-analysis concluded a small yet significant association between parental sensitivity and infant disorganization. Out *et al.* (2009) findings identified that extreme maternal insensitivity alone did not predict attachment disorganization. Therefore, caregiver insensitivity may be more likely to contribute to disorganization when combined with additional parental factors and the behaviours previously mentioned.

The evidence concerning the influence of maternal depression on an infant experiencing disorganization appears to be conflicting. There have been findings documenting an association between maternal depression and subsequent anomalous parenting that has led to DA behaviour in the infant (Teti *et al.* 1995, DeMulder & Radke-Yarrow 1991). However, there have also been findings that have reported a weak association (NICHD Early Child Care Research 1997, van IJzendoorn *et al.* 1999). Sleed and Fonagy (2010) discuss how depression in some circumstances may prove to be adaptive. They draw on findings from Hughes *et al.* (2006) study that demonstrated that for some mothers who suffered from unresolved trauma depression can be considered a protective factor, as it can prevent her from entering into a dissociative state, which can then contribute to parental behaviour that can cause alarm and unavailability, leading to state of disorganization in the infant.

Madigan *et al.’s* (2006) influential meta-analysis sought to explore the mediator pathways linking unresolved states of mind, disrupted maternal behaviour and disorganized attachment relationships. They reported that only a small proportion of the association between unresolved states of mind and disorganized attachment was mediated via anomalous parental behaviour. They concluded that further exploration of other variables that could provide mediator pathways from unresolved states of mind to infant disorganization is needed.

When considering an infant who is being maltreated by an attachment figure and who may then display ‘disorganized’ behaviour, the use of the word disorganized to some extent captures the disorientation, disintegration and potential behavioural breakdown that the infant is faced with if their source of protection is also a source of threat. In these cases the infant is believed to have no organized and effective coping strategy to deal with the ‘irresolvable bind, (Sleed & Fonagy 2010) or ‘unsolvable dilemma’, (Lieberman & Amaya-Jackson 2005) that comes from experiencing ‘fright without solution’ (Hesse & Main 2000). Findings suggest that infants who instead experience fear for their caregiver, for example when their caregiver is a victim of domestic abuse, may also exhibit signs of disorganization due to the fear of losing their source of protection and being unable to intervene (Owen & Cox 1997, Liotti 2004, Lieberman and Amaya-Jackson). However, Main and Hesse (1990) cautiously note that fear will play a significant part in some disorganized behaviour but not all the indices they created. A number of researchers and clinicians have asked for greater clarity on the role of fear in contributing to a disorganized state (Duchinsky 2018). Further exploration of the ‘explanatory mechanisms’ behind behaviours that are not necessarily induced by fear continues to be required (Duschinsky 2015).

DA behaviours that have been observed under the experimental conditions of the strange situation procedure are inclusive of freezing or stilling behaviours, stereotypes, anomalous movements or posture, hair pulling, contradictory distress/avoidance behaviour, undirected or misdirected movements and expressions, displays of fear and apprehension, and/or confusion, and disorganization in relation to the parent (Main & Solomon 1990). It is important to note that in isolation these behaviours would not lead to a DA classification, as only when five or more are observed is an ‘interruption’ or ‘ breakdown’ in the attachment system thought to have occurred (Duchinsky 2017). Granqvist *et al*. (2017) note that classifications by accredited coders are based on single observations and therefore they may not be reflective of the infant’s overall attachment experiences. It is also important to remember that such behaviours can only be reliably classified as DA behaviour when observed under the conditions of the strange situation procedure or similar situations, which activate the child’s attachment system under conditions of stress (Shemmings 2016). Schuengel *et al.* (1998), however, documented a case whereby a child displayed DA behaviour at home during a video recording but not during the strange situation procedure. The need for further observational evidence is reinforced by the lack of findings detailing the precise distribution of DA behaviours that have been observed in studies, as well as the lack of consistency in observations of these behaviours on more than one occasion (Duchinsky & Solomon 2017).

Van IJzendoorn *et al.* (1999) discussed the need for researchers to develop additional ethical ways of triggering these behaviours. However, almost two decades later, this has yet to be achieved. In addition, a further issue holding back advancement in the depth of DA knowledge and understanding is that mechanisms that contribute to the distinct difference in behaviour displayed by disorganized infants have not significantly developed past the initial theories. As such, there has been a limited critical evaluation of the theoretical concept as a whole (Lyons- Ruth 2013). However, criticisms have been voiced, O’Shaughnessy and Dallos (2009) expressed that Main and Solomon had reduced complex human behaviour to fit into their formulated typologies. Gaskin (2013) asserts that Main and Solomon have simply taken behaviours that do not fit into Ainsworth’s standardized categories when creating the disorganized concept, which she feels weakens its significance and applicability.

The last few years have also seen an increase in publications of papers that are asserting caution when it comes to the assumption that DA behaviours are indicative of maltreatment. This is predominantly due to the fact that some maltreated infants will in fact not show signs of DA during the strange situation as well as some infants who may show signs but are in fact are not being maltreated (Granqvist *et al.* 2017).

A greater emphasis has been placed on potential ‘alternate pathways’ to disorganization. It is hoped that this may reduce the perceived ‘fuzziness’ around the interpretation of DA behaviours, which may have led to an ‘explanatory muddle’ (Duschinsky 2018). It has also been suggested that this confusion may have led to improper use of this concept within the social work field (Granqvist 2016). However, specific examples of when this may have occurred have not been documented.

Cyr et al. (2010) conducted a meta-analysis on attachment security and disorganization in high-risk families. They reported children that were exposed to five socioeconomic risk factors, which included: income, substance abuse, maternal age at birth, education level and single parenthood, were almost as likely as children who had been maltreated to develop a disorganized attachment strategy. They propose that the parent who is preoccupied by the stressful environment created by such risk factors is likely to neglect to meet the needs of the child, leading to ‘chronic hyper arousal’ in the infant who is fearful of the caregiver’s lack of availability and such fear can induce disorganization. Further replication of these findings would be useful, focusing on these variables and specifically examining them rather than drawing from meta-analysis.

Additional pathways have also been proposed that do not relate to the child being maltreated such as genetic predispositions, temperament, and significant periods of separation (Granqvist *et al.* 2017). Intense marital conflict has also been linked to periods of disorganization within the attachment relationship (Owen & Cox 1997, Solomon & George 1999, Zeanah *et al*. 1999), and this links in with the previous hypothesis mentioned that a child can become disorganized due to ‘fear of’ or ‘fear for’ their caregiver. In both cases, their ‘safe haven’ is at risk of being unavailable to them. Lastly, behavioural ‘stereotypies’ that feature within the disorganized indices can be present in children with an autistic spectrum disorder and therefore cannot be presumed to indicate ‘disorganization’ (Granqvist *et al*. 2016).

Regardless of these alternate pathways, in the cases where maltreatment has occurred and a pattern of disorganization has been identified, then these findings have been able to offer valuable insight into the potential ways the unavailability of a caregiver can impact on an individual from infancy through to adulthood. This research evidence appears to have made an important contribution to understanding the influence that regular experiences of abuse and more specifically a potential sense of ‘fear’ within the attachment relationship can have. The remainder of this chapter will therefore discuss these findings in order to continue a review of literature by exploring the potential ways that the state of disorganization could compromise development and thus increase the likelihood of intergenerational cycles of trauma continuing.

There is evidence to suggest a link between attachment disorganization in pre-school and early years and later social and behavioural problems in the classroom (Moss *et al*. 1998, Goldwyn *et al*. 2000, Geddes 2006, Green *et al.* 2007). Cognitive development has also been shown to be compromised in children who were classified as ‘disorganized’ (Moss *et al.* 1998, Green & Goldwyn 2002, Juffer *et al.* 2005, van IJzendoorn 2009).

Internalizing behaviours such as depression and social isolation have been reported amongst disorganized children, which in later childhood have been closely linked with low social functioning and low self-esteem and can subsequently lead to difficulties making and maintaining friendships and a higher likelihood of peer rejection (Verschueren & Marcoen 1999, Jacobvitz & Hazan 1999, Moss *et al.* 2004, Lee & Hankin 2009). In addition, in the same way that these children may tell ‘bizarre’ stories during assessment tasks they may also display ‘bizarre’ behaviours within the classroom, which again is likely to impact negatively on their peer relationships (Jacobvitz & Hazan 1999, Geddes 2006, Green *et al.* 2007, Swarbrick 2017). Externalizing behaviour such as aggression has also been linked with attachment disorganization (Moss 2004, Madigan *et al*. 2007, Fearon *et al.* 2010, Satchwell-Hurst 2017).

When the developing child’s needs change and their cognitive awareness increases, DA behaviours that were present during infancy can take on different dimensions and by the age of six these children may be described as ‘controlling’ (Moss 2004, Lyons-Ruth & Jacobvitz 2008, Liotti 2011, Swarbrick 2017). However, there is evidence of this behaviour emerging earlier in children aged three and four (Moss *et al.* 2005). Controlling behaviour is thought to be the result of exposure to a caregiver who is unpredictably frightening or experiencing fright and helplessness themselves (Solomon *et al.* 1995, Steele 2016, Swarbrick 2017). It can be considered a defence mechanism as its purpose is believed to be to reduce the anxiety created by the uncertainty that surrounds the child (Green & Goldwyn 2002).

The controlling behaviour can manifest itself in one of two ways. Either the child can behave in a way that is ‘caregiving’ whereby they assume a role as ‘rescuer’, appearing superficially cheerful and offering help to the caregiver, but not always to others, or they may be hostile, punitive and persecutory, displaying verbally and physically threatening behaviour, but again they may not do this to others, (Liotti 2004, Hennighausen *et al.* 2011, Lyons-Ruth *et al.* 2015). Over 80% of disorganized school age children are believed to display one of these two types of controlling behaviours towards their caregiver (Lyons-Ruth & Jacobvitz 1999). In the case of the caregiving child, it appears that instead of activating their attachment system these children have activated their caregiving system and in doing so they are not care-seeking. The punitive children are also not care seeking either; instead they are believed to use aggression to try to achieve dominance over caregivers (Sloman *et al*. 2002).

The concept of internal working models was introduced in Chapter One and discussed in Chapter Two. Liotti (1999, 2002, 2004) proposed that Karpman’s (1968) ‘Drama Triangle’ accurately summarizes the internal working model of a ‘disorganized’ child. The three components of the drama triangle are victim, persecutor and rescuer. Liotti (2004) suggests that the child can view themselves and their caregiver as interchangeably switching between any of these three roles. As previously mentioned, DA behaviour can be characterized by experiencing fear of a caregiver who is also the source of protection, therefore the parent may be viewed as both ‘persecutor’ and ‘rescuer’ leaving the child to view themselves as the ‘victim’.

Chapter Two detailed the ways in which a child’s mind may cause them to believe that they are responsible and deserving of the abuse they receive in order to try and make sense of it. Therefore, Liotti states that they can also assume the role of ‘persecutor’ and view the caregiver as the ‘victim’. Lastly, because the child may seek to offer comfort to their caregiver they can view themselves as ‘rescuer’. The switching of roles in such a way between how the child see’s themselves and their caregiver corresponds with the three main personalities that an individual diagnosed with dissociative identity disorder can assume (Liotti 2004).

Attachment insecurity has been regarded as a risk factor for mental health difficulties. However, its predictive validity is somewhat lessoned due to the fact that mental health difficulties occur in approximately 40% of the general population (Green & Goldwyn 2002). Mary Main’s (1990) addition of the ‘disorganized’ category has strengthened the association of attachment related experiences and psychopathology. It is evidenced within the literature that a child who demonstrates DA behaviour may be more likely to experience later psychopathology during their adult years (Bakermans-Kranenburg *et al*. 2005, Kobak *et al.* 2006, Liotti & Gumley 2008, Lyons-Ruth *et al*. 2011, Obsuth 2014, Borrelli *et al.* 2017 ).

A number of behavioural symptoms featured in the DSM IV (Diagnostic and statistical Manuel of Mental disorders) and ICD 10 (International Classification of Diseases) are described within the categories for coding of DA behaviour (Bakermans-Kranenburg *et al*. 2005), thus demonstrating how symptoms of attachment disorganization have the potential to lead to distinct mental health conditions. A significant association has been reported between DA behaviour and the development of PTSD (Cook *et al.* 2003, Van Ee *et al.* 2016). Liotti (2004) has hypothesised that the child’s disorganized style, in response to a caregiver who has ‘unresolved’ trauma, could act as a mediating variable for the transference of PTSD symptoms from one generation to another An association has also been established between DA behaviour and the development of personality disorders such as Borderline Personality Disorder (Herman, Perry, & van der Kolk, 1989, Liotti 2004, Lorenzini *et al.* 2013 Mosquera *et al.* 2014), and Anti-Social Personality Disorder (Cook *et al.* 2003, Wenzel 2017).

Dozier and Tyrrell (1997) investigated attachment organization in a group of psychiatric patients and reported that 50% of the schizophrenic group were classified as ‘disorganized’. They also reported that the patients’ ‘deactivation of attachment strategies’ was closely linked with a higher rejection of treatment and limited disclosure of their symptoms, yet clinicians rated their symptoms as more extreme. This finding has important implications for individuals who may not have developed a severe mental health condition but may have engaged in this process of ‘deactivation’ in respect of their attachment strategies. They may be likely to find themselves behaving in ways that are symptomatic of previous attachment related trauma yet they are unlikely to be aware of this and disclose this to professionals and if approached may be unwilling to engage in treatment. This could be the case for some parents who are requested to work with social services and who present as ‘resistant’ or ‘hard to reach’ and reject opportunities to try to make positive changes.

Earlier in this chapter, there was discussion around the impact of parental dissociation and its potential contribution to a disorganized state within the infant. Attachment researchers have hypothesised that DA behaviour is also indicative of a dissociated state in the infant (Hesse & Main 1999, van IJzendoorn, Schuengel & Bakermans- Kranenburg 1999, Liotti 2006, Muller 2014, Frankish & Sinason 2017). A number of the behaviours demonstrated by infants classified as ‘disorganized’ during the strange situation procedure are on the same ‘phenotypic level’ as those that indicate dissociation within adults (Liotti 2004). It is believed that the dissociated state in infants is defensively assumed to protect against the trauma induced by the caregiver (Sleed & Fonagy 2011), which could be attributed to exposure to the dissociated state of the caregiver. Therefore, parental dissociation could be considered one pathway by which attachment disorganization could present within a number of generations. Dozier *et al.* (2008) discuss how the link between infant attachment and later psychopathology is most established when there is evidence of DA behaviour during infancy and dissociation during adulthood. Liotti (2004) also emphasised how these concepts are closely intertwined by titling his paper ‘Trauma, Dissociation and DA: three strands of a single braid’.

Failure to develop an organized attachment strategy to guide an individual through the workings of close relationships could lead to intense and consequently unstable and chaotic relationships (Bentovim 2011). The ‘maladaptive interpersonal schemas’ of children believed to be ‘disorganized’ are thought to impact on the individuals’ thoughts and behaviours in relation to key components within close relationships such as trust, conflict resolution and intimacy (Riggs 2010). These children are believed to develop negative interpersonal dynamics whereby they may misread even accidental behaviour, such as spilling a glass of water, as an intentional attack on them (Steele 2016). In addition, the behavioural ‘approach-avoidance paradox’ experienced by a disorganized child can be repeated within adult relationships causing an individual to appear desperate for close and intimate contact followed by disconnection and disengagement with their partner (Riggs 2010).

Individuals who may have experienced disorganized states of mind may become heavily dependent on abusive partners, causing a constant switch between positive and severely negative emotional states (Bentovim 2011). Alternatively, the presence of DA behaviour in infancy combined with controlling behavioural strategies in childhood may lead to controlling and dominating behaviour towards partners (Riggs 2010). Attachment disorganization can impact on the individual’s ability to self-regulate and therefore extreme negative states created by relationship dysfunction are likely to be destructive and long lasting. Some individuals may be vulnerable to using drugs in an attempt to dull these negative affect states (Fletcher & Simpson 2013, Cook *et al.* 2017).

It is important to be aware that many of these findings are still regarded as only evidencing a small to moderate association between DA behaviour and later difficulties. Therefore the connection is not necessarily inevitable (Granqvist *et al.* (2017). Subsequent difficulties could also be due to continued exposure to stressful stimuli in their lives rather than being solely attributable to early disorganization within their attachment relationships (Sroufe 2016).

This chapter has detailed the impact that ‘unresolved’ attachment trauma can have on parental behaviour and the subsequent impact this can have on the attachment relationship and the developing child. A review of the literature indicates an association between ‘unresolved’ mental states in a parent and the ways in which this can influence parental behaviour and potentially lead to the infant experiencing states of ‘disorganization’. Therefore, the concept of infant disorganization has been discussed at length. It is important to note however that observations of DA behaviour are clearly not sufficient to make conclusions around maltreatment. This is why the concepts of mentalization, emotion regulation and parental attachment history have been discussed at length during this literature review as they appear to be key aspects to consider within the assessment of maltreatment as well as intervention.

The final chapter will explore trauma therapies and interventions for adults as well as parental interventions that could offer the opportunity for ‘resolution’ to the previously abused parent and increase the likelihood of improvements in their parenting capacity.

**Chapter 4- Intervention**

Expansion in our understanding of the human mind has provided opportunities to develop interventions that alter cognitions and behaviour in such a way that it is possible to diminish or in some cases eradicate negative symptomology. The last thirty years has seen an increase in the development of trauma focused interventions and therapies. In relation to parenting interventions during the past decade, there has been a significant rise in the development of parenting programmes. However, as will be discussed later on in this chapter, very few interventions have solidly integrated both of these elements in a bid to resolve parental attachment traumas and improve the parent’s capacity to offer optimum care to their child.

The previous chapters of this literature review presented the evidence that has established a link between maltreating and/or neglectful parental behaviour and the potential derailment of a child’s development and functioning. Therefore, it appears important that, where possible, intervention should be implemented prior to the formation of ‘maladaptive patterns’ of behaviour (Joyce 2005). Childhood trauma and the associated patterns of behaviour when left untreated can have huge monetary and societal implications (Cook *et al*. 2003, Cook *et al.* 2017) and therefore it has been referred to in the US as the single most important public health issue (van der Kolk 2014). Childhood trauma is also regarded as the most preventable cause of adult mental health issues due to the potential for success if early intervention is offered (De Bellis 2001, Teicher & Samson 2016, McCrory *et al.* 2017). McCrory *et al.* (2017) assert that service provision in social care and mental health is structured in such a way that it ‘discourages innovation’ in terms of preventative intervention for children who present with the greatest ‘latent vulnerability’ for developing mental health difficulties. Allen (2011) was requested by the UK government to complete a review of early intervention and stated that in many places we appear to be dealing with the symptoms that have caused considerable social problems yet ignoring the causes.

In both the US and the UK symptoms caused by early childhood trauma are often dealt with through the overuse of medications such as anti-depressants rather than investing in psychotherapeutic resources. In the UK Hollinghurst *et al.* (2005) conducted a study which reviewed the frequency and associated costs of anti-depressants prescribing between 1991 and 2002. Prescriptions increased 2.8 fold during this time with an increased cost of £310 million. This figure could have covered the cost of employing 7700 therapists to provide 1.54 million treatment courses, which would cover a third of all adults with depression and mixed anxiety and depressive disorders. If the treatment is delivered by a graduate, this figure increases to 2.34 million.

Blake (2010) however highlights the struggle an individual may experience who is seeking access to ‘talking therapies’ rather than medication when they are not known to mental health services. Often their only option may be to self-fund sessions with a charitable organisation, which are often oversubscribed. She also discusses how if they have an undiagnosed mental health condition they will be unable to claim for sickness benefit. Therefore, for these individuals their unresolved traumatic past and the subsequent impact this may have on their mental health can have extremely negative implications in relation to daily living. With the addition of the potential stressors and demands of looking after a child, the situation may then worsen considerably.

‘Helplessness and isolation’ are believed to be the core emotions experienced by those suffering from psychological trauma and therefore a central pathway to recovery is thought to be experiencing ‘empowerment and reconnection’ (Herman 1992). This highlights not only the potential need for therapeutic intervention but also the importance of relationship based practice when it comes to engaging with families where attachment based trauma could be present. The following section will discuss the potential interventions that can be used with victims of trauma.

Chapter Three briefly discussed how traumatic memories are stored in the mind of the victim. Ordinarily, when a non-traumatic event occurs, it is integrated within the memory network via association with previously similar experiences. Traumatic events can unbalance this system and the thoughts and feelings that were present during the event can be subsequently locked into the brain and stored within a separate neural network. Traumatic memories can therefore remain in a state of ‘neurobiological stasis’ (Shapiro 2001 p.117). The majority of trauma therapies seek to unlock those memories through recall of traumatic events in order to reintegrate them correctly and achieve some form of ‘resolution’ for the victim.

Trauma-focused cognitive behavioural therapy was developed in the late 1980s and usually consists of between 12-16 sessions. The patient is required to construct a ‘trauma narrative’ of the event. Holmes (2001 p. 91) has referred to these as ‘stories that are in search of a voice’ and once it is found that voice is thought to be crucial to the process of recovery. Its purpose is to ‘desensitize’ the individual to thinking about the difficult memories in order to effectively process them as existing within their past so that they can then be directed to focus on the present (Cohen *et al.* 2000). This method of ‘stimulus confrontation’ and ‘cognitive restructuring’, are often the preferred treatments for PTSD (Foa *et al.* 2008). This treatment is regarded as one of the most effective and supported interventions used within the field of trauma (Cohen *et al.* 2000). It has been evaluated through the use of several randomised control trials, (RCTs) all of which have supported its efficacy in improving the reduction in trauma related symptoms such as depression and PTSD (Cohen & Mannarino 2008). However, Wampold *et al.’s* (2017) investigation of three meta-analyses revealed issues with effect sizes, focus on disorder specific symptom measures, and inclusion of problematic trials. In addition, Liotti (2004) discusses how three additional psychotherapeutic models state that patients who would have exhibited DA behaviours during their childhood can benefit more from a therapeutic focus on their past and current relational difficulties rather than the level of explicit discussion of traumatic memories seen in trauma focused CBT. Fosha (2017) also highlights that language based therapy for some traumatized clients may not be sufficient.

Eye Movement Desensitization Reprocessing (EMDR) is a firmly established therapeutic procedure that was developed by Francine Shapiro during the late 1980s and offers an alternative to explicit discussion of traumatic experiences. Shapiro noted that when thinking about something disturbing, her eyes would move from left to right and if she focused on this movement then the memory would move from conscious thought and when considered again the associated feelings of sadness had gone. This process forms the basis of EMDR as the client is encouraged by the therapist to recall a distressing memory and shortly after this, whilst doing so, they are asked to focus on the stimulus of either the therapist’s finger moving from left to right or in other cases finger taping and tones can also be used. Unlike exposure therapies, such as Trauma-focused CBT, EMDR does not require the client to stay focused on the traumatic event. Instead there is an allowance for free association and the therapist moves the client in and out of recall, therefore they hold the traumatic memory in mind for a limited amount of time (Shapiro 2001). In addition, this treatment does not require the client to verbally discuss in detail their feelings surrounding those memories, which is positive for those trauma victims who may, as a result of the trauma, suffer with Alexithymia, (mentioned in Chapter Two), which is the inability to identify and describe their emotions.

There are two main hypothesis that have been offered as an explanation for the effectiveness of EMDR. The first is the orienting response model which proposes that when recalling these events due to the focus on a stimulus (finger movement) that causes de-arousal, the highly emotional material travels from the right hemisphere of the brain, where it has been stored within the visual sensory network, to the left hemisphere where it is stored in narrative form. The second hypothesis is the working memory hypothesis, which has received the most research support and states that EMDR is successful due to the way in which the focus on eye movement (or other stimuluses) has the ability to disrupt the working memory (Leeds 2012).

The International Society for Traumatic Stress Studies regards EMDR as an effective treatment (Shapiro 2001). There has been a significant amount of research published that highlights the efficacy of EMDR including a large scale meta-analysis of PTSD treatments (van Etten & Taylor 1998, Shepherd *et al.* 2000, Bradley *et al.* 2005, National Collaborating Centre for Mental Health 2005). Additional researchers have demonstrated its success within a small time frame compared to other treatments. Scheck *et al*. (1998) reported findings that after 3 hours of EMDR over three quarters of subjects within the study were no longer displaying PTSD symptoms. Further studies have found that after 4 hours of EMDR the diagnoses of PTSD was no longer present in 85-90% of participants (Rothbaum 1997, Wilson *et al.* 1997). Furthermore Marcus *et al.* (1997) reported that after five hours of EMDR, 100% of victims who had reported single traumas were no longer experiencing the symptoms of PTSD. Twenty four RCT’s have produced support for the use of EMDR for individuals who have suffered various forms of trauma. The eye movement component had been criticized by some researchers based on findings from earlier dismantling studies. However, the International Society for Traumatic Stress Taskforce indicated these studies were methodologically flawed (Shapiro 2014). In the last decade an additional twenty RCT’s demonstrated the positive impact of the eye movement element by evidencing a reduction in emotional arousal, vividness of images, attention span and memory association (Shapiro 2014).

The World Health Organization (2013) guidelines list trauma focused CBT and EMDR as the recommended psychotherapies for children, adolescents and adults with PSTD. There have been very few comparison studies of the use of these techniques. Van Etten and Taylor’s (1998) meta-analysis concluded that EMDR was more efficient given on average it requires less treatment time. However, Seilder and Wagner (2006) criticised their methodological approach as effect sizes were calculated based solely on pre/post comparisons and should have included a post/post comparison. They do note that at the time of the meta-analysis there was only one study by Vaughan *et al.* (1994), which offered a direct comparison between EMDR and behavioural therapies. Seilder and Wagner (2006) conducted their own comparison study and concluded that both EMDR and Trauma focused CBT were equally as effective. They stated that research should now focus on investigating which of the therapies would be more beneficial for certain trauma patients.

Both of these therapies have the potential to bring about fundamental change for parents who have suffered significant attachment based trauma. Walker (2007) highlights the need for such therapies to become available treatments for parents within the child protection system whose parental difficulties may be largely attributable to their childhood trauma.

Within the last ten years, there has been a steady increase in the number of parenting intervention programmes that have been devised and implemented within the UK. However, evaluation of such programmes appears to have provided mixed conclusions surrounding efficacy. This may be due to the large variations within participant groups, the services provided, and the extent to which they have been evaluated (Berlin 2005). Fonagy (2014) highlighted that less evidence surrounding a parenting intervention doesn’t necessarily mean it’s less effective. He notes that evaluations must include support from RCT’s, an instrument to assess mechanism, and practice based evidence. However, attachment behaviours are difficult to evaluate due to the variation of peoples experiences and circumstances, as well as the challenge of controlling for unidentified extraneous variables (Ziv 2005, Brown &Ward 2013).

Berlin (2005) states that participant numbers of at least 200 are needed for meditational analyses in order to detect small effects. It would appear that there is a significant need for evidence in relation to interventions for high risk families and yet the evidence base for this group is the smallest, most likely due to the fact that these families are the hardest to reach and engage in services (Stewart-Brown & Schrader-McMillan 2011). Researchers struggle to gain access to what is deemed a ‘vulnerable group’, which often results in small and skewed samples (Brown & Ward 2013).

In terms of the focus of the parental intervention, there has been some debate with regards to whether making changes to parental internal working models will lead to improvements in parenting capacity or whether improving parenting behaviour, for example through the use of increased child development knowledge or mentalization based approaches, is sufficient to lead to a more organized attachment relationship (Cicchetti *et al.* 2006). Van IJzendoorn’s (1995) meta-analysis of 850 parent-child dyads reported a strong association between the parent’s internal working model and the attachment security of their child. However, parenting behaviour accounted for a small proportion of this association and so targeting parental behaviour alone is unlikely to prove successful. They also note that interventions that improve parental behaviour may not lead to positive changes of internal working models or that it may take longer for these changes to occur. Crittenden (1993) believes that negative parental behaviours are the result of the parents ‘pre-consciously’ excluding from thought information that induces emotion. Therefore, if this were to be the case, increasing child development knowledge alone would be ineffective in reducing abusive or neglectful behaviour (Duchinsky 2013).

Further debate within the literature surrounds the length of interventions, with two conflicting meta-analyses commonly referenced. The first was completed by Egeland and colleagues (2000) who stated that interventions should consist of intensive long term comprehensive programs. Whereas Bakermans-Kranenburg and colleagues (2003) concluded that ‘less is more’ and advocated that short term interventions were more successful in improving attachment relationships. Van IJzendoorn and colleagues (1995) meta-analysis reported similar findings that intense therapeutic intervention was less effective than preventative short term interventions.

Some of the most prominent programmes detailed within the literature may vary in terms of techniques, but they all share the focus of aiming to increase parental sensitivity and improve mentalization capacity. Intervention methods using video feedback include ‘Video Interaction Guidance’ (VIG) (Kennedy *et al.* 2010) and ‘Video-feedback Intervention to Promote Positive Parenting’ (VIPP) (Juffer *et al.* 2008). Both of these have produced promising findings when assessed for efficacy and meta-analytically (Musgrave 2015, O’Hara *et al.* 2016, Juffer *et al*. 2017). ‘Circle of Security’ (Powell *et al.* 2013) is an additional established programme that has also demonstrated positive outcomes when reviewed with meta-analysis (Yaholkoski *et al.* 2016). Lastly, the ‘Attachment and Biobehavioural catch up’ (Dozier *et al.* 2018) combines’ video feedback with ‘in the moment’ feedback during home visits. A meta-analysis has yet to be conducted, however, randomised control trials have evidenced its efficacy in cases of potential maltreatment (Bernard *et al*. 2012) and with foster carers (Dozier *et al.* 2011). Whilst the existence of these programmes is positive, Wright & Edington (2016) note that it is important that consideration is given to the most suitable form of intervention for parents based on the characteristics of the parent and child. The availability of these forms of intervention for families within social care settings is also unfortunately likely to be limited given the costs of training and implementation.

Graham Allen MP completed a report for the government in 2011 entitled ‘Early Intervention: the next steps’. He stated that there should be cross party support for providing families with early intervention and ensuring ‘emotional bedrock’ for current and future generations. He urged the government to accept that late intervention is expensive and ineffective and recommended the implementation of 19 intervention programmes. Following his report, ‘The Early Intervention Foundation’ was launched in 2013, which aims to combine the evidence of leading researchers to provide guidance on effective early intervention. However, there appears to be a lack of strategy in relation to implementing the recommended intervention programmes and the recommendations of the foundation. A number of local authority teams have undergone significant changes in the past few years, which has meant that for some there are no longer ‘child in need’ teams instead there is one ‘referral and assessment’ team who are expected to offer short term intervention with those families who do not meet threshold for child protection’. However, social care practitioners are not likely to have been trained in administering interventions and are unlikely to be able to easily refer to services who may provide the programmes that have been recommended by Allen, therefore they are unlikely to be able to access them. Families could be referred to their local children’s centres. However, once again the availability of trained facilitators to implement the recommended interventions does not appear to have been invested in. This has resulted in what appears to be a ‘postcode lottery’ of intervention provision.

Despite Allen’s recommendations, there seems to be a gap in terms of ensuring access to the early intervention services for those families who they believe would benefit, as well as training the necessary professionals to deliver the intervention. This gap was highlighted by ‘The Early Intervention Foundation’ in their 2015 report entitled ‘Spending on late intervention’. They state that, despite all major political parties supporting the need for early intervention, there is no assigned government department or cabinet minister to ensure the required plans for prevention and early intervention are put in place.

High risk families are believed to be unlikely to benefit from attending these types of parenting intervention programmes (Stewart-Brown & Schrader-McMillan 2011). The efficacy of interventions that target parental sensitivity for families where there is attachment disorganization has been debated with mixed findings, due to the fact that attachment disorganization is not believed to be attributable to parental insensitivity alone (Green & Goldwyn 2002). However, Bakermans-Kranenburg *et al*. (2005) meta-analysis concluded that interventions that focused on sensitivity were more effective in reducing attachment disorganization than interventions focusing on support and parents mental representations. However, the interventions offered were not specifically aimed at reducing attachment disorganization but included it as an outcome measure. Interestingly, they also reported that interventions were more successful when administered after six months of age and believe this could be due to the fact that it is after this point that a more selective attachment relationship is formed. This conflicts with a number of other researchers’ view that intervention should be offered as soon as possible (Buist 1998, Guedeney 2014, Brown & Ward 2013, Allen 2011).

Bakermans-Kranenburg and colleagues conclude that there is a significant need for interventions focused on the prevention of attachment disorganization that aim to reduce frightening or frightened parental behaviour. Juffer *et al.* (1997) suggested these behaviours could decrease by focusing the parental attention on the child in the present and raising awareness of the child’s competing needs against internal parental preoccupation.

An additional contributor to significantly abusive/and or neglectful parental behaviour can be unresolved trauma, which was discussed in detail in Chapter Three. Unresolved attachment representations have been found to influence the success of parenting interventions as well as parents ‘self-reports of the benefit of the programmes (Routh *et al.* 1995). Bailey *et al.* (2006) identified why attachment based interventions may not be effective for parents with unresolved trauma and believe this to be due to transference. They discuss how the unresolved parent is likely to carry feelings of rejection, disappointment and inflexibility from their previous attachment relationship, which can cause them to have similar expectations surrounding the parent-infant relationships. The infant’s behaviour is then interpreted based on these expectations and therefore can be inaccurately perceived, which is likely to cause them to demonstrate low mentalizing behaviour. This is why Bailey *et al.* (2006) do not feel that unresolved parents can successfully engage and benefit from sensitivity based interventions.

Research has highlighted that intervention should perhaps focus more on unresolved trauma and subsequent mood states as well as parent-child interaction (Green & Goldwyn 2002). Schechter and colleagues (2005) study of traumatized mothers found that neither trauma focused therapy nor parent infant therapy alone led to more appropriate mental representations. Therefore, they believe that effectiveness of intervention with traumatized parents is reliant upon dealing with stress responses and subsequent defence mechanisms, as well as improving the parent’s capacity to regulate their infant’s emotions and offer a mentalized response.

Bateman and Fonagy’s (2004) work with patients with borderline personality disorder and subsequent low mentalization has prompted the development of ‘mentalization based therapies’. These treatments are specifically focused on increasing mentalization capacity and improving the patients understanding of their own and others mental states. The principles of these treatments have been applied to some parental interventions mentioned above, as an increase in the capacity to mentalize may offer the opportunity to improve parental sensitivity, attunement and emotion regulation.

Parent-infant psychotherapy (PIP) is a therapeutic intervention that seeks to modify the parent’s internal working model and is regarded as a ‘powerful tool’ in terms of its ability to alter the intergenerational cycle of trauma inducing relationships (Moroz 2005). Selma Fraiberg’s (1975) concept of ‘ghosts in the nursery’ was discussed in Chapter One and details how previous traumatic attachment relationships can distort the parent’s view of their own child, which in turn can cause them to exhibit behaviours that are traumatising for their infants. This concept is considered to be an underlining principle applied to most parent-infant psychotherapies (Slade 2005), which seek to disentangle the infant from the traumatic relational web in which they are placed, woven by a parent who has previously been entwined themselves.

This service is typically offered to infants under two years of age due to consideration for the significance of the first few years of development (Barlow *et al.* 2015). The therapy consists of sensitive reflection and interpretation of the ‘traumatizing dance’ (Stern *et al.* 1998) between the parent and the infant. Neither the parent nor the infant are viewed by the clinician as receiving treatment, in fact, it is their relationship which is viewed as ‘the primary patient’ (Baradon 2016 p.44). This appears in line with Winnicott’s (1964 p.88) view that ‘a baby cannot exist alone and is essentially part of a relationship’.

Detailed throughout this literature review has been a discussion of the nature and influence of mentalization and emotion regulation on the quality of the attachment relationship. The main aim of parent-infant psychotherapy is to improve the parent’s ability to mentalize in relation to themselves, their infant and their relationship. In addition, it is deemed important that parents learn how to regulate their own and their infants affect states (Baradon & Joyce 2016). As discussed above, there is also a focus on disrupting the negative intergenerational cycle of potentially traumatising parental behaviour as well as encouraging the development of the infants sense of self (Baradon & Joyce 2016).

Improvements in mentalization and emotion regulation are attempted through the use of a scaffolding process in which the therapist represents the infant’s mental state and enables them to feel understood, whilst also communicating this mental state to the parent and in doing so attempts to improve the parent’s ability to accurately interpret the infant’s mental state themselves (Baradon 2005, Gibbs 2005). It is believed to be vital that the parent begins to see the infant as ‘sentient’ and ‘intentional’ (Tomas-Merrills & Chakraborty 2010).

In order to effectively process ‘unresolved trauma’ Selma Fraiberg (1975) noted that parents needed to ‘remember and re-experience’ emotions and thoughts that had been defensively repressed during childhood. The parent is encouraged to reflect on the traumatic relational experiences they endured and find the words to describe these and in doing so unconscious procedural memories can be processed and resolution may be achieved (Broughton 2005). This is based on the principles of trauma focused CBT discussed earlier in the chapter. Within the parent-infant setting, it is important for the parent to perceive the connection between their past experiences and their present parental behaviour and consciously reflect on any repetition of negative parental behaviours (Baradon 2005, Jones 2015). The therapist assists this process by being present during the recall of traumatic experiences and acknowledging the emotional pain, as well as gradually and sensitively increasing the parent’s awareness of the ways in which their infant has been exposed to their own ‘traumatized and unavailable state of mind’(Dalley 2010 p.122).

Lieberman (2005) developed the concept of ‘angels in the nursery’, which describes the way in which the exposure to one positive close relationship in childhood with a parental figure is likely to have provided at some point feelings of ‘security’ and ‘self- worth’. Lieberman believes that these ‘angels’ can be revisited during the therapeutic processes and serve to interrupt the continuous cycle of negative parental behaviour and contribute to the exorcism of potential ‘ghosts’. This theory is often implemented within parent-infant practice and supported by clinicians such as Amanda Jones (2015) who is a Professional Lead Perinatal Psychotherapist in North East London. A recent pilot study conducted by Narayan *et al*. (2017) has been the first to empirically test the ‘angels in the nursery’ concept. They reported that memories indicating the presence of an ‘angel’ significantly moderated childhood maltreatment and adulthood PTSD symptoms.

Where parent-infant psychotherapy is successful in transforming fractured and traumatising relationships, this is thought to have been achieved through the processing of unresolved trauma and the parent’s recognition of the impact their previous behaviour was having on the infant through improving their capacity to mentalize. This improvement can lead to more accurate attunement to their infant’s emotional states and therefore the parent can offer more effective emotion regulation, both of which can strengthen the attachment relationship and repair previous ruptures. With those essential parental elements in place, the parent is then able to take ‘pleasure’ from the relationship with the infant (Jones 2010) and ‘primary maternal preoccupation’ is possible (Joyce 2005). The duration of this therapeutic treatment is dependent on the type and severity of the relational problems that are present, but treatment will usually range from 5-20 weeks (Barlow *et al.* 2015). Therefore, once again, application of this type of intervention within child protection cases could offer an increased opportunity for positive outcomes for some families within the necessary timescales.

Despite a great deal of support from clinicians in relation to this approach, there is a limited amount of evaluative research on the effectiveness of parent-infant psychotherapy. The studies that have been completed have demonstrated improvements in infant-presenting problems, a decrease in parental stress, and a reduction in intrusiveness and conflict between the parent and in the infant (Cohen 1999). In addition, Cohen *et al.* (2002) also reported improvement in mother-infant interaction, emotion regulation and attachment security or organization during the six month period after treatment, as well as infant cognitive development. Cicchetti *et al*.’s (2006) findings also demonstrated support for improved attachment security in those groups who received PIP. Fonagy *et al.* (2002b) reported considerable improvements in infant cognitive development six months after the therapeutic treatment and at the one year follow up this was sustained with slight improvement. There is evidence to suggest that using parent-infant psychotherapy can reduce avoidant, resistant and angry behaviour towards the mother (Lieberman, Weston & Pawl 1991) and when used during the later stage of development during toddlerhood can help foster more secure attachments (Toth 2006). Fonagy *et al.* (2016) completed a randomised control trial of parents receiving PIP with mental health problems who had ‘high levels of social adversity’ as they identified that previous studies had not specifically included ‘hard to reach’ sample populations. They reported no differential effects between the groups over time in relation to measures such as capacity to mentalize. They did, however, report improvements on measures of mental health, parental stress and representations of the baby and their relationship

In relation to evaluations of this approach, Kennedy and Midgely (2007) completed a ‘thematic summary’ but did not access the evidence systematically. Barlow *et al.* (2015) did complete a systematic review and despite noting improvements in attachment security in high risk families they reported no differences between treatment and control groups, and there was no evidence to suggest that parent-infant psychotherapy was more effective than other therapeutic treatments. They recommended that further ‘rigorous’ research is required in order to examine the impact of PIP on mediating factors such as parental reflective function, mental health and parent-child interaction. Although there have been some small scale studies, there appears to be a distinct lack of qualitative explorations of PIP, which could offer further insight into the dynamics and experiences of this intervention (Jones 2005, Barlow & Kirkpatrick 2007, Haimovici 2017).

‘Minding the baby’ is a mentalization based intervention that was developed at Yale University in 2002. It has combined two approaches, the first is ‘home visiting’ which was proven by Olds *et al.* (1998) to be successful as an intervention offered to young mothers who were visited weekly by a nurse. Olds then founded the Nurse-Family Partnership in the US (Family-Nurse Partnership in the UK) and a number of studies have demonstrated its effectiveness in improving health, parenting behaviour, child development and life course outcomes (Olds *et al*. 2007, Kitzman *et al*. 2010, Olds *et al*. 2010). The second approach drawn upon in ‘Minding the Baby’ is that of parent-infant psychotherapy as it makes use of therapeutic mentalization focused work completed with the mother and her infant. The intervention is delivered by a team of professionals consisting of a nurse, a social worker or therapist, all of whom offer practical support as well as focused sessions to improve reflective capacity. This intervention is also regarded as beneficial for mothers who are showing signs of trauma from their own attachment relationships as it aims to address the current relationship disruptions with their infant that may have been caused by the mother’s previous attachment traumas (Slade *et al.* 2005). This interdisciplinary model uses the strengths of both approaches and is therefore regarded as more successful in meeting the multiple needs of families (Sadler *et al.* 2013).

Sadler *et al.* (2013) completed a randomised control trial which reported that those families who received the ‘Minding the Baby’ intervention were more likely to have kept up to date with their infants’ immunizations at 12 months and were less likely to be referred to social services. The presence of disrupted mother-infant interactions was less likely when the infant was 4 months old and the dyads who received the intervention were more likely to show secure attachment styles and less likely to exhibit disorganized attachment behaviour. In addition, even the most high risk mothers demonstrated improvement in their capacity to mentalize. Another RCT is currently underway in the UK conducted by the NSPCC and UCL to measure the effectiveness of the intervention against other support services. However, results will not be published until the end of 2018.

Grayton *et al.* (2017) conducted the first qualitative review of service implementation in the UK, identifying failures to mentalize at different stages within the professional network. The parents spoke positively about the focus of the intervention on the ‘mother-baby dyad’ compared to previous experiences when they had been treated separately. The practitioners felt that their therapeutic relationships with the parents were central in responding to challenges but also in engaging the mother in reflective processes.

Whilst it is extremely positive that there are therapies and interventions which can be offered to parents with some successful findings, the attachment and trauma literature implies that there are likely to be a number of individual factors that could impact on the extent to which these methods are successful. However, consideration of these is often absent within the literature, particularly in quantitative methodologies where the aim is largely to provide numerical significance to establish efficacy. In addition, there also appears to be a lack of data that has explored the potential reasons behind why the interventions may have been unsuccessful for some individuals. This is perhaps in part due to the difficulties previously mentioned in terms of the willingness of parents who have not had a positive outcome to take part in and remain engaged in the research project.

For parents who have been maltreated during their childhood, it can take a great deal of time to break through defensive ways of relating that may have become embedded. Chapter Two mentioned how traumatised individuals may function in ways that involve being instinctively distrusting of any relationship. Therefore, it may take time for the individual to become desensitised and willing to engage in any supportive service (De Bellis 2001). A history of interpersonal trauma can also increase the likelihood of prematurely ending the therapeutic treatment (Lau, Liu, Cheung, Yu and Wong 2003), which may prevent individuals from getting to the stage of breaking any defensive barriers of distrust. Three additional defence mechanisms that can interfere with the parent’s engagement in intervention are: (i) denial of the concerns, (ii) a good bad split of the world (as seen in disorganized children) and (iii) projective identification whereby the parent behaves in a way that will cause people to think negatively about them, which can reinforce the negative feelings they have about themselves (Jones 2010). A further defence mechanism that has been discussed in detail in Chapter Three is the process of dissociation. If the patient enters a dissociative state during treatment that requires discussion and thoughts of traumatic experiences this can present as a significant barrier to the process of achieving ‘resolution’ (Schore 2007).

A number of studies have reported an association between adult attachment style and response to different forms of psychotherapy and intervention (Fonagy *et al.* 1996, Bosquet & Egeland 2001, Dozier & Sepulveda 2004, Janzen *et al.* 2010). Several articles have highlighted the need for consideration of characteristics related to attachment styles that may cause some parents difficulties in engaging both with their infant and the intervener or therapist (Beckwith 1988, Heinicke *et al.* 2000, Spieker *et al.* 2000, Broughton 2005, Jones 2016), as well as the attachment style of the therapist (Bucci *et al.* 2016) Liotti (2004) discusses how a ‘disorganized’ internal working model can impact on how the individual views the therapist’s behaviour and this relationship may become ‘unbearably dramatic’ and difficult for a single therapist to deal with. Personality type may also play a part in the success of parental intervention. Those with narcissistic/paranoid/obsessive traits tend to have a ‘defensive pull’ not to attach to others. However, those with borderline/dependant/histrionic traits are believed to have a desire to attach to others and a ‘surviving wish for intimacy’ (Jones 2010).

Timing of interventions is also believed to be an important factor. For some mothers, the birth of a child may signify a turning point in relation to change and restructuring within the family, which may mean that the parent is more open to engaging with intervention (Prachi *et al.* 2010). This could be why a number of therapeutic interventions have been recommended to begin during pregnancy. As previously discussed in Chapter Three, for some parents with attachment related traumas, the birth of an infant, their cries of distress and their vulnerability can cause negative feelings to be displaced onto the infant. Therefore, intervening at an early stage is likely to be beneficial. Current legislation means that when pre-birth concerns have been raised social services may begin assessments from 12 weeks of pregnancy. However, there is no legislative requirement for the implementation of intervention. Therefore, once again, it may depend on what is available in the area where the parent resides.

The quality of the relationship with the therapist or intervener is felt to be critical to the success of any intervention, and some view this as more important than the severity of the abuse (Richardson 2008). Bowlby’s ‘secure base’ concept can be applied to this relationship, as engaging in treatment can activate the individuals attachment system (Bentovim 2009). Viewing the therapist or intervener as a ‘secure base’ is believed to aid the parent in their confidence of exploring new ways of thinking about their relational trauma (van IJzendoorn 1995). In doing so they may then be provided with the opportunity to rework their internal working models of relationships (Bretherton 1992). Herman (1992) notes that feeling safe within this relationship can enhance the process of healing and therefore can be central to the success of treatment. The parent may be provided with a relationship that is often unlike anything they may have experienced previously, where they feel listened to and valued and this can contribute significantly to the process of freeing both the parent and the baby from previous traumatic projections (Slade 2005). Continuity and consistency are also considered essential elements in therapeutic work as well as within the parent-infant relationship (Broughton 2005, Jones 2015) and could be tested and compromised by the defence mechanisms discussed previously.

The success of this type of intervention is also dependant on the skill of the intervener who needs to witness the parent’s pain and anger without becoming dysregulated themselves and continue to focus on vocalising the thoughts and feelings of the infant amongst what can be an environment of uncertainty and chaos (Slade *et al.* 2005). Jones (2016) discusses the need for the therapist to offer a parental kind of love to the parent, whereby they witness somebody taking pleasure in them. This will then contribute to their capacity to take pleasure in their infant, which is key to disrupting the ‘malignant projective processes’ that have manifested (Jones 2010).

Professionals must also have the capacity to fully comprehend how it feels to develop within a climate of traumatic family relationships (Bentovim *et al.* 2009). Despite the presence of research that focuses on measuring effectiveness of therapeutic intervention, there have been very few studies that have investigated the influence of the level of skill and attributes of the intervener (Stewart-Brown & Schrader-McMillan 2011). Korfmacher, Kitzman, and Olds (1998) reviewed the effectiveness of their home visiting programme and reported that the mothers rating of the intervener’s level of empathy predicted the level of empathy she demonstrated towards her own child. Forresters (2007, 2008) work has highlighted the importance of empathy within the field of social work and he has concluded that perceived empathy by the client from the social worker can have the most significant influence on the client’s responses and engagement. Therefore, empathy is likely to have an important role in both the success of therapeutic and social work intervention.

‘Epistemic trust’ is also likely to influence the dynamic within therapeutic relationships as well as relationships with social care practitioners. The term ‘epistemic’ originates from the Greek term ‘episteme’ meaning knowledge, closely associated with the philosophical term ‘epistemology’ relating to the theory of knowledge, in particular its origins, methods and validity. Fonagy *et al.* (2014 p.1) define epistemic trust as ‘trust in the authenticity and personal relevance of interpersonally transmitted knowledge’. Fonagy (2015) asserts that the success of therapeutic treatment is dependent on whether epistemic trust is present as it enables the patient to view to the therapist as a credible source of knowledge. He states that unless this is achieved then the patient may hear what the therapist is saying but they will not be truly listening. In order to achieve it Fonagy believes that the patient must feel that the therapist understands what it is like to be them.

As is the case with many interpersonal behaviours, attachment theory offers a framework from which to understand the potential origins of this concept. During infancy, the parent will provide the infant with cues that signal to them that they understand their internal states by providing the necessary response. These cues are believed to trigger the development of epistemic trust and increase the chance of a secure attachment relationship developing (Fonagy *et al.* 2007, Corriveau *et al.* 2009). Similar to the discussion in Chapter Two surrounding mentalization, if epistemic trust is not present within early close relationships then its presence within additional relationships may be compromised. In the case of maltreatment, Fonagy (2015) states these cues from the parent are likely to be absent or destabilised by states of fear and confusion, thus damaging the process of epistemic trust and causing the mind to become partially closed to accepting new information. In future relationships, the individual may therefore demonstrate ‘epistemic vigilance’ (Fonagy *et al.* 2014).

The developing maltreated individual is then believed to also be vulnerable to ‘epistemic mistrust’ or in more extreme cases ‘epistemic freezing’, which is more likely to be the case for individuals who have experienced significant attachment based trauma and may have subsequently developed a personality disorder (Fonagy *et al.* 2014). Within the context of therapy they may be labelled as the ‘hard to reach’ clients and the therapist may feel they are not listening to them when in fact the client is struggling to ‘trust the truth of what they hear’ (Fonagy 2015).

Not surprisingly, the ability of the therapist to mentalize for their client is believed to increase the chances of establishing epistemic trust. Fonagy & Allison (2014) note ‘the experience of feeling thought about in therapy makes us feel safe enough to think about ourselves in relation to our world’. They discuss how ‘epistemic trust’ opens up ‘epistemic highways’ from which the patient can begin to acquire knowledge by social means, start to trust the social world as something that can provide them with important information about themselves, their past behaviour and strategies to help them with their future. Outside of the context of therapy McCrory *et al.* (2017) highlights that young people who have experienced attachment based trauma, yet have been able to recalibrate ‘reconfiguring their responses to environmental and internal threat’, demonstrate the greatest levels of epistemic trust. This is most likely why researchers have linked the capacity for epistemic trust with resilience (Fonagy *et al*. 2014, McCrory *et al*. 2017).

In the context of social work, epistemic trust also appears to be important. Without it, the parent may hear what the practitioner is saying but may not be listening, in which case they may not follow advice in relation to safeguarding concerns, which could cause the child to continue to be at risk of harm. How to develop epistemic trust within this type of relationship and avoid ‘epistemic mistrust’ or ‘epistemic freezing’ is likely to be a beneficial area for future studies.

Therefore there appears to be many relational components that could impact on the efficacy of therapy such as the trauma history of the parents and the relational skills of the therapist that also appear to be applicable to the relationship between a parent and their child’s social worker. One potential barrier to achieving this type of relationship is likely to be the fact that the social workers primary concern is the welfare of the child. As such, the social worker ‘must always tread a path between care and control’ (Turney 2012). Not doing so could compromise the extent to which a positive relationship is able to form. The difficulty in achieving this balance and working effectively with families is widely acknowledged (Forrester *et al*. 2008, Ferguson 2009, Cooper 2012, Jones 2016). Being able to refer families into services that could provide therapeutic intervention for some cases, whilst they also work with social services, could potentially improve not only the outcomes for families but also their relationships with social care practitioners.

The cost of providing therapeutic intervention to families is likely to be what prevents many individuals, who might benefit from these services, from having access to them and the opportunity to make necessary positive changes. However, Moroz (2005) asserts that the cost of relational trauma if left untreated is likely to be far higher than the cost of investing in prevention and intervention. In England and Wales, almost £17 billion is spent per year on addressing difficulties, which may have been caused by damaging early attachment experiences such as mental health problems, youth crime and unemployment (Chowdry and Oppenheim 2015). This figure only relates to the cost within that single year and does not take into account the long term cost of these outcomes during adult life and then the potential for intergenerational transmission as well as wider societal and economic costs. Allen (2011) discusses how every tax payer is having to foot the bill caused by low educational achievement, poor aspirations, substance misuse, criminality and a dependency on benefits. He argues that investing in the right interventions will pay for themselves in the long term as well as significantly reducing other costs. The New Economics Foundation and Action for Children have estimated that if their proposals for early intervention are not implemented then the economy could stand to lose £24 billion a year.

De Bellis (2001) expresses that maltreating parents are often likely to have mental health problems that are treatable and therefore recommends that it should be a US policy that all parents involved in child protection services should receive mental health screening. In the UK NICE guidelines published in December 2014 highlight gaps in perinatal mental health provision. 10-12% of pregnant women and new mothers reportedly experience mental health issues with insufficient services to offer appropriate support in approximately half of the UK (Bauer *et al*. 2014). The Maternal Mental Health Alliance (MMHA) consists of a large number of organizations who seek to improve the mental health of women and their children during pre and postnatal periods. They highlight a ‘current shortfall’ in relation to service provision and a lack of understanding in this area from both health and social care professionals.

Research indicates that women who have experienced previous unresolved trauma and associated anxiety symptoms are more at risk of developing postnatal depression (Sutter-Dallay *et al.* 2004, Guedeney 2014, Dennis 2014). This is not surprising when the process of giving birth on its own can cause post-traumatic stress symptoms (Ballard *et al.* 1995, Alcorn *et al*. 2010, Soderquist *et al.* 2009) and this is likely to be worse for trauma victims and victims of sexual abuse in particular (Reynolds 1997).

Baur *et al.* (2014) report that perinatal depression, anxiety, and psychosis cause a long term cost to society of £8.1 billion a year, the majority of which relates to the associated impact on the child. The parent-infant therapies that have been discussed in this chapter would be costly to implement as an available service for parents whose infants are on child protection plans due to concerns in relation to the attachment relationship. However, the longer term costs of not offering this service to those who may have had a successful outcome appears likely to be much higher.

This chapter has outlined two trauma therapies that have been proven to aid the process of resolution for victims of trauma and as such would be beneficial to parents whose previous relational trauma is impacting on their functioning and capacity to care for their child. A number of parental interventions have been discussed. However, the gap between existence, evaluation and service implantation and access appears to be present. Influencing factors were considered and demonstrate the impact that previous attachment experiences and associated defence mechanisms can have on the efficacy of support and intervention and may shed some light on why some families do not successfully engage in the services they are currently provided with. One of the most significant barriers preventing children’s services from offering these treatments to parents is likely to be the financial costs. However, the figures that have been discussed evidence the longer term savings that can be made by investing in this level of provision. It would appear that funding is often being allocated in a way that prioritises ‘sticking plaster’ solutions and doesn’t attempt to tackle the root causes. The plasters may then need to be in endless supply, costing the government and society as a whole far more than investing in interventions that could offer the opportunity to deal with the root causes.

This literature review began by introducing the concept of attachment theory and influencing factors on the attachment relationship in order to then consider these factors within the context of maltreatment. The intergenerational transmission of maltreatment was explored and the potential joint influence of genetics and the environment was considered in order to gain further insight into the transmission process. The second chapter covered at length the impact that exposure to attachment based trauma can have on an individual from birth through to adulthood. The third chapter focused on the impact that this trauma can have when that individual becomes a parent and the potential for attachment disorganization, which in turn can impact on the infant’s future capacity to parent. The final chapter has focused on the types of support and intervention that are believed to be required in order to provide the best chance at preventing trauma inducing behaviours that may pass from one generation to the next.

This literature review has not included theoretical and research based findings pertaining to foetal attachment and the in utero experience. Although this is a burgeoning research area with key implications linking to early intervention it was deemed more crucial to focus on the research knowledge that relates to the relationship once the baby is born, as this is when the majority of social care intervention occurs. Lastly, with such a vast wealth of literature on attachment, abuse and neglect it felt more critical to focus this review on the post birth literature.

**Chapter 5-Methodology**

The literature review highlighted that whilst there had been some research conducted on the effectiveness of parent-infant psychotherapy (PIP), this has not been extensive and has included methodological limitations. In addition, none of these studies had focused exclusively on patients who were involved with children’s social services but more commonly focused on those who were experiencing mental health difficulties. Another area that had not been explored was the potential reasons as to why the treatment may not have been successful for some but was for others. The previous work in this area has been predominantly quantitatively investigated and therefore the narrative experience of the parent has often not featured within the analysis of efficacy.

There have been studies that have used randomised control trials, whereby some parents received PIP and others did not but none that have also included interviewing parents who received other forms of intervention such as being placed in a parent-infant foster placement or a residential assessment unit. Therefore, to clarify, intervention in this context refers to social services intervening by requesting that a family attend parent-infant psychotherapy and/or move temporarily out of their home and into a placement. Intervention is connected to measurements of change and in this context relates to the therapeutic and/or placement settings that participants were offered, with the expectation that they would provide various forms of support, during which an assessment would take place in order to assess whether these provisions had enabled change and the parents could then return to the community.

Although exploration of potential risk factors and protective factors within attachment relationships has been documented by a number of researchers, as well as factors that could affect parental capacity to change, this study aims to explore qualitatively whether these continue to be of significance. It is also hoped that this thesis could be a starting point for adding to this area of knowledge, particularly in relation to intervention for cases deemed ‘high risk’ by social services.

 **Research Question**

**What factors affect the parental experience and outcomes of parent-infant intervention?**

Competently and reliably answering the above research question required the acquisition of detailed narrative data that accurately captured the lived experience of the parental participant prior to, during, and after the intervention they had received. The questions that would best elicit the narrative depth required were carefully planned and selected using a combination of established research interview tools used within the field of social psychology, specifically, attachment research, as well as interviews that were designed for this project. This chapter will now discuss the research paradigm, epistemology, methodology, research design and method of analysis.

Packer (2011p.3) asserts that qualitative exploration enables us to;

 *‘Open our eyes to unnoticed aspects of human life and learning, unexplored characteristics of the relationship between humans and the world we inhabit, and unsuspected ways in which we could improve our lives on this planet’.*

Qualitative research therefore appears to fit well within the field of social work, which by nature is about the ‘social world’, as its primary concern is people, their wellbeing, behaviour, experiences, and what can be done to try to improve these. Therefore, although there are many examples of quantitative research that has been applied to this field, if our focus is people and seeking to understand the complexity of them as an individual, then qualitative research methods provide the researcher with the opportunity to capture that complexity. It allows for deeper understanding of the individual, not simply their score against an empirical metric.

With the emergence of a focus on ‘evidence-based practice’, there is a necessity to produce research that is not only reliable and valid but applicable and relevant to the everyday functioning of the current social care system. Shaw and Holland (2014) use a quote that has been taken from the field of sociology when referring to what is required to produce the best qualitative research, which is that it will ‘manage to tread a path bordered on one side by the theoretical and on the other by the practical or applied’ (Merton 1971p.793). This research study has been designed with the intention to bridge the gap between theory and practice, by aiming to produce data that captures the lived experience of parents, followed by the application of theory to better understand it.

Consideration of the philosophical underpinnings of a piece of research enables the researcher to obtain a clear framework in which the ontology, epistemology, methodology and method used complement one another. This provides the best opportunity for findings that, not only competently answer the research question but are also reliably sound.

**Ontology**

The first to consider within this paradigm is ontology, as this will subsequently influence the epistemological and methodological position of the researcher. Ontology is defined as ‘the science or study of being’ (Blaikie 1993). It is concerned with the way in which social reality is perceived and whether reality is perceived as subjective or objective. The objective position is referred to as ‘positivism’ as it is associated with the mind-set that a single factual truth exists, which is best investigated by measurable means that usually generates quantifiable data, and which is then statistically analysed. The subjective position is referred to as ‘interpretivism’ and by contrast argues that there is no single truth or reality and that the social world requires interpretation. Therefore, the ‘truth’ of the data is to an extent dependant on the ‘interpretive framework’ used by the researcher (Cooper 2009).

The practice that exists within social work is one that aims to gain information about the individuals’ lived experience, to interpret it and then make sense of it. There is not one single approach or way of understanding what can be a complex and vulnerable population. Thresholds vary from one local authority to another and this reflects the subjectivity that exists within this field. Cases that meet the threshold for legal proceedings require evidence to be presented in court, but ultimately the outcome rests with the judge’s interpretation of that evidence. It is therefore not uncommon that the ‘interpretivist’ position is often assumed for social care research. The ontological position of this research project is therefore ‘interpretivist’, as it consists of narrative qualitative data detailing the participants’ lived experience within the social care system, which requires interpretation to effectively answer the research question.

**Epistemology**

Epistemology is defined as ‘the study of the nature of knowledge and justification’ (Schwandt 2001 p.71). It asks questions such as: what is knowledge? And what do people know? In terms of epistemological positions, they are associated with constructing subjective meanings for social phenomena, focusing on the details of a situation, its reality, and the subjective meanings motivating those actions (Dudovskiy 2016). The ‘situation’ in relation to this project is that of participants receiving social care intervention, with the desire to gain insight into the individual’s ‘reality’ of this situation via interviews designed to elicit detailed narrative data. These interviews are then analysed for the ‘subjective meaning’ created by the participants, in relation to their situation to provide the opportunity to better understand their ‘motivated actions’ and the subsequent outcome.

**Methodology**

The methodology that is complimentary to the interpretivist epistemology is that of Hermeneutic (Interpretive) Phenomenology. The origins of Hermeneutics date back to the time of Greek mythology when ‘Hermes’ was responsible for interpreting what the gods were saying to the mortals. It then progressed through the centuries to interpretation of text, and at the time of the reformation became an embedded approach to gaining further insight around the teachings of the bible. Further development established a focus, not simply on description of text but the meanings concerning lived practices that can be discovered. These meanings may not always be clear to the participants but they can be assembled and then interpreted from their narrative detail (Kay & Willis, 2004), and this is the case for many of the interviews in this thesis. At the centre of hermeneutic inquiry is the human experience rather than their conscious knowledge (Solomon 1987).

Phenomenology is ‘a philosophical approach to the study of experience’ (Smith *et al*. 2009 p.11). Its formation took place in Germany, driven by the philosopher Edmund Husserl during the years 1913-1930, whose focus was on the intricate examination of the human experience. He is most famously referenced for his assertion that we need to ‘go back to the things themselves’ (Willis 2001). Those ‘things’ refer to the ‘experiential content of consciousness’ (Smith *et al.* 2009). One key belief of Husserl was that to gain such knowledge about the human lived experience one must remove themselves from their own ‘natural attitude’, their expertise and bias to achieve what has been termed ‘transcendental subjectivity’(Lopez & Willis 2004). The use of ‘bracketing’ has been one way to assist with this and consists of the researcher being consciously aware of how their own experiences and how potential preconceptions could influence their response’s and reflections. For example, if the researcher was interviewing someone who discussed the violence between themselves and their partner and the researcher themselves had witnessed violence between his/her own parents. The researcher would need to ‘bracket’ their own experience and the associated thoughts and feelings in order to ensure they remained focused on listening to the participant and providing subjective analysis.

Martin Heidegger (1962) was a philosophy scholar who was supervised by Husserl and was responsible for a movement within the phenomenological field away from transcendentalism towards existentialism. He discussed the need for inquiry into an individual’s ‘life world’ if we are to grasp their reality, as well as their meaning of being in the world (Lopez & Willis 2004). This consists of gaining narrative accounts of their everyday experience inclusive of interactions, relationships and bodily responses. This can then be used to understand that experience within the context in which it occurs. The concept of ‘situated freedom’ further supports this existential phenomenological position and asserts that individuals have access to freedom of choice, but the experience of their everyday life will lead to limitation of such freedom. This has relevance to the way in which the previous experiences of the participants in this study may impact on their ‘everyday life’ particularly their attachment relationships and functioning, and thus can limit potential experiences.

In contrast to Husserl, Heidegger placed value on the prior knowledge that the researcher may bring to the inquiry and felt it could in fact add further meaning to the phenomena of choice. He discussed the impossibility of the researcher operating in the way Husserl had suggested as Heidegger felt it likely that the researcher’s previous understanding of the area of study would ignite their interest to explore it further and that this could not be separated (Heidegger 1962). Personal knowledge is regarded by hermeneutic scholars as a requirement when conducting phenomenological research (Geanellos 2000) and this provides a further reason as to why this research project is suitably linked to the methodology of interpretive phenomenology.

**Methods**

Given the volume of information that was obtained from participants on three separate occasions and, in most cases, over a period of six months, the individual’s data set can be regarded as a case study. Case studies are viewed as ideographic with an interest in how they fit with other cases within the same unit of individual’s, as well as their fit with existing theoretical ideas and findings. Ideographic findings can be of particular relevance to the social work field, which operates on an individual case by case basis, and may also provide detailed information relating to practice issues and environments (Gilgun 1994). Furthermore, a case study can provide the opportunity to understand the subjective meaning the individual has made of certain life experiences and identification of themes within those experiences, as well as the potential for investigation of causal relationships (Runyan 1982).

The research question for this project seeks to explore the causal relationship that influencing factors could have on a positive or negative outcome for parents. However, given the nature of the qualitative data the aim is to produce a starting point for discussion and potential further research, rather than to make any specific causal claims.

**Reflexivity**

The experiences of the researcher may inform actions and decisions that are made in the research process, which in turn could impact on the phenomena being investigated (Horburgh 2003). Working within the field of child protection since 2009 has led to an extensive amount of experience as a practitioner in the social care system. This experience initially became the driving force for engagement in this piece of research and continuing to work within the field whilst completing it has inevitably influenced the academic journey. At the start, further clarity was achieved in relation to a potential gap in the literature from not only composing the literature review but also observing what the wider implications of closing or narrowing that gap could mean for practice, both in relation to myself and others.

Working with families in child protection is at times, challenging, emotive and all-consuming, and an awareness of how engaging with potential participants could trigger some feelings associated with those previous experiences was important. Consideration was given to the possibility of this happening and the need for self-awareness and composure, as well as the need to resume the position and mind set of being the ‘interviewer’ in this case rather than the ‘social care practitioner’. This was central to ensuring that the participant’s narrative was in no way influenced by such thoughts or feelings of mine, if they were to arise.

Forrester (2016) who has conducted a number of studies within the field of children’s social work highlights the importance of being aware during interviews with parents of potential ‘power dynamics’ whereby the researcher could be viewed as ‘an extension’ of the social work team. It was therefore important to present as a researcher rather than a social care practitioner, as the latter could have impacted quite considerably on the participant’s willingness to engage in a detailed narrative regarding their lived experiences, in relation to their past history, as well as their relationship with social care practitioners.

The majority of the interviews were semi-structured, therefore there was also the need to establish the ‘researcher voice’ and ask further questions that would provide clarification in relation to the research question of the thesis and remain in this mode of thought. Therefore, an instinctive ‘practitioner voice’ that had developed over a 6-year period, at the start of data collection, needed to be tuned out and turned off. There was no need to be in pursuit of further clarification in some areas of discussion because this was not a case where my professional contribution would be required, and if anything, such probing may well have interfered with the natural thought processes and reflections of participants. In addition, the need for paraphrasing as adopted in practice, as both a relationship-based tool and again to offer clarity on points of discussion, also needed to be halted. Paraphrasing within this domain could have caused the participant to change, alter or agree with a summary of their viewpoint that may not have ultimately been what they intended.

When you sit within the academic sector of social work, as well as frontline practice, the desire to attempt to bridge the gap between what is known, how this can be applied, and what needs to happen, is monumental and can often be the driving force behind many thoughts and behaviours. Whilst that passion has provided the motivation to continue with this academic challenge, it has been essential that any associated bias has been kept in check, in order to ensure that the story associated with my data is derived from the data itself, rather than my desire for what I want or feel it needs to say. For example, my practice has led me to believe that the capacity to mentalize is an extremely critical element within the attachment relationship, but I needed to be open to the fact this may not be clear from my findings. Or the focus I have placed on what I deem to be essential relationship based skills for social care practitioners may not have been what my participants reported as important for them.

**Reactivity**

In qualitative research the researcher is essentially the ‘main instrument of the study’ rather than standardised data collection (Shaw & Holland 2014 p.6). Researcher reactivity relates to the way in which the participant’s response could be influenced either positively or negatively by the interviewer’s reaction to their answers. Facial expressions such as a smile, nod, frown, laughter or upset, could alter how the participant chooses to respond to further questions. Conscious consideration was therefore given towards reactivity during the interviews. Given the nature of the interviews and the need for participants to recall incidences of trauma, as well as relationship experiences, a balance needed to be struck. Maintaining a neutral facial expression or not nodding a head was likely to not convey the level of empathy required to ensure the participant felt comfortable within that moment, and therefore continued with discussion of this narrative as well as any further difficult experiences. Adopting many of the ‘skills counsellors use such as active listening, mirroring and centring of their ‘emotional clay’ provided the best chance of participants feeling at ease during these interviews, and limited the need for a more noticeable facial expression or verbal response from me.

Another form of reactivity is when the participant chooses to react to the questions themselves in a way that is more closely linked with how they wish to see themselves rather than an accurate depiction of reality. Although all the participants were aware that the detail of the interviews and their engagement with the study was separate from their involvement with social services and would remain confidential, they may still have been conscious of this during discussions. The fact that the final outcome, regarding whether participants would continue to care for their child, would be known at the end of the data collection period allowed for awareness of when this may have been the case. The disconnect between how they viewed themselves, particularly in relation to parenting, and the reality was an important element to consider within the research question and so occurrence of reactivity in this form was not viewed as a hindrance to reliability but rather had the potential to provide further reflection for understanding the participant.

**Research Design**

*Participant Selection*

The sampling method employed for this project was non-probability purposeful sampling. Initially, the criteria for involvement in the research was that the participant was a parent who was receiving parent-infant psychotherapy through The Perinatal Infant Mental Health NHS service, based in north east London. All of the therapists within this service hold a qualification in either psychology, family therapy or adult/child psychotherapy and they use techniques associated with psychoanalytic, and attachment theory. Appropriate participants needed to have one or more children placed on a child protection plan and a previous history of attachment based trauma. Their mental health needs had to relate to an environmental cause rather than any organic form of psychosis, as this would have impacted on the generalizability of findings to the population being studied. They also needed to be engaging or be about to engage in parent-infant psychotherapy with one of the perinatal therapists within the service. Consideration needed to be given to how and when the therapist would introduce the concept of the research. Although a participant information sheet (see Appendix B) had been compiled, most therapists felt it necessary to have a verbal discussion with participants first before giving them the written information. They felt this provided a better chance of gaining their agreement to participate. Ideally, the recruitment of participants would have taken place at the start of the work with the therapist. However, one therapist understandably wanted to have laid the foundations for their therapeutic relationship before broaching the topic of involvement in the study.

The aim was to recruit between 15-20 participants. However, after a period of six months, only one participant had met the criteria and been interviewed for the study. The lead consultant perinatal therapist from the service was surprised by this, having predicted more potential participants would have accessed the service by then. The problem seemed to be two-fold: firstly, the project was of course reliant on the referrals that were coming in meeting the research criteria. In order to play a more active role in this process, I attended a number of referral and staff meetings, as well as maintaining regular correspondence with the deputy manager of the service who supervised the referral process. The second aspect of the recruitment problem appeared to relate more to the participant type under study who had experienced previous significant attachment trauma and had associated mental health difficulties, as well as managing the process of working with children’s social services. Therefore, although some participants had been identified, some declined or were not consistently attending therapy, or in one case they had their child removed from their care and no longer continued with the therapeutic treatment.

Given the need to stay on track with the final deadline for the thesis, a second plan for widening recruitment criteria was required. Although this was disappointing, it did highlight the lack of referrals being made from practitioners within children’s services to what is a free service that has the potential to offer intensive therapeutic intervention until a child is five years old. The reasoning for this remains unknown. Perhaps it was caused in some cases by a lack of awareness that the service exists, or could it be that social care practitioners are not always aware of the exact functioning of the parent’s mental health and the implication on the attachment relationship and therefore the required intervention.

The next plan of action was to use the same research tools that will be discussed later and recruit from additional services offering parent-infant psychotherapy. The Perinatal Infant Mental Health service in north east London is unique, as there is no other NHS perinatal mental health service that runs as a standalone service anywhere else in the country. Contact was made with The Anna Freud Centre in London, which offers parent-infant psychotherapy. They were willing to provide participants, however, they wanted the study to be conducted exclusively within their service. They also wanted to change one of the research tools to a measure they used more commonly within their practice, so for those reasons this was not a viable option. Contact was then made with a wider organisation that provides parent infant psychotherapy across parts of the country i.e. Parent Infant Psychotherapy UK (PIP). The director of the organisation was not willing to allow recruitment from the service as there was another project currently being undertaken with their clients.

The final plan was to attempt to recruit participants from local authorities using the same research tools but with slightly amended criteria due to the unlikelihood of local authority families having access to parent-infant psychotherapy. Instead, what constituted ‘intervention’ was a family that had been placed in either a parent-infant foster placement or residential assessment unit. This would have been decided due to the level of safeguarding concerns the local authority had about the family if they were to reside in the community with their children. The rest of the criteria remained the same in relation to previous attachment trauma history. Involvement with children’s services had already been widened to include parents with children on child in need plans, to increase recruitment opportunities within the NHS service. The fact that the research tools and the criteria remained, for the most part the same, meant that the data that had already been collected from one participant within the NHS service, whose story was incredibly thought-provoking with a significant depth of narrative, could remain included.

Recruitment within the local authority did eventually improve participant numbers but it was far from straightforward. Agreement from the local authority’s research and development teams had to be obtained, and each local authority had a different process for achieving this. Once agreement was gained, contact needed to be made with the managers within the children’s services teams so that a discussion of potential cases that met the research criteria could begin. From there, the contact details for the allocated social worker were required. Getting a response from some managers and practitioners was, at times, challenging and therefore frustrating but understandable given the daily demands of work within the service. I would estimate that around half of the practitioners that were contacted were willing to help, and appeared pleased that this area of research was being explored.

It became clear that consideration needed to be given to how the (potential) participant within the local authority would be informed about the study. Ethical considerations will be detailed later, but it did not seem appropriate to gain access to their phone numbers via the local authority, as the initial contact made could feel to them like they had experienced ‘cold calling’. The most suitable plan seemed to be to briefly discuss the research with the family’s social worker and ask them to mention the project to the parent, leaving them to decide whether they agreed to the researcher contacting them. This may have been the most suitable option, however, it could have posed problems for two main reasons. Firstly, if the social worker was introducing the research idea to the parent then it may have appeared as if there was a connection between their participation, and their involvement with social services. Although the social worker had been asked to emphasise that the two were in no way connected, it was made even more explicit in the participant information sheet. Secondly, if they had a particularly turbulent relationship with their child’s social worker that may well have also influenced their decision. However, contacting parents via the social worker felt the most suitable plan of action.

For the participants who were receiving therapy, the therapist initiated the conversation introducing them to the research. If participants agreed to being contacted, they were then offered a meeting to discuss, face to face, what the project was about and what their involvement would entail. In most cases, the purpose of these meetings appeared to be for them to form an opinion of the researcher and most likely decide whether this was someone to whom they would feel comfortable divulging personal information.

Gaining access to this participant group is widely acknowledged within the field as being especially challenging. As previously stated in the literature review, their attachment histories may have caused some potential participants to become programmed to ‘fear and distrust’ others (De Bellis (2001). Therefore, it is not surprising that recruitment for this project was not a straightforward process.

The final number recruited was 18, with one participant dropping out after the first interview. Considering most families were followed over a period of 6 months, this was a surprisingly low dropout rate for this participant group.

The final sample consisted of 3 participants who had received parent-infant psychotherapy, all of whom had children placed on child protection plans, one of which had also been placed in a parent-infant foster placement. The remaining 14 were recruited via local authorities; 9 were placed in a residential assessment unit and 5 were in a parent-infant foster placement. 13 participants from the local authority had children placed on child protection plans and one was on a child in need plan. Participants came from 7 different local authorities. There were 12 females and 5 males. The individual’s demographics such as age, location, and sex were not recorded, as they were not deemed necessary for answering the research question. This also assisted with helping ensure participants felt more confident in their anonymity. The male population are notoriously harder to engage in social work practice, as unfortunately in many cases they are not taking an active role in family life, and therefore do not feature in large numbers in social work research either. Therefore, it was helpful to have 5 males who were willing to take part, and rather uncommonly this study included one father who attended the placement as the sole carer. There were 7 parents who had previously had children removed by the local authority. Of the total 17 that took part in the research project 9 parents continued to have their children in their care, 7 had children removed by social services and 1 continued to care for the two youngest children but not the eldest.

In addressing qualitative requirements for sample sizes, the most important element to consider is ‘saturation’. This refers to the point at which the data consists of an acceptable range of experience and opinions. Therefore, findings can successfully answer the research question. The aim is to achieve homogeneity between participants and once this has occurred the consensus amongst qualitative researchers is that saturation has been achieved, and therefore increasing participant numbers does not contribute anything more than what is already available to be known. If this is not the case and a high level of heterogeneity exists, whereby there are vast differences between the data, then an increase in participant size is likely to be required. Acknowledgment of this cannot be done retrospectively but should take place during the data collection process. For this project, it was done by maintaining an awareness of any reoccurring content or potential themes that may have been emerging during the process of data collection.

*Interviews*

Participants were interviewed on three separate occasions for the semi-structured interviews. A table detailing the interview schedule can be found in Appendix E and the questions designed specifically for this study can be found in Appendix F/G.

Interview 1

During the first interview, participants were asked to complete the Trauma Symptom Checklist (see Appendix A) designed by Briere & Runtz (1989). This lists 40 symptoms that are associated with the experience of trauma and the participant is asked to rate the symptoms on a four-point scale. 0 indicating that they never suffer with that symptom and 3 being that they often do. Four symptoms relating to sexual behaviour, thoughts and feelings were removed, as this information could have made some participants uncomfortable and was not deemed necessary for the research question. The checklist has been designed to provide a quantifiable score in relation to the participant’s mental state pertaining to the following categories; dissociation, anxiety, depression, sexual abuse trauma, sleep disturbance and sexual problems. This checklist was not scored, partly because of the removal of the four items, but instead provided an opportunity for the participants to talk about their current emotional and physical states. Each item was discussed within the interview for further elaboration rather than a score in the box, thus linking with the merit of qualitative rather than quantifiable data for a depth of detail.

The first interview also consisted of participants being asked a series of questions that were specifically designed for this research project. These explored the participants’ understanding of why they were receiving the intervention, their thoughts on engaging in it, whether they felt they could benefit from it, as well as a discussion about their relationship with their child’s social worker and foster carer/key worker or therapist. Lastly, initial exploration of their past and current attachment relationships also took place. It felt necessary to explore this during the first interview in case further interviews did not take place due to immediate removal of their child, and therefore there could still be some value to obtaining this data.

The final research tool that was used within this interview was The Working Model of the Child Interview (Zeanah *et al*. 1995). This interview is designed to assess the parent’s internal working model of their relationship with their child. Zeanah and colleagues (1995 p.1) point out that ‘the purpose of the interview is to have individuals reveal as much as possible in a narrative account of their perceptions, feelings, motives and interpretations of a particular child and their relationship to that child’. An official coding system can be applied to the interview, which requires training, whereby participants fall within three categories in relation to their overall state of mind in respect of their relationship with their child. Given the fact that this study was qualitative, it was not deemed necessary to use this classification system and instead the interview was used simply due to the way it encouraged the participant to talk at length about their relationship with their child. During the initial stages of the research design, the use of the ‘Reflective Functioning Questionnaire’ (Luyten *et al.* 2009) was explored. However, this was designed with a specific complex coding system and required training to gain full access to the material.

Interview 2

The second interview took place for most participants a few weeks later, aside from one participant who was interviewed a few months later due to difficulties getting back in touch. The Adult Attachment Interview (Main & Goldwyn 1994) was used with participants, which is designed to guide individuals through discussion of their childhood attachment experiences, additional trauma and loss, as well as the current dynamics of close relationships and the future hopes for their children. The interview was originally designed in conjunction with a coding system. However, this requires intensive training with accreditation to classify the participants’ adult attachment style which was not necessary for the qualitative purposes of this study. Therefore, the interview was used simply due to the way its design encourages participants to talk at length about their relational experiences. When this interview is used within a therapeutic setting the client can receive feedback afterwards. Given that it was conducted for research purposes and was not coded or scored for attachment style this did not feel appropriate. Doing this may have caused some confusion for the participant in relation to the role of the researcher and could also have been perceived as intervening in the participant’s case. In addition they may not have seen the researcher again and this feedback is more appropriate when a longer term professional relationship can be offered. For those participants who received parent-infant psychotherapy they agreed for the interview to be shared with their therapist who was able to use this information in their sessions.

Some of the questions in the Adult Attachment Interview (AAI) are believed to offer an explicit measure of an individual’s capacity for reflective function (Fonagy *et al.* 1998). Training on how to code reliably for this was completed prior to engaging in the research project and this coding system was not used numerically but as part of establishing patterns within and across the narratives. The principles of this coding framework can be applied to any guided conversation whereby someone is asked to explicitly discuss their thoughts and feelings on relationships and behaviour of themselves and others. Therefore, this was also applied to the Working Model of the child Interview (WMCI) (discussed above), as well as all of the initial and final interviews.

The narrative discussion from this interview provided the majority of the content for the key themes that emerged relating to trauma and mentalization.

Interview 3

The final interview took place a maximum of six months after the initial interview (Appendix G). This timeframe was set in line with child protection legislation, which states that once court proceedings are initiated by the local authority there is a period of twenty-six weeks until the final hearing, at which point the outcome for the child is ordered by the court. Therefore, this ensured that by the time the final interview was conducted the outcome would be known. During the final interviews, the trauma symptom checklist was repeated to offer the opportunity to observe whether there were any changes before and after the intervention but once again this was used purely for qualitative discussion rather than any statistical analysis. An additional set of questions was prepared specifically for this interview to provide an update on what had happened since the last meeting, what the final outcome for the family was, as well as to offer reflection on the overall experience and relationship with the professional network involved in their case (Appendix G). For most participants, this interview was conducted with a phone call rather than face to face. This decision was made in light of the logistics of planning a face-to-face meeting that was not likely to be lengthy. However, those participants who had not had a positive outcome and whose children had been removed from their care were offered the option of a face to face meeting or phone interview. Only one couple opted for a face-to-face interview and it very much felt as though they welcomed the opportunity to meet with an ‘outsider’ and discuss their reflections on what had happened.

As mentioned previously, follow-up interviews with this group of participants are often not successful and therefore it was surprising that only 3 out of the 17 were not able to be contacted. This did not impact too greatly on the overall findings because the outcome for the family was obtained through communication with the child’s social worker, or placement.

The purpose of these three interviews was to enable participants to provide detailed accounts concerning their past and current experiences, as well as their relationship with their child. The combination of standardised questions, as well as interviews designed specifically for this research project has, it is argued, contributed to the originality of this study.

*Ethics*

The original research design consisted of recruiting exclusively from the NHS north east London Perinatal Mental Health service. To recruit participants from any service located within the NHS requires extensive processes to be undertaken before approval for the project is granted. There is no distinction made between research based on a clinical trial and research that consists of qualitative narrative inquiry. The first task was to complete an online examination on ‘Good Clinical Practice’. Completion of an application to ‘The Research and Development’ department was then required alongside a separate application for ethics approval. Given the sensitive nature of the discussions that would be taking place with participants, some of whom could be considered particularly vulnerable, it was deemed necessary that the application be discussed at a meeting with a board of professionals, comprising senior lecturers, medical staff and a legal representative. This meeting took place on the 8th of July 2015, with the addition of some further information supplied following this meeting. Ethical approval was then granted on the 5th of August 2015.

The following areas were given ethical consideration:

Informed Consent

Following the initial discussion about the research project participants were provided with an information sheet. This detailed the purpose and background of the project, what their involvement would entail, and the potential advantages and disadvantages of taking part. This was written in simple, clear language, providing the necessary amount of detail, being mindful of not wanting to overwhelm potential participants. Before agreeing to consent, participants met with the researcher who read through the information sheet with them and gave them an opportunity to ask any further questions. They were then provided with the consent form (see Appendix D) and this was also read to them and again they were given the opportunity to ask questions before consenting to take part. The literacy level of some participants was not known and so this also ensured that they were made fully aware of all the information that had been listed for them. It was also appropriate that full consideration be given to their capacity to consent, which was considered during all discussions that took place prior to placing their signature on the consent form. If at any point during interviews this capacity had diminished and they appeared unable to coherently answer the questions due to a cognitive difficulty or intoxication, then they would have been withdrawn.

Participant Wellbeing

The Adult Attachment Interview involves potentially detailed discussion of psychologically distressing events such as incidences of abuse, loss, and additional trauma. The likelihood of participants becoming upset during the interview can be quite high. Consideration therefore needed to be given in relation to how this would be responded to and managed both within the interview and once it had finished. Having become accustomed to using this interview within six years of social care practice, a great deal of experience had been gained in terms of its administration and offering the appropriate level of emotional support. For the NHS patients, their therapist would have been contacted if there had been any difficulties in providing the necessary level of support, and if it did not feel appropriate to leave the participant. The local authority participants were residing in foster placements or residential units and therefore a professional support network was available, should this have been required. Participants would also have received a follow-up call from me later that day if they had become distressed at any point during the interview.

It was unlikely that participants would have got to the end of the interview and remained in a distressed state due to the design of the questions. This interview is used by many therapists as a measure of assessment and to facilitate later therapeutic intervention. It offers the interviewer the opportunity to take the interviewee on a journey, from past to present, with the final questions moving the individual’s focus and conscious thought back to present day. The final questions detail the future wishes they have for their own children and what they would like their children to have learnt from their experience of having them as a parent. Despite some participants becoming upset at times when discussing difficult experiences, none of them remained in this state at the point at which the interview ended.

Data Recording

All the interviews were recorded using a Dictaphone for the purpose of later transcription. Permission to record the interviews using this device was sort via the participant consent form and detailed in the participant information sheet. It was also made explicit that all data would be stored in accordance with the Data Protection Act (1998). The data was likely to include some extremely personal information, hence participant anonymity was critical. Participants were not asked to provide any personal data and were assigned a participant number. Names of people and places mentioned during the interviews were omitted from the transcripts to ensure that publication of data would not result in identification of participants.

Confidentiality

Participants were informed verbally and via the participant information sheet that all the discussions that took place with the researcher would remain confidential. However, if the participant mentioned anything that could cause harm to themselves, their child, or anyone else then this would be passed to their child’s social worker. It was made clear that unless this was the case then all the information they provided to the researcher would be kept confidential from children’s social services. It was also made clear that their involvement with social services would in no way be affected by taking part in the study, and that they could withdraw their participation at any point, which would not impact in any way on decisions being made by their child’s social worker.

Researcher Safety

Finally, the safety of the researcher also required consideration. Previous training had been received whilst working for social services in terms of managing conflict and aggression, as well as risk assessment. If participants were being visited at home, communication with their therapist or social worker took place in order to be made aware of any potential risks within the home environment. The location of the interview was given to the academic supervisor who was notified of the researcher’s entry and exit from the property.

**Data Analysis**

As stated above, all interviews were recorded using a Dictaphone for later transcription. It has been argued that transcription should be viewed as ‘a key phase of data analysis within interpretative qualitative methodology’ (Bird 2005). This research design required a semantic record of the interviews, which included documenting all the words spoken by both the participant and the researcher. These words were spelt conventionally unless they were non-conventional words such as slang. If unfamiliar terminology was used by the participant then further clarification was requested. All non-verbal utterances such as laughter, significant hesitations or pauses were documented, as well as participants’ dialogue with anyone else during the interview. All transcripts included line numbers to aid with the later process of coding. In total, there were 48 interviews that needed transcribing and the use of the speech recognition software program ‘Dragon Naturally Speaking 12.0’ sped up this process considerably.

*Thematic Analysis*

Thematic analysis is not tied to a specific theoretical framework and as such it can be used across various epistemological and methodological domains. It is suited to hermeneutic (interpretative) phenomenology by providing the reader with detailed extracts of an individual’s account of their experiences and then interpreting this to produce themes both within and across data sets. These themes then offer potential explanation of the phenomena under investigation. The key advantages of using thematic analysis have been listed by Braun and Clark (2006) and the following relate closely to the aims and objectives of this project. Firstly, they assert that this method of analysis can summarise significant features of large bodies of data to offer ‘thick description’ of the data set. Most participants engaged in 3 interviews that culminated in an average of 2-3 hours of recordings per participant. It was therefore important to use a method of analysis that would consolidate the important features, whilst enabling the reader to maintain a connection to the raw description and depth of feeling conveyed by the participants. Secondly, it can be used to highlight similarities and differences across the data, which was important if these emerged across participants who had a positive outcome and their baby remained in their care, compared to those whose baby was removed from them. Lastly, they highlight how thematic analysis can be beneficial for producing qualitative analysis that is suitable for informing policy and development, whilst this piece of research would need to be replicated on a much larger scale to do this, it certainly has been designed with current social care policy and procedures in mind.

Interpretative Phenomenological Analysis (IPA) was also considered, however once further reading around its application took place thematic analysis appeared to be a better fit. IPA and thematic analysis share several similarities as an approach but there are some key differences that made it less suitable for this project. The focus of IPA centres on the person’s description of their experience and ‘giving voice’ to that experience, whereas thematic analysis also wishes to offer a comprehensive ‘analysis’ of that voice. This project aimed to capture the experiences of parents being offered intervention but also to produce detailed analyses on the potential reasoning for these experiences. Thematic analysis offers greater flexibility to be able to apply this framework of ideas, and therefore work deductively. In addition, sample sizes tend to be kept reasonably small when using IPA, with a recommendation of between 3-11 participants (Smith, Flowers, & Larkin 2009). This may not have captured the range of interventions included in the way that a slightly larger sample size has for this study. IPA has an ideographic focus in terms of the depth of detail included for each individual within the study, as such its approach to generating codes and later themes is in line with this. In IPA research codes are produced after analysing the first item of data and then subsequent themes for that item before then moving onto additional items for that individual. Both themes and codes are produced before data from the other participants are analysed. Thematic analysis conversely focuses initially on developing codes across the entire data corpus, which are then sorted into appropriate themes. This latter approach felt more suitable in order to become aware at an early stage of analysis if potential patterns were emerging in relation to positive or negative outcomes experienced by parents and therefore keeping these in mind when coding across all of the interviews.

At the start of engagement with the thematic process, several decisions regarding the analytical approach that will be used must be clear in the researcher’s mind. The research question will essentially dictate whether an inductive (data driven) or deductive (theoretical) approach is used. Given the specific nature of the research question and its connection to the framework of attachment theory, a deductive approach to analysis has been applied. Coding therefore took place with the research question and theoretical framework in mind, with potential identification of themes that might represent influencing factors on outcomes for parents. Secondly the choice of whether a semantic or latent approach would be used was considered. Braun and Clark (2006) use the analogy of the data representing an uneven blob of jelly, to help clarify the difference. Semantic analysis would provide a description of the jelly’s surface, whereas the latent approach would attempt to identify what and why it came to be. To successfully answer the research question for this project analysis needed to move beyond purely semantic description of the data and include interpretation of why the description exists in the way that it does, and how this might have impacted on the overall outcome for the parents. Additionally, the use of latent analysis fits suitably within the interpretative epistemology discussed at the start of this chapter.

Before any initial coding, it felt beneficial to consider what constitutes a ‘theme’. McLeod (2011 p.145) discusses the application of thematic analysis within counselling and psychotherapy, and given the content expressed by the participants in this project, his definition felt applicable. He states how a theme moves beyond the simplicity of content and is ‘a recurring pattern, which conveys something significant about what the world (or the particular aspect of the world being discussed) means to a person’. In addition to this Braun and Clark (2006) assert that a theme ‘captures something important in relation to the overall research question’. Both these statements were kept in mind during all stages of analysis.

Guidance on how to carry out accurate and reliable thematic analysis was gained from Braun and Clark (2006) who are among the only researchers to have produced clear and concise step by step guidelines that are accessible for any qualitative researcher. Boyatzis (1998) is also referenced amongst thematic analysts. However, his five-step procedure contains less instructional detail and is more often situated within the positivist empiricist paradigm (Braun & Clark (2006). Each stage of the analysis will now be discussed, although it is set out sequentially thematic analysis is regarded as ‘a nonlinear recursive (iterative) process in which data collection, data analysis, and interpretation occur throughout the study and influence each other’ (Willis 2007).

**Phase 1: Familiarisation with the data**

The transcripts for the entire data set were read through twice to facilitate an immersion in the depth of content. Although this was time-consuming Braun and Clark (2006) consider this phase to be the ‘bedrock’ for the following stages of analysis.

**Phase 2: Generating initial codes**

At this stage interesting aspects of data were highlighted and assigned an initial code. Each code was matched with the data extract from which it had been derived. A table was constructed for each participant to list all the initial codes and the associated data extracts for each interview. This provided a base from which reoccurring codes across the data set could be observed. To explore this further the codes for the first three interviews were placed in a 3-column table so similarities and differences could be observed. Knowledge of these initial patterns was then kept in mind as the coding process for the remainder of the interviews continued. Once all interviews had been assigned initial codes, a further two tables were produced to look for patterns of similarity and difference between the codes of the participants who had a successful outcome after placement against those who had their child removed from their care.

**Phase 3: Sorting codes into themes**

This phase consisted of analysing the codes to collate them into a broader theme. All codes were placed in one large table and where similarities occurred these codes were placed into an additional table, which was then titled with a theme. By the end of this phase each theme had its own table with all the relevant codes and data extracts for each code. Some of the initial codes became themes, whilst others became sub-themes. Throughout this phase it was important to maintain a reflexive position, being mindful of the story the data was telling and therefore in no way forcing it to fit with an established theoretical position.

**Phase 4: Review themes**

Once the candidate themes had been produced, these were reviewed to ensure they provided an accurate depiction of the coded data, and that there was enough data to support them. A ‘thematic map’ then provided clarity on the decided themes and sub-themes that would be used within the next stage of analysis. Consideration for the validity of the themes took place during this stage by questioning their link to the ‘meaning evident in the data’, ‘how well they fit together’, and ‘the overall story they tell about the data’ (Braun & Clark 2006).

**Phase 5: Defining and naming themes**

At this stage, I wanted to trial being able to produce a written account of what each theme was saying about the data. I was mindful of not simply paraphrasing what the participants had said, but detailing why these accounts were interesting and were of significance in answering the research question.

**Phase 6: Final analysis and write up**

During this stage, I selected the final narrative extracts I wanted to use for each theme, as for many of them there had been a large amount of data extracts obtained. I then began the process of writing a detailed analysis of each theme. I was mindful of telling the complex story of my data in a way that demonstrated its validity without compromising its accessibility.

Qualitative research tends to achieve validity through different means to quantitative methods. Firstly, there is a need for a ‘*rigorous research design*’, and it is hoped that this chapter has provided a clear account of the thoughts and considerations given at the start to achieve this. Secondly ‘*confirmability*’ should be achieved by the researcher operating in a reflexive manner. The extent to which I was mindful of needing to function reflexively during the processes of the research design, interviews and analysis was discussed earlier in this chapter. A further method of ensuring confirmability was to continuously re-read the transcripts and making note of any anomalies. ‘*Credibility’* refers to the extent to which the findings represent truth. Using a deductive approach has arguably strengthened the credibility of the research, as the majority of the findings have been explicitly linked with previous theory and research from within the field of attachment. Further discussion of this as well as the *‘transferability’* of findings will feature in the final chapters of this thesis. Finally, ‘*dependability*’ reflects the extent to which another researcher could repeat the study and produce consistent findings. Within the approval process of conducting research using NHS patients, a peer review of the research design was required. Dr Wilkins, Senior Research Fellow at the Tilda Goldberg Centre for social work and social care, kindly provided this for me. This indicated that the research design was understood, which suggests that another individual could replicate it. Given the fact that there did not appear to be any considerable anomalies within the data, and it was a respectable sample size that achieved homogeneity between participants, this indicates that similar findings could occur if replication of the study took place.

This chapter has introduced the research question and the reasoning behind why this appeared to be an appropriate area to study. It has outlined the philosophical stance that was taken, the decisions made regarding the most suitable research design and analysis, as well as how this method of analysis was applied.

**Chapter 6- Findings**

Thematic Findings

The following section details the themes that emerged from the guided interviews with the participants. All of the themes from the interviews with participants who passed their assessments will be discussed first, followed by the themes that were present for those who did not pass their assessment. All of the names mentioned during the interviews have been anonymised. Table 1 lists the individual themes identified within each participant outcome group. Tables 2, 3 and 4 list the experience factors that emerged for each group. Table 5 details the distribution of types of intervention and the participant outcome, and Table 6 shows the distribution of thematic factors for each outcome group. The distribution of thematic factors for each individual participant can be found in Appendix H.

|  |  |
| --- | --- |
| **Positive Outcome**  | **Negative Outcome**  |
| Acceptance  | Denial  |
| Determination  | Low Mentalization  |
| Mentalization | Negative talk about baby  |
| Positive talk about baby | Lack of factors |
| Angel in the nursery | Disconnect with trauma  |
| Internal Working Model intact |  |
| Caring for siblings |  |
| Feeling loved and cared for |  |
| Connection to trauma |  |

*Table 1: Individual Thematic Factors*

|  |  |
| --- | --- |
| **Intervention**  | **Themes**  |
| Residential/Foster Care | Anxiety |
|  | Isolation |
|  | Time out restricted  |
|  | Balanced approach |
|  | Feeling cared for |
|  | Helpful |
| Therapy  | Initial reluctance/hesitation |
|  | Positive change |
|  | Positive mentalization |

*Table 2: Intervention experience factors for participants with a positive outcome*

|  |  |
| --- | --- |
| **Intervention**  | **Themes**  |
| Residential/Foster Care | Anxiety |
|  | Isolation |
|  | Helpful |
|  | Perfect parent fallacy  |
|  | Controlling  |
|  | Switch of viewpoint  |

*Table 3: Intervention experience factors for participants with a negative outcome*

|  |  |
| --- | --- |
| **Positive outcome themes for relationship with social worker** | **Negative outcome themes for relationship with social worker** |
| Negative approach | Initial Positivity  |
| Negative communication | Potential misinterpretation  |
| Lack of transparency  | Confusion over role |
| Conflicting views | Lack of transparency  |
| Tunnel vision  | Trauma inducing  |
| Perfect parent fallacy  |  |
| Lack of empathy  |  |
| Persistent worry/Trauma inducing  |  |

*Table 4: Relationship with social worker experience factors*

|  |  |  |
| --- | --- | --- |
| **Intervention** | **Positive Outcome**  | **Negative Outcome**  |
| Therapy  | 2 |  |
| Foster Placement and Therapy  | 1 |  |
| Foster Placement | 4 | 1 |
| Residential Placement | 2 | 7 |

*Table 5: Participant intervention and outcome distribution*

|  |  |  |
| --- | --- | --- |
| **Thematic Factors**  | **Positive Outcome** | **Negative Outcome** |
| Acceptance | 8 |  |
| Determination | 6 |  |
| Mentalization | 8 |  |
| Positive talk about baby | 9 | 1 |
| Angel in the nursery  | 7 | 2 |
| Internal Working Model in tact | 5 |  |
| Caring for siblings  | 4 |  |
| Feeling love and care for  | 6 | 2 |
| Connection to trauma  | 9 |  |
| Denial |  | 8 |
| Low Mentalization |  | 8 |
| Negative talk about baby  |  | 4 |
| Disconnect with trauma  |   | 7 |

*Table 6: Distribution of Thematic Factors for each outcome group.*

**Positive Assessment Outcome Themes**

Acceptance

All the participants had been requested by social services to engage in some form of intervention: therapeutic, residential or a parent-infant foster placement. This was due to the fact that concerns had been raised in relation to their parenting capacity. It became apparent from the data that some participants appeared accepting of these concerns and communicated this with a narrative that was clear, detailed, and reflective.

For some, that acceptance appeared to be present from the start of the placement, both in terms of acknowledging that concerns from social services were warranted, and that there were aspects of their parenting they would need help and support with. Luke was receptive to the idea that things needed to be different and seemed to welcome the advice from staff within the assessment unit.

***‘So, what did you think social services might be concerned about?’***

*‘That we would go back to the state we were in, that we wouldn’t care for Bella and meet her needs and that lot’.*

***‘And what’s your thoughts in relation to that?’***

*‘It’s good because we do need help because we haven’t had a baby before, so it is good, yeah it is nice here, it’s really nice here they are nice people’.*

Luke’s partner Chloe was also in the assessment unit with him and shared a similar viewpoint in terms of accepting the help, and acknowledging that there might be areas they would need to make improvements in. She talked positively about the plans in place for supporting them to make any necessary changes.

*‘If there is anything we are struggling with to do with Bella then we get help. They show us how to do it, or tell us how to do it and then we just have just got to improve on it and they give us like an assessment of how we are doing. We had one in three weeks and we should have one in six weeks and then twelve weeks of how we are doing and what we need to improve on’.*

Lucy had her son removed from her care after her mental health struggles led her to call social services one night because she could no longer cope with his cries. When she became pregnant some years later she contacted social services and informed them of the pregnancy with a view to starting the process of receiving any support they thought she was going to need. Therefore, she had continued to be accepting of her difficulties and any necessary intervention. In addition, when discussing the guilt she experiences due to her son having to live with her mother, she stated, ‘*What he is going through at the moment…the only reason he lives there is because I couldn’t do my job properly’.*

Tracey articulated that she had been responsible for the removal of her previous children stating, *‘I brought it on myself*’. Similarly, Lisa also implied some responsibility in the need for social services to intervene, ‘*I hold my hands up I have done wrong since before coming here*’.

Sarah acknowledged that she would benefit from ensuring that that the social worker’s concerns did not happen again. She also mentioned her commitment to therapy long term if that was deemed necessary, therefore demonstrating her acceptance of continued intervention.

*‘If I still need it in two years’ time or five years’ time or whatever I will still do it just to get me to the level that I need to be, so I can be a better person in myself, address the issues that I have had and obviously be a better parent’.*

Some participants did not show signs of initial acceptance, however in time they could reflect on why the intervention had been required. For example, Becky’s dislike of being in the placement meant that initially she was less open to accepting why it was necessary. However, as time passed and her experience in the placement became more positive this appeared to change, and she was able to articulate a reflective accepting response.

 *‘I was homeless at the time when I had Grace in hospital I had nowhere to go, but also with what happened with my son they wanted to keep a close eye on me to see if I was going to be able to parent Grace or not. So I can understand why I was there but at the same time I didn’t want to be there. In the end it was the best thing for me because I got the help. I got the support I needed and the best chance to bond with her’.*

Determination

Participants whose narrative indicated ‘determination’portrayed a strong sense that their baby remaining in their care was their sole focus and priority. They would therefore be willing to do all that was necessary to ensure that this happened. The fortitude of this mind set appeared to influence many aspects of their daily life, ranging from their conscious thoughts, to their behaviour as well their interactions with social care practitioners. There were three main areas where determination emerged most strongly: determination to care for their baby; determination to prevent the intergenerational cycle of abuse and determination in relation to their hopes for their baby’s future.

 Determination in caring for baby

There were some narratives that communicated there was nothing that the participant wouldn’t do to ensure they continued to care for their baby. For some this came in the form of simply making that statement.

*‘I would do anything that was possible to help me keep my child’.*

*‘I would sacrifice anything’.*

*‘I was going to do everything to get her home here, anything’.*

For others they were more explicit about what they would be willing to do such as relocating to the furthest place possible, or agreeing to several things that they didn’t want to. Lucy expressed the way she would be willing to risk her own life if it meant she could keep her baby.

*‘Listen if somebody tells me to go and sit in a cage with a bear for five minutes just to keep her… I would do anything, absolutely anything, as I love my baby, that’s why I’m doing it’.*

Jack struggled to comprehend how the partner of his baby did not have the same mind set as him when it came to being prepared to do anything for their son as she had missed several contacts with him.

*‘If it was the other way round and I had to travel to come to see him, and I didn’t have a travel warrant, I would just start walking two days before hand and I would pitch a tent, you know. I would literally do anything for him’.*

Determination in preventing the intergenerational cycle of abuse

Many participants expressed strong feelings that they would never treat their child in the way they had been treated. The assumption that the care they offered their child would in any way resemble the care they had received appeared absurd and for some appeared to anger and upset them. Being able to connect with their childhood attachment experiences and the associated feelings seemed to provide a driving force to think explicitly about why this was not something they would want for their own children. Leah appeared to feel the most annoyance by this presumption concerning the type of care she might provide to her baby.

*‘I have been told that like so many times…she was like you are gonna turn out just like your mum. And that pissed me off because you don’t even know, I can tell you but you don’t know. You don’t know what is running through my head about that woman. I hate her so much, like like no one understands what I did go through and it’s hard to explain, like especially like when people say that to me and I am like are you dumb? Are you thick? I will never in my life treat my daughter the way she treated me I would rather die’.*

Sarah also spoke passionately about ensuring that her children would never go through anything that resembled her own experiences.

*‘Just because I had a bad childhood there is no way that I am gonna let my child have a bad childhood. I know I’m not much in my children’s lives as much as I’d like to be, but I wouldn’t never let anything like that happen to any of them, especially Lexi is in my care, and I would never let her witness anything like that’.*

Lucy stated how not only would she not do what her mother did to her to her own baby, but implied this had shaped her intentions to ensure that she gives her daughter everything her mother didn’t provide for her. She also talked more specifically about her mother’s responses to her mental health difficulties and how she often felt misunderstood.

*‘I am going to take everything my mum never was for me and give that to her. I would never try and turn this baby into anything that she wasn’t. If she was to have mental problems then there is absolutely no way that I would do anything other than try and understand. Like I said my mum calls me a drama queen for my overzealous reactions to things’.*

 Determination for the baby’s future

 Determination for a positive future for their babies was indicated through narrative discussion that was detailed and appeared thought through. Participants connected not just with concrete aspects of life such as a good education or a good job but the desired mental state for their child. One participant specifically mentioned how toys and presents are not what matters but what was more important was his son’s ‘*emotional side’*. The most prevalent desires for their children’s future mental state was that they would feel safe, loved and cared for. Sarah’s narrative demonstrated a variety of feelings she would like her daughter to experience and the role she intends on playing in order to make this happen.

*‘I don’t want her to be growing up in someone else’s house. I want her to know where she belongs having a sense of security and know you know where her roots are and…know that she is wanted and loved by her own family. All I want to do is enrich her life and give her the best life I possibly can’.*

Another area where determination for their baby’s future was evidenced was through consideration of the type of relationship they hoped they would have with their baby. This sometimes appeared as a desire for closeness as well positive communication whereby the child would feel able to bring to them whatever was on their mind. In addition, it suggested a desire for their child to feel that their parent was available as and when they needed, as well as a recognition of the fact at times things won’t always be harmonious.

Lisa drew a comparison between her relationships with her own mother, whereby she felt unable to communicate openly with her, therefore it seemed this was of importance to her in her relationship with her daughter.

*‘That she can open up and talk to me because I don’t think I have that relationship with my mum, anything good or bad…Just be honest with me, talk to me, don’t think you can’t talk to me because she can. I’m always going to be there at the other end of the phone, night or day, and I wouldn’t want her to feel any other way’.*

Leah also made direct reference to her own mother and what she described as a ‘*disgraced relationship’* by discussing how she would not want her own daughter to talk about her in the same way she speaks about her mother.

Lucy, who has a diagnosis of borderline personality disorder, had given thought to how this could impact her relationship with her daughter in the future, specifically her daughter’s mental wellbeing. She had considered what would be an appropriate response in the event that her own behaviour had impacted negatively on her daughter’s state of mind.

*‘Ava will be brought up to know that if I am feeling down I will tell her mummy is not feeling too great at the moment, that it has nothing to do with you, she loves you more than anything in the world. You make mummy happy, there are just things that are making her sad. Mummy can put a smile on her face and that’s because it’s you making mummy smile, but there is lots that is making mummy sad. They need to understand so they know that and not left guessing what’s wrong with mummy? Is it me? Mummy’s got the hump, has mummy got the hump with me? Have I done something wrong to mummy? Am I the reason mummy’s upset?’*

Mentalization

The literature review detailed what is meant by the term ‘mentalization’ and its likely influence on attachment relationships. To reiterate, mentalization refers to an individual’s ability to be able to make links between thoughts, feelings and behaviour. For example, ‘I was thinking I can’t believe you have done this to me. I was just so angry and so I screamed at him’. Being able to make links in this way, between what is felt and how this affects behaviour is considered necessary for engaging in the process of self-reflection.

The capacity to mentalize also enables us to make sense of other people’s behaviour, which in turn influences how we choose to respond to them. Its relevance to the attachment relationship centres around the need for the parent to be able to accurately understand what might be in their child’s mind in order to recognize how their child feels, and thus provide an appropriate sensitive response. The parent’s response communicates to the child the extent to which the parent is available and able to meet their needs, and thus impacts on their developing relationship.

Mentalization was one of the most prevalent themes to emerge from the data, both in terms of narratives that evidenced appropriate levels, as well as narratives where it was coded as ‘low’. What follows is the findings of participants whose narratives indicated they had the ability to mentalize for themselves, their baby, and others.

Self mentalization

When it came to mentalizing for themselves some participants evidenced this in response to being asked about their past behaviour and attachment experiences. They could talk about what they had experienced, and the associated thoughts and feelings at the time, as well as how they felt that influenced their behaviour.

For Jack, he felt his father’s encouragement of violent behaviour directly affected how he interacted with others, until he realized and reflected that this was not the right way to behave.

*‘He, to begin with, made me quite a nasty kid, like even when I was sticking up for people I didn’t used to stop until the person was crying or something. Whereas as I got older I realised that if that person has not actually hurt me what gives me the right to hurt them? You know, just because my dad said you know make sure they are hurting and make them cry and that, that doesn’t make it the right thing to do’.*

Becky talked at length about feeling left out of her family and how this carried with it a strong sense of rejection. She reflected on how that need for attention caused her to behave in a negative way towards her siblings and mother.

*‘I would lash out because even if it was bad attention I was getting I was getting something. I was having five minutes even if it was just my mum shouting and screaming at me, or smacking my bum, I got the attention that I was craving’.*

Lucy often experienced a mother who was not emotionally available to her and was dismissive of her thoughts and feelings. She reflected on how she adapted her behaviour because of those responses.

*‘I think my mum was always accusing me of being an attention seeker so I would think, you know, I would try to, you know, not be acting the way I was actually feeling. Just like to get her to listen you know. I would be so so upset about something and I would talk to her in a way that she wouldn’t pick up on that because I don’t want her to accuse me of being a drama queen’.*

Luke discussed the physical abuse he experienced from both his mother and step-father and the impact it had on him. Although his narrative is not ‘sophisticated’ it still implies at some point he has made links between how he was treated and how this affected his behaviour.

*‘I think I’m more talkative than when I was at my dad’s, I was quite quiet. It’s showed me how not to behave and not to be like my mum or my stepdad and that…be like my Nan nice and calm, then never lay a finger anyone. I used to be quite violent when I was little. [--] They thought that would help me behave more and that they were bringing me up well disciplined and that lot but it wasn’t it made me more violent because if somebody made a fist to me I would cower’.*

Mentalizing for the self was also apparent for some participants when they reflected on their current behaviour and functioning. Becky, for example, demonstrated an awareness of how and why she can sometimes get to a point where she becomes angry over something relatively small.

*‘I have always been one of these people that I will let it get to me, well I won’t let it get to me, and then a few other incidences will happen and I will be like oh I can brush that off, I can brush that off, and then it just builds up and builds up and then there could be one incident, it could be something silly, and I just blow up’.*

Throughout all her interviews, Sarah took some time before answering the questions. She was conscious of wanting to explain what she had been through and her associated thoughts in the best way possible. Not only was she mentalizing in relation to her past self, but she was also able to do this in the present moment in respect of her behaviour during the interviews. Although she stated that she found it difficult, she was one of the participants with the most data extracts that had been coded for mentalization.

 ‘*I am trying to find the right words, sorry I find it very difficult. I am taking time to think exactly what to say and how to word it’.*

Some parents demonstrated an awareness of what tended to be their typical pattern of thoughts and subsequent behaviour during relationships. Tracey, for example, reflected on her usual response to people behaving in a positive way towards her and what she believes is the reason for this.

*‘It’s quite hard to accept that when people are nice to me, I sort of think I don’t like this, and I sort of try and distance myself from people in terms of, until I get to know them properly, because nine out of ten people that I have actually met have got an ulterior motive for being nice, and I don’t like it so I tend to try and get to know people before’.*

Similarly, Becky also talked about how she approaches relationships with caution, due to her past experiences.

*‘I am very wary with that, because last time people showed me love it went very wrong, so now when they do it I think no you don’t really want that, because it’s all going to go wrong, so I am really wary of it, because they could be doing it out of the kindness of their hearts because they want to show me love and affection, but in my mind it it’s not like that I don’t see it like that…’.*

For Lucy, she discussed the function that sexual behaviour has had in her relationships, as well as her awareness of recurring patterns of wishing to test the behavioural limits of both partnerships and friendships, which can often be the case for those who have experienced attachment based trauma.

‘*At first I would come across very promiscuous, tried to come across like I will do everything for you if you pick me almost, if you know what I mean. Then, when I am with someone it will be a case of pushing the boundaries of a break up with me and then managing to win them back but never going that far again’. [--]Even friendships you’re thinking you will push your friends to breaking point to see, you know, how far you can push them before they will leave you…’*

Mentalization of baby

The ability to mentalize for their baby was demonstrated by participants through narratives that accurately referred to what was likely to be in their baby’s mind, as well as including details of how they would respond.

Jack mentioned the issue of managing his son’s cries when he is in his cot, and his understanding of why he behaves in the way that he does.

‘*If he is awake and I am not there, sometimes he is ok, but if I leave the room and he doesn’t realise he will be absolutely fine, but if I go to leave and accidently knock my foot on the door so he accidently looks at me and then I leave he will cry because he has realised I am not there. [--] Now I know the difference between his cries and if he is hungry or tired, upset because I am not in the room…’*

Leah understood what can frighten her daughter and adapted her own behaviour to try to relieve her daughter’s fear.

*‘She is really frightened of the hairdryer and the shower and sometimes the toilet so I can’t dry my hair. I have tried to slowly get her used to it, putting it on down really low whilst holding her to show her that it’s nothing to be scared of’.*

Tracey mentioned observing her baby’s behaviour and what she believed she was thinking but recognised that this may not be the case. She was however still curious.

*‘When you talk to her she looks at you and she watches, she is taking it all in, but you don’t know what she is thinking at this stage you can only assume she is taking everything in but she is probably not’.*

Lucy also stated that she couldn’t be sure of exactly what was in her baby’s mind, but her narrative implies an interest to know and try and work it out.

*‘She is recognising her name a bit but I don’t know whether that’s her name that she is recognising or the voice, it might be a bit of both’.*

The ability to voice what is in the baby’s mind is a technique used in many of the mentalization based interventions such as ‘Minding the baby’, ‘Circle of Security’, and ‘VIPP’. Some narratives included what participants felt their baby was saying to them.

Lucy would breastfeed her baby before she was put down for the night and she vocalised what she felt her daughter was thinking on these occasions.

*‘When she gets the booby, the smile on her face, that is her way of saying yes I have been waiting for that all day’.*

Tracey regarded the noises her daughter makes when she starts to need a feed as her communicating this to her.

‘*It’s like a five-minute warning I am hungry I am hungry’.*

Jack discussed what he felt his son was feeling after he rolled over for the first time and acknowledged he appeared to be a little shocked and unsure of what had just happened.

*‘And he looked up and just started crying, as if to say what have I just done? I am looking at this and then I’m looking at that’.*

Mentalization by linking self and baby

Another area where mentalization appeared in the narrative was for those participants who made links between their own thoughts and behaviour and the ways in which they believed this had impacted on the thoughts and behaviour of their babies.

Chloe, for example, discussed how because she was feeling apprehensive when she was caring for her daughter on her own in hospital she often held her, which meant this was something her baby had got used to and therefore wanted regularly from her.

Lucy also reflected on how her behaviour in the hospital might have made her baby feel. She accepted that she may not know for sure, but demonstrated a curiosity for what she may have been thinking given her experiences.

*‘I was in hospital she was only a day old, but was she picking up on that I was going crazy? Was she scared when she had to have the light therapy? Was she fed up with getting passed from pillar to post? Was she annoyed?’*

Sarah acknowledged how her own mood can impact directly on the behaviour of her daughter.

 ‘*Sometimes when I might be feeling a bit down, not that I feel like I always let it show, she will play up more, she will be a harder child to look after. Whereas, normally she is quite easy to look after but when I am having my down days, which is now and again, it affects her as well because she will be a bit more challenging to look after her, because she is feeding it and feeding it off of me’.*

The last area specifically linked to mentalizing for their babies was in relation to their future relationships with the other parent. It emerged during discussions about how they would manage future contact between their children and their partners, whom they were no longer in a relationship with, specifically acknowledging how their child could feel in the future.

Tracey discussed how her daughter might feel about not having had her father in her life. However, she felt, given his behaviour, this was more of a positive for her.

 ‘*When she gets older and wants to know about her dad, yeah because she will probably feel that she has missed out on something whereas actually she hasn’t’.*

Jack provided a more detailed narrative demonstrating he had considered how the mother’s behaviour could make his son feel and how he planned to respond to this.

*‘I worry about the fact that she is letting him down and how he is going to feel but obviously he is too young to know at the moment. It’s not really a warranted worry, but I do worry about it you know. I worry about how that will affect him when he gets older’.*

 Mentalization of others

Discussions about past attachment experiences provided the opportunity for some participants to suggest a mentalized response in relation to their parent’s behaviour, in terms of what they thought may possibly have been in their mind, and then try and make sense of it. The ability to be able to do this is closely linked with the concept of ‘resolution’, which was detailed in Chapter Three and is believed to potentially influence parenting capacity. Therefore, it was interesting to note that the sub-theme of mentalizing for others, in particular abusive parents, was only present in the group who had a successful outcome.

Leah discussed how based on her mother’s behaviour she would doubt the authenticity of her apologies, as well as the impact this had on her feelings towards her.

*‘She sat down and she cried to me I am so sorry, and I was like if you were sorry then you would have stopped, or you wouldn’t have hit me so bad or… from then I think that’s when I started hating her’.*

Sarah’s father knew about some of the physical and emotional abuse she was experiencing from her mother and step-father. However, she mentioned feeling as if he was disinterested, and demonstrated a curiosity for understanding his thoughts.

‘*I told him isolated things but nothing too much he just couldn’t… my dad just didn’t wanna know either. Don’t know whether it’s too painful for him or… he just didn’t wanna know, he didn’t have the time to know, I don’t know, it might have been a mixture of all of it’.*

Mentalization for others was also noted in conversations that some participants had with the interviewer. Their narrative indicated they had considered what was in the interviewer’s mind while discussions were taking place. These responses ranged from being mindful of whether the interviewer had understood an analogy that required they had seen the Spiderman movie, to being apologetic because they needed to change their seating position and would no longer be able to look at the interviewer while talking. One participant apologised for not being able to offer a cup of tea, and another for not having answered the questions as well as the interviewer may have wanted.

Lucy stated how her concern over what she thought the interviewer was thinking was impacting on how she was interacting with her baby. She said she was more wary of immediately attending to her than she would normally be.

*‘I feel like I have to see to her every five minutes just with you here, but what are you going to think if I leave her to cry? I know she doesn’t need anything, but I don’t know if you noticed but I kept pointing out to you I had fed her and given her a dummy’.*

The final area where mentalization appeared in the narrative was when some participants discussed their feelings in relation to the previous children who had been removed from their care. For some, they discussed feelings of guilt, which appeared to stem from an awareness of how their child would be feeling.

For example, Becky felt that if she had been placed in a mother and baby foster placement with her son, like she had with her daughter, she would have cared for him better and she often felt guilty that her daughter has had a different experience of her care.

‘*I have an older son as well and he lives with my mum so sometimes I will think if I got the opportunity I was given with her would it have gone better. What went wrong with my son I am always feeling guilty about that. Every time I look at him I feel that guilt inside me and it’s horrible…’*

Lucy’s narrative indicated she had considered what is in her son’s mind regarding her not caring for him and the struggle in her mind of managing her response to him.

*‘How am I supposed to explain to him that I was mentally screwed up then and technically I was still mentally screwed up when I fell pregnant with her, because I hadn’t had no therapy and stuff, hadn’t understood my mental health or nothing but I did it for her but not for him. That sort of tells my son that I didn’t give a shit about him really, if you look at it in those terms, because that’s the way he’s gonna see it’.*

Positive talk about Baby

The three interviews with participants provided the opportunity for them to engage in narratives about their babies. In general, these tended to include discussions around their babies temperament and state of mind, which has some overlap with the theme of ‘mentalization’. In addition to details of their interactions with their baby, their feelings regarding their baby, and reflections on the impact the baby has had on them.

Attunement

Narratives coded for attunement demonstrated a recognition of the baby’s mental state, and what might have caused them to feel this way. They implied a sense of knowing their baby in terms of their state of mind, needs and behaviour, and therefore what may be the necessary way to respond to them. The overlap with mentalization is that one wouldn’t be able to be attuned to the baby’s needs if they weren’t able to accurately think about what their baby might be thinking, feeling and why. Jack, for example, described how his baby is generally pretty settled. However, he acknowledged that at times this is not always the case and was aware what could cause this.

*‘I always liked to think he was going to be a happy baby, but I guess I was right because apart from when he is getting his nappy changed or if he has been woken up, like today the doctor woke him up prodding and poking him so he is a bit grumpy, but generally he is content’*

Jack also talked about how his responses to his son then influences his son’s behaviour. For example, he mentioned about his interactions with him on his playmat and how this keeps him engaged.

‘*When he is on his playmat he will just lay there and look at you, but if you start poking the rattley things he will start touching them and he will look at me and smile, and I will say to him you’re a clever boy its playtime, and then he will start playing again’.*

Luke spoke about how his daughter’s teething was often affecting her mood, and how he would try other options to work out what was bothering her.

*‘Just her teething, her crying you don’t know what it is, try nappy and bottle and you just do what you have to do. She cries quite often with her teeth because they are moving or breaking through’.*

Becky described how her daughter was pretty sure of her own needs and was aware of the ways in which she communicated this to her.

*‘She is a cheeky little girl she is a cheeky little madam, she is very stubborn she knows what she wants, like bottles. She can’t have it too hot, she can’t have it too cold, otherwise she wont take it she will just spit it back out at me. She knows what she wants she is very strong headed’.*

Emotion Regulation

There were some participants who provided examples of their responses to their babies when they were in a dysregulated state and what they had learnt was the best method of comforting them. For many of them, they seemed to run through a list of all of the potential problems that could be affecting their babies in order to determine the cause.

Leah found that offering her daughter physical affection, such as cuddling her, seemed to be the most comforting way of settling her.

*‘I can stop her crying really when she cries like if she is teething or something I just model coddle her really and just hug and she feels so much better. [--] She will get ill but she copes okay with it, like I’ve seen kids that are really bad with it, she is just like mummy’s girl. She is alright when she just hugs me and I tell her it will be ok’.*

There were some parents who acknowledged the need for them to remain calm in order to calm their babies. Their narratives implied they had the ability to provide themselves with ‘self-talk’ regarding what they had done and what was needed.

Sarah demonstrated an awareness of how her own emotional state interlinks with her daughter’s and therefore how she consciously tried to regulate herself in order to comfort her daughter.

*‘I know I can elevate her so you know as much as she’s crying I pick it up from her, but then if I pick it up too much off of her then she is gonna pick it up off me and elevate it, so I’ve got to, you know, calm myself down again’.*

Jack acknowledged his own emotional state at times when his son was signalling his needs and stated he would feel ‘*upset*’ and, in the beginning, a level of uncertainty at what could be the reason for this. However, as time passed he felt more confident in knowing what the potential reasons could be and ruling these out in order to provide his son with what he thought he needed. Chloe’s narrative acknowledged the influence her mental state had on the process of comforting her daughter and the need to stay calm in order to calm her down. She also discussed being aware of when her daughter felt frightened and was mindful of what she needed to do for her to help her feel more content.

Baby’s development

For some parents, their narratives included aspects of their babies’ development and demonstrated an interest and awareness of observing them and considering what they were able to do. These ranged from discussions in relation to their physical movements and progression to what they tended to focus their attention on, as well as development’s in their speech.

Jack described his son’s progression from observing others talking to being able to say ‘dadda’.

‘*He will hold your gaze and look at you in the eye whilst your talking and watch your mouth and then he will start to move his mouth but not say anything, he is copying the way your lips are moving. When he first learnt to say dadda he would sit there just moving his mouth and then it came out as a little scream, but then he learnt that actually it doesn’t need to build up I can just say it normally’.*

Sarah mentioned how her daughter is now babbling and communicating with her. She was also aware of how her physical movements were developing such as sitting up, but also in relation to her being able to turn herself around in her cot.

Lisa felt that her daughter was close to moving into crawling, and was aware of the different scenarios that tended to make her laugh.

*‘She is standing on her tiptoes she is not crawling but she is almost there. She has a lovely smile, she don’t smile with her cheeks, she smiles with her eyes. She looks for me if she can’t see me, she can hear my voice but she is looking for me, if you know what I mean. [--] When you play peek a boo and she proper laughs, or when you see her laying on the floor and the dog walks past and she properly belly laughs. When I swing her over my shoulder and she grabs my nose and laughs’.*

Luke discussed lots of different aspects of his daughter’s development ranging from her physical movement to her interests in other people and her giggling, which seemed to please him as he often smiled widely himself during the interview when talking about making her laugh.

*‘She is biting her hand now, she is teething, she lifts her head up more, smiling a lot more, a little giggler. I think she is quite smart, especially watching everybody, she likes watching people, she is very nosey. She is now giggling, she has got a little giggle now, rather than just a squeak she will laugh when you tickle her. She is attempting to roll over and sit up, although she is not quite got the hang of it, you know, but she is trying. She loves to be on her feet now, she didn’t back then but she does now to be honest… the bouncing’.*

‘Delight in Me’

The concept of being delighted by your baby’s behaviour is considered by attachment researchers to be fundamental to the attachment relationship. The idea being that the baby picks up on the positive emotional response they receive, which creates a sense of being loved and cared for by a caregiver who will continue to be available. Several participants provided narratives that portrayed a feeling of delight in being with their babies. For some, they simply described them as being ‘*perfect*’, for others they detailed certain examples of things their babies had done, which had pleased them.

Chloe described her enjoyment of the way her daughter interacted with staff and herself.

*‘I think she is pretty intelligent. There is one lady that came in and had a cough and Bella would do a little fake cough when she coughed, and if I sneeze she will sit there with a big smile on her face every time I sneeze. When she is pulling your hair or something she would just smile at you, like she knows what she is doing and you can’t help but laugh sometimes because it’s so funny and cute the way they just know’*.

Sarah smiled herself when talking about how her daughter shows her affection, whilst still appreciating what a baby of her age will be able to understand and do.

*‘She does like sort of kissing me at times. I suppose, um well I see them as kisses, she sort of when I’m holding her, like close to me, close to my face, she sort of leans in and she sort of got her mouth open and she goes (subject opens mouth) towards my lip, so you know, or when I go to kiss her she sort of opens her mouth and tries to sort of kiss me back sort of thing so. I don’t know we share little kisses with each other, the best that we can where obviously she is only a baby, um she does like to put her arms round me and hold me tight, and you know clench at my clothing, you know grip hold of me or hook her little fingers around my hands’.*

Both Jack and Leah had used their mobile phones to capture many moments that they had enjoyed with their babies. In some ways, it appeared to maintain the sense of delight they felt when they could revisit the photos and videos and share with others. Jack, for example, was keen to show his video of his son turning over during the interview, and Leah her daughter’s photos.

*‘He first rolled over from his belly to his back, he was having belly time and I had my camera out, and I could show you the video, and he was just sat there. He fidgeted a little bit then he started to go, you could see him half go, and then he properly rolled onto his back. When he first done that and I told everyone, it was just, it was brilliant. Look here you go’, (subject shows interviewer the video of him rolling).*

*‘Lots of things her first movement when she started rolling over we watched a video of that last night just looking at pictures when she was bald and now she has a lot of hair. Just everything and I have got about 3000 photos of her and they just all means so much to me’.*

Impact of baby on self

The last category to emerge was narratives that detailed the ways in which having the babies had impacted on themselves in terms of their mind set and behaviour. For a few participants they appeared to notice a change in their mind set before their babies had been born. This may have potentially been the start of feeling motivated and determined to care for their babies.

*‘The moment I found out she was pregnant, that was it, I didn’t care, I didn’t care how I felt, I made sure that I was going to be there for him’.*

*‘I felt her kick and I think my maternal instincts kicked in and I thought this is it. It changed everything. That was when I went into protective mummy mode, I wasn’t gonna let anyone hurt me, hurt my baby’.*

*‘After I left the doctors I realised I was defending her and that’s when I realised I love her because I’m defending her and she is not even here’.*

Some parents talked generally about the positive ways their babies had impacted on them and how they had encouraged them to be the best version of themselves. Others gave specific examples, such as Jack, in relation to how caring for his baby had helped him to overcome his social anxiety.

*‘I am much more comfortable going out, because I had anxiety I was nervous around groups and things like that, and generally I would just stay indoors, but with Alfie I have now started going on buses, which I never would have done before, and I go out into town when it’s quite busy. He is the one that’s pushed me to overcome those things’.*

Leah discussed how her determination to be successful is driven by her daughter and her desire for her to be proud of her, as well as her wanting to be a good role model for her.

*‘I always have this goal that I will always make it further than them because I think that just because I am here doesn’t mean that I am going to stay a bum forever. I am gonna make it in life, and then go far and I’m gonna make my daughter proud [--] I want to show her really. I want to be successful so I am not just a slob so she follows to be a slob. Do you know what I mean? I want to make myself something in life and be creative and show her that she can do it’.*

Lucy had a diagnosis of borderline personality disorder and had several suicide attempts in the past, one of which she had been hospitalized for. She discussed how she views her baby as a protective factor in terms of the effect she has on her mental health and managing her thoughts.

*‘She is the reason I have to stop myself from losing the plot, because I have to stay strong for her. She is my everything that is what she is to me, she is my daughter but she is my saviour, she is everything. She has definitely become my distraction because she is there to remind me no mummy you can’t go crazy. She is like the other piece of me, she is the breaks on my train, my run away emotional train, she is like the anchor to my ship. She is just she is like my realization to everything. I like to think the reason why I haven’t died from the overdoses is because she was meant to be here’.*

Angel in the Nursery

The ‘*angel in the nursery’* refers to someone who offered a child a positive experience of a close relationship amongst what may have been abusive and or neglectful behaviour from their caregivers. The ‘*angel’* is likely to have been someone who demonstrated they cared about the child; someone who provided them with help regulating their feelings; someone who could teach the child about the mental states of others by demonstrating they were aware of what was in the child’s mind. A child who experiences a sense of this is thought to then be better placed to offer warm nurturing care to their own children. It may also increase the likelihood of success during parenting interventions. This close relationship is also thought to act as a potential buffer against the negative relational experiences elsewhere. Therefore, it seemed important to be aware of whether the participants could identify an ‘*angel*’ figure of their own.

For some participants, their narratives indicated having had a positive relationship with one of their parents and therefore they had one parent whom they depicted as being available to meet some of their needs.

Becky experienced both physical and emotional abuse from her mother and although she had not appeared to previously reflect on the positive relationship she had with her step father, in her interview she mentioned some of the things he did for her. Therefore, although he may not have been considered an ‘*angel*’ in her mind, he was still someone who had been caring towards her at times.

*‘I’ve never really thought about it but if I had to pick anyone it would probably be my step dad and he came into our lives when I had just turned five, and he raised us as his own, and I feel like I was close to him, that I could go to him, I could speak to him. He used to go out and buy me fags and keep it secret from my mum sort of thing. [--] My step dad had been there and given us the attention, all of us the same attention, and it was good attention. It wasn’t like you have been naughty, it was like he would cuddle me and stuff like my mum never did’.*

Similarly to Becky, Chloe had a mother who physically attacked her and often said horrible things about her and to her. Her parents had split up when she was young and she would visit her father and then eventually ended up living with him. She talked openly about how different the care she received from her father was in comparison to her mother.

*‘He taught me how to ride a bike because my mum never would, she said she didn’t have time. Erm and obviously took me in and even though he only had a one-bedroom house at the time, because he knew I wouldn’t go back to mum’s, so gave me his room and he slept on the sofa in the front room. [--]My dad because honestly he was there for me and I just felt more comfortable because I wasn’t getting hit or shouted at. If I had done something wrong he would sit down and talk to me in a nice way and say can you sort it out, and if he did give me a punishment he wouldn’t stick to grounding me because he thought that would make the situation worse if I was in all day’.*

For Jack it was his mother who appeared to be a *‘safe haven’* in amongst the emotional abuse he experienced from his father but also during the times he was unwell.

*‘She was just always there she always put us first [--]When it come to being there and having my back, like you know if I done the right thing but gone the wrong way around it, like she would support me. If he tried to say anything about me or my sisters that was nasty or horrible she would you know tell him straight, you know, don’t say things like that, you know, you can’t treat them like that. [--] Yeah when I was ill my mum put my head on her lap and put her arm around me, and with her other hand she used to run her fingers through my hair’*.

There were some participants whose ‘*angel’* was most likely their grandparent/s. In the absence of care from their parent, they provided them with the opportunity to form a relationship, which appeared to give them a sense of feeling loved and cared for. Their availability to meet their needs led many of them to view them as more like parents.

Tracey talked warmly about her relationship with her grandparents. Her narrative indicated the extent to which they were available figures to her, but in particular the way they met her emotional needs. She also implied that her grandma may have provided her with a model of what it was to be kind to others.

‘*My whole memories of my childhood are me and my nan.* *I had a better relationship with her than I ever had with my mum. [--]Yeah, no loving without a shadow of a doubt, she was always cuddling and giving us kisses and caring erm. She just would have gone out of her way to have helped anyone. [--]* *My nan and grandad they were always telling me they were proud of me (teary) my nan and grandad they were there when I hurt myself, it was nan and grandad that was there when I needed to talk to anyone so....’*

Sarah’s also discussed the positive influence her grandma’s kind nature had been on her, although she did not see her as often as she would have liked the times they were together appeared to have been happy occasions. Sarah experienced significant tortuous abuse throughout the majority of her childhood from both her mother and step-father.

*‘I feel like in some ways when my nan was around she kind of raised me [--] It is hard to pin point certain things of my childhood that were good memories, but I do remember my nan being a great influence on me, and a positive influence but pacific things some of them are not… but my nan was a very loving caring genuine person, she would help anyone’.*

When Sarah was eventually placed in foster care during her early teenage years, she appeared to develop a close relationship with her foster carers. They seemed to provide her with help in understanding and expressing her feelings, and she reflected on how if she hadn’t lost them due to ill health then she may not have had her previous children removed.

*‘I just feel if they were still around I wouldn’t have lost… I probably wouldn’t have lost my kids because they would have been there to help me make sure that I kept them. Someone um… to explain things to me, having more of an understanding in some way of what I was feeling and what was going on’.*

Luke went to live with his grandma at the age of ten, having experienced significant physical abuse from his mother, father and step-father. The care that Luke received from her was unlike anything he had received previously and as such he viewed her as his mother figure.

*‘My Nan, yeah I love her to pieces, she was kind, spoilt me rotten. [--] Oh my Nan’s lovely she really is. She took me on when I was 10, cared for me, gave me my clothes and everything she was lovely. My Nan taught me everything really, how to cook clean and that lot, so she is like a mum to me’.*

Internal Working Model intact

This theme specifically relates to the internal working model that participants appeared to have in relation to themselves. The internal working model of the self was discussed in the literature review as it is believed to be influential in development given that it is based almost entirely on the interactions and behaviour the individual has been exposed to, particularly during their childhood years. The construction of it is likely to begin as soon as a baby becomes aware of the tone of voice and facial expression directed towards them. They then start to piece together, and make sense, of their experiences based on the model they are forming of themselves. As discussed in Chapter Two of the literature review, in cases of maltreatment what can happen is the only way the child can make sense of this behaviour is for them to internalize that they were somehow deserving of it, or that they are unlovable, useless, or worthless. Their model of themselves may quite literally be that they are all the things that are said to them, for example they are stupid, nasty, and horrible. This can cause the development of a ‘false self’. Perhaps one of the ways this can be so destructive is that the individual may continue to behave in a way that fits with this model of themselves, for example being nasty or horrible to others, causing people to dislike them and thus reinforcing those negative thoughts about the self.

A theme to emerge from some of the participant’s narratives was a sense of preservation of the internal working model of the self. Therefore, remaining aware that what they were experiencing was not ok and not justified, thus possibly preventing a negative view of the self and the associated behaviour.

Jack for example had talked at length about the emotional abuse he suffered from his father, but appeared to maintain an awareness that he shouldn’t have been treated that way and a connection to how it made him feel. Perhaps this was made possible due to the close positive relationship he had with his mother.

*‘You’re a grown adult your meant to be my dad, and the shameful bit is just generally, you know, he didn’t behave like how a dad should have behaved, like I felt ashamed of the way he was or how he treated me. [--] They have given me a model of what to do and what not to do, like the way my mum was towards me, like the things she used to say and do*. *The way that my dad and step dad were just made me realise that’s not how you should treat a kid, the way they made me feel*’.

Lucy detailed the ways in which the sexual abuse she experienced from her step uncle affected her, but appeared to be able to hold onto the fact that she wasn’t to blame for what happened.

*‘Yeah so like I said at the time, I was upset and things like that but I didn’t realise how badly it would affect me in later life, I really didn’t. It makes you internalise a lot of stuff, what did I do? You question stuff that you’ve done even though it’s not your fault this dick head decided to do things to you, it’s not your fault’.*

Despite experiencing relentless physical and emotional abuse throughout her childhood, Sarah fantasised about the kind of parents she wished she had, and being rescued from the life she was living. These fantasies suggest that her internal working model of herself was that she deserved to be treated better.

*‘Making us feel that we wasn’t worth anything um that she regretted or resented us. I’m not saying we was angels but we didn’t deserve what we got. [--] Wishing my friend that lived a couple of doors down that I had that family life, um because she seemed to, you know, be with a mum that was very loving and caring and my friend seemed to be always happy and bubbly and doing things and going shopping and always a happy child and having cuddles with her mum. I just used to wish that I was part of that. [--] I wished that sometimes I wished that I was never born in that family. I used to sometimes wish that I was dead. I used to sometimes wish that I could run away. [--] I used to believe in some of those so called fairy tales that someone would rescue me… how stupid and naive was that?’*

Although Sarah felt this was naive of her, it demonstrated she felt worthy of being rescued and this sense of self-worth may have prevented her from behaving in ways that could have been extremely destructive. For example, despite the traumatic abuse she endured, she had not become caught up in using drugs or consuming excessive amounts of alcohol, she had not self-harmed or ever attempted suicide, unlike her siblings.

There were some participants who had demonstrated the preservation of a more positive internal working model who later in their adult life had a desire to discuss their experiences with their abusive parents. This could have served the purpose of aiding them in further processing what had happened and the reasoning for this. However, all of them appeared to be met with denial and hostility from their parent.

Despite the significant abuse Sarah experienced from her mother, interestingly she still had the desire as an adult to attempt to move forward and have some sort of relationship with her. Perhaps this was due to the desire to gain some kind of closure over these experiences, or it could possibly demonstrate the continued need for an available attachment figure. However, before attempting to have a relationship with her mother she first felt she needed recognition of what she had been through but her mother was unable to give her this.

*‘I thought, you know, things had happened and many years gone past without her being much in my life that maybe when I was a bit more grown up, and more of an adult, maybe she’d changed and wanted to put some of our issues behind her and start again. Last year I raised some of the things she done as a child to for her to have some sort of acknowledgement of what she done, she went all lies, figment of my imagination.* *I went no they are vivid memories how can you make those sorts of things up? She won’t take no recognition of them’.*

Leah stated how at the time when she was in her mother’s care, she knew that she should not have been treated the way she was. In her adult life, she also attempted to discuss her experiences with her mother who did not acknowledge that she should have behaved differently.

*‘I know that she should have treated us a lot better than she did, and I know that she should have fed us a lot better than she did, and clothed us a lot better. [--] She never realized nothing until I left and then I told her, but even to this day she doesn’t think that she has done anything wrong and that’s what makes me hate her even more’.*

Caring for Siblings

The desire to take care of others, in particular siblings, emerged from some of the participant interviews and included detailed narratives of the physical care tasks that were undertaken as well the extent to which they seemed to take on a protective role. Although this theme was not particularly prevalent across the data set, it felt worthy of highlighting for later consideration of the extent to which caring for siblings may have influenced the development of a more mentalized and caring parental response to their babies.

Sarah appeared to have dedicated much of her time during her childhood to looking after her siblings. She would prepare their meals and take them to nursery or school, and she felt a responsibility to attend to them in the night, which often meant she was too tired for school herself the next day.

‘*I was forced to take my brothers and sisters to school or nursery, look after them all the time. My younger ones, like my younger brothers and sisters, calling me mum and I had to explain to them that they was my sisters or my brothers…having to like try and prepare meals. [--] My sister was just having tantrums all the time, she was only little herself, she was having tantrums all the time always getting up in the middle of the night. I would have to see to her whether it was a school night or not’.*

On more than one occasion, Sarah had actually protected her siblings in potentially life threatening scenarios. The first was when her baby sister grabbed hold of a heroin needle. Although at the time she did not know what it was herself, she said she had known it was something dangerous and removed it from her. The second incident Sarah discussed was when she had to catch her baby brother after her mother and step father threw him out of a window. Interestingly, at one point in the narrative she refers to him as ‘*my son’* and then corrects herself. This potentially indicates her instinct to protect him was as strong as that of parent towards their child.

*‘When he was not even…could be no older than six weeks to two months old, they was all high off their face and alcoholed up and the boyfriend, his own son, he my mum was laughing finding it absolutely hilarious, went to drop my son, my brother, their son, my brother, out the window, and it’s only because I happen to scream… could hear them screaming I was in the front room… I knew there was no point running up the stairs, but I just peered out the garden looked up and seen me brother getting dangled out and I run outside and stood underneath the windows as best that I could with my height… and wait to see whether they was going to drop him or not… they did and lucky enough I caught him’.*

Leah had a similar experience and found herself assuming the main role of carer to her siblings. She mentioned how this meant during her teenage years her mother would not allow her to go out simply because she wanted to go out herself. Similarly to Sarah, Leah was responsible for a great deal of her siblings’ care and they often referred to her as their mother. Leah felt that caring for her siblings had in some way prepared her for the difficulties she might encounter when it came to caring for her own baby.

‘*Like where I had to look after the kids, I felt like erm that’s why she wanted me home all the time, she’d be like I am going out drinking [--] Where I am looking after them all the time, even my little brother started calling me mum and I did tell him don’t call me mum because I am not your mum but I was looking after them that much that she thought I was. [--] I always looked after my brothers and sisters, so I knew what looking after a baby takes and I knew what I was in for’.*

Leah herself was still relatively young and as such the siblings she used to care for remained in her mother’s care, her mother had also had more children. Therefore, Leah’s anxiety in relation to their care was still apparent. In addition, again similarly to Sarah, at one point she referred to her siblings as ‘*my kids’*.

*‘My little brother just needs to go in care, I will say it to him, and I say it might be hard I went through it but it will get you in a better place. [--] I met her at the beginning of June just to speak to my kids, my brothers and sisters’.*

Jack had several examples whereby he had wanted to take care of his mother and sisters. He was aware of the financial strain his mother was sometimes under and, unlike Sarah and Leah, this was not an expectation of him. He appeared to want to do this, as he was grateful for the care he received from her as this relationship had not been abusive. Instead she was likely to have been his ‘*angel in the nursery’.*

*‘I started working when I was really young, I had paper rounds and DJ, and removal work from about twelve thirteen years old, because she used to do so much for me without her knowing I used to take the electric key and put electric on the metre, and obviously she probably knew it was me but she never used to say anything, you know. It just meant that she was able to do more for me and my sisters because she didn’t have to worry oh there is only a pound on the electric if she didn’t get paid till the following week’.*

Jack’s father was often violent towards his mother and he recalled one incident when he felt he had to step in and protect both his mother and sisters from him.

*‘I heard everything kicking off from my room so I come downstairs and he was, from what it looked like to me it looked like he was going to hit my mum, so I remember going into the kitchen, picking up the kitchen knife and picking up the house phone and I said if you lay a finger on my mum or sisters I am going to stick this knife in you and call the police, and then he left’.*

Feeling loved and cared for

This theme links closely with the preservation of a positive internal working model of the self. If an individual in their adult life has positive relational experiences then this may contribute to maintaining their sense of self-worth and value. This could then promote healthier ways of functioning and interacting with others. These were important aspects to consider within the parenting assessments that participants were taking part in.

For those participants who could discuss ‘feeling loved and cared for’ the most common person to receive this from was their partner. The actual experiences within their relationships may not have been as harmonious as they described, but feeling a sense of being loved may have been enough to contribute to a more positive outcome. However, it is worth noting that this theme was one of the least prevalent across the data set but still felt worthy of discussion.

Chloe mentioned how supported she felt by her partner when she was in her first placement alone. His desire to keep checking how she was doing appeared to communicate to her that he cared about how she was doing.

*‘Just being there for me, in that mainly when I was in a mother and baby unit because I was on my own he was worried about me, he was always ringing me and everything because he was worried about me because he knows I didn’t like it there’.*

Leah discussed how she felt loved by her partner and his family, whom she had known since her childhood. She also spoke about the support her partner offered her in relation to caring for their baby.

*‘My partner and his family really, they have been there since I was little. [--] That’s why I like it now when my partner is here I don’t feel like I am doing it on my own, like when he comes round he is so like…I don’t know I feel like I have got that sigh of relief’.*

Lucy also discussed feeling loved by her partner and how helpful he can be at settling her daughter back to sleep.

*‘With Adam yes he loves me so much and I love him it’s… I have been in a relationship where I thought I was loved and then figured out that I was some sort of sex toy, but yeah I definitely feel loved by Adam. [--]* *My partner is great at getting her back to sleep, he is a miracle worker’.*

Some participants discussed feeling loved by their children and spoke about what their child does to show them that they love them. Although this is a different kind of love compared to that received from an adult, acknowledging feeling loved by your child may also contribute positively to the individual’s internal working model.

Sarah’s older children were no longer in her care as they were removed due to neglect. She appeared to feel they all do love her in their own way. One thing to consider is the extent to which this could be more of Sarah’s desire for them to feel this way towards her than the reality, because to think anything else may be too painful. However, at some point she may need to connect with the reality of how they could have felt towards her, given their previous experiences of her care, in order to then reflect on how she may need to provide something different for the baby she currently cares for. Feeling that they did love her may, however, help her to maintain a more positive mind set in relation to what she offers this baby. Therefore, there appears to be two ways in which this could have impacted on her.

Lucy detailed how she felt both her children have their own way of showing her that they love her.

*‘And I know she’s not old enough to say but I can feel it from her already, like because she will be crying and everyone else will go and pick her up and she was still cry. I will go pick up and she will stop crying and that is her way of saying I don’t want you, I want my mummy. My son is old enough to tell me that he loves me and he misses me. He says the sweetest things sometimes, sometimes he says the scariest things like he can’t wait for nanny to die so he can come and live with me’.*

A couple of participants had very positive experiences in their current foster placements, and mentioned the foster carer as being someone who they had felt had cared for them. For some, this was their first experience of having someone looking after them. Someone who was preparing meals for them, and mindful of how much sleep they were getting, or how they were feeling, taking them shopping to get things they needed for themselves or the baby, and just generally offering them support.

Interestingly, Sarah mentioned feeling as if her parent-infant therapist cared about her in a professional way. She also mentioned the interviewer as an example of someone behaving in way that she considered caring. The fact that she mentioned both the therapist and the interviewer could have been an indication that her network of people whom she felt cared for her was reasonably limited.

Connection to past trauma

It was important to provide the participants with the opportunity to talk at length about what they had experienced in their childhood attachment relationships. The main purpose was to see whether there were any observable differences in the themes assigned to the narratives of those that had a successful outcome after the intervention and those that didn’t. Their interviews were coded into categories that captured the dynamics within their attachment relationships, the description of the trauma they experienced, trauma related behaviour, and their current family relationships.

Relational Dynamic

Rejection

Most participants described feeling rejected by one or both of their parents. A couple of participants mentioned they had felt this ‘*all the time’*. These feelings appeared to come from a sense of being unwanted and not cared about, with some participants noticing a stark difference in how they were treated compared to other siblings. Jack felt like he never had a father-son relationship with his dad due to the emotional abuse he was subjected to. His father appeared to end his relationship with him when he was fourteen.

‘*It just used to feel like I am not even your son like the way he used to speak to me and that [--] He told me on my fourteenth birthday he didn’t want nothing else to do with me’.*

Leah seemed to regularly experience a mother who did not want to spend time with her and disliked it when she tried to be affectionate with her.

*‘I would say to my mum like on my birthday I just want me and you to go out and spend time together, and she would be like no why would I want to spend time with you? [--]She never really liked hugging us to be honest, she just didn’t like when I asked her for a cuddle she’d be like what do you want? I just want a cuddle, I love you, and she would be like get off me’.*

Fear without Solution

The literature review described in detail what the term ‘fear without solution’ is referring to when it is experienced within the attachment relationship. It captures the sense of fear a child experiences when they are being significantly abused by their caregiver, who is the one person who is supposed to comfort and protect them. Therefore, when they feel fearful during incidents of abuse there is no available person to offer a solution to relieve this feeling for them. Several participants described scenarios in which they felt frightened and were harmed by their caregivers. Luke had received a significant head injury as a young baby from his father and then from the age of seven he described feeling ‘*frightened*’ by his step father who used to hit him ‘*every day’*. He recalled a time when he grabbed him by the throat and he struggled to breath for a few minutes.

Leah was also overwhelmed with fear at times as a child due to her mother’s behaviour. She described being strangled by her and feeling as if her mother was going to kill her. A cousin told her mother to get off her because he thought she was going to die, to which her mother replied, ‘*I don’t give a fuck she is a nasty child*’.

For Sarah, she was physically abused by both her parents and seemed to describe a constant fearful state, whether she was awake or dreaming.

*‘Having nightmares all the time, half the time not even sleeping, as a child always fearful of what is going to happen next. [--] We’d all flinch from her and try and keep out of her way and his way. [--] We never knew when we was going to get a hiding or a punishment or whatever it was they thought of next’.*

 As discussed in Chapter Three of the literature review, fear without solution can occur when a child experiences ‘fear of’ their caregiver or ‘fear for’ their caregiver. The latter refers to when a child witnesses somebody harming their attachment figure as this can create a sense of fear without solution because their caregiver is in danger of being taken away from them and they are powerless to stop it. Lisa described one occasion when she was particularly fearful as she watched her step father pinning her mother against the window but felt unable to help her.

*‘Just what happened with my mum and my stepdad it just plays into your head sometimes like when you’re sitting there thinking. I will never forget my sister asking for help and I went up the stairs and there was nothing I could do, nothing I could do’.*

Lack of Safe Haven

The attachment figure who is a ‘*safe haven*’ for their child is available to meet their emotional needs. The child feels welcomed in at times of distress or illness and is offered the appropriate level of comfort. Many of the participants described scenarios in which they did not experience this with their caregivers, as such they would shut themselves away when they felt upset. Becky described an occasion when she was being bullied at school and someone had thrown her packed lunch over her. She returned home and her mum told her to have a shower and ‘*get on with it*’.

Leah’s mother responded to her cries often by swearing at her or physically harming her.

‘*If I started crying she is just one of those people she won’t hug you she will say just fucking shut up or go to your room, that’s what she used to say, just shut the fuck up, or she would just slap us and say there is something to cry for’.*

Sarah and Lucy had both experienced sexual abuse. For Sarah this was from her brother and step father, and Lucy from her step father’s brother. When they had told their parent about what had happened they both did not get the response they were expecting.

Sarah’s father did not believe her:

*‘Must have been about five years I’ve not known my dad not wished to, I told him the truth that my brother was raping me and he didn’t want to believe me’.*

Lucy felt that her mother was aware of what was happening when she observed her step uncle in her bedroom, but she did not intervene. When Lucy then told her mother, she was concerned enough to contact the police. However, Lucy didn’t feel physically comforted by her mother or reassured in the way she felt she needed.

Traumatic Abuse

All the participants had experienced some form of abuse in their childhoods and for many of them it was a combination of emotional and physical. These incidences appeared to happen on a regular basis, and the content discussed places them at the extreme end of a traumatic spectrum. Their narratives of these events were raw, in depth, and for the most part, coherent.

The accounts of emotional abuse tended to include descriptions of being called names by a parent and receiving a harsh or critical response when they became upset. For example, Jack felt his father bullied him by disregarding his feelings and by making negative comments to him and about him.

*‘He was almost like a bully, like even when I was doing martial arts with him, like if I said I didn’t want to do it he would bully me into doing it. Like he was just really forceful and arrogant. [--] Not physically abusive but emotionally abusive, like he would try and put you down and that’.*

When Leah was sixteen, she had an argument with her mother and then decided she no longer wanted to tolerate the physical and emotional abuse, and chose to go into care.

‘*She started calling me a slag and she was like fuck off don’t come home, just fuck off, like go die and shit like that, and I thought fuck off I am not coming home I would rather be in care and she was like ok go to care. [--] She sent me a message saying you’re a nasty fucking child, like proper slagging me off and telling me not to come home’.*

A couple of participants discussed the distress they felt when watching their siblings being emotionally or physically harmed. Sarah and her siblings were regularly abused by her mother and step-father, in many ways their behaviour was often torturous. For example, Sarah recalled being forced to eat several tins of baked beans, which she disliked and if she was sick she was forced to continue. She also had to witness similar behaviour towards her siblings. She became very upset when recalling an incident that happened at Christmas.

 ‘*Getting locked in the bathroom when he was five years old with a little window open, a couple of days before Christmas. Toilet seat glued, hands and legs tied behind his back…he wasn’t allowed to eat or drink anything for a few days… and was brought out Christmas day to watch all of us open our presents and then shoved back in there… The little window was left wide open, he had nothing on and a little bit of string tied around his willy, and if he was, if he went to the toilet, not that he could, but if he went to the toilet he was made to clear it up and he was five’.*

Physical abuse was another category that many participants discussed experiencing. The types of behaviour mentioned in narratives included being slapped, punched, kicked, hair pulled or for two participants their throat grabbed. In all incidences where participants spoke about being physically harmed the perpetrator of this abuse had been one of their primary attachment figures.

Chloe mentioned how the physical violence she experienced from her mother appeared to get worse in her late childhood.

*‘Name calling hitting pulling hair stuff like that, when I was 11 or 12 and it all started to get worse because to start off with it wasn’t that it was just like slaps and that and then it got into the punches and everything else. She would hit me, throw me around and stuff like that so yeah’.*

Similarly to others, Sarah spoke about how the physical attacks from both parents occurred daily and she felt that often there was nothing that they had done that warranted this response.

*‘A punch a kick a shove slap as well but to the point where it would leave handprints on our skin, um bruises on our bodies [--] We would get several beatings a day and half the time it didn’t need a reason [--] It got that petty that we couldn’t even drop a bloody cup on the floor of spilt drink without getting an hiding or getting made to do something’.*

Becky often ran away from home, and she spoke about one occasion when her mother found her and dragged her back to her car by her hair.

*‘I was frightened that she would find me because this one time she did and it was on a main road and she grabbed me by my hair and pulled me back to the car, erm dragging me across the ground by my hair in public, there were cars stopping and things saying why are you doing that to a child?’*

As mentioned previously, both Sarah and Lucy discussed being sexually abused. Neither of them provided specific details of the incidents, and it was not necessary to ask further questions. For Sarah, she had been raped on several occasions by different males. It started with her step father in her childhood, then her brother during her teenage years, and then also an incident during her adult years.

*‘I didn’t really know what sex was and he chased me up the stairs and he raped me- - shouting out the words you wanna know what sex is I’ll show you what it is and he abused me. I was raped by my half-brother when I was 14 to the age of 16. Had one of my first boyfriends set me up um to be raped, but he used me as a prostitute and took two hundred pound from the person that raped me’.*

Lucy’s account of the abuse she experienced revealed how she had perhaps made sense in her mind of why it seemed able to have happened, due to having a mother who was emotionally unavailable to her and a man who seemed able to manipulate her by making her feel special.

*‘My sister’s dad’s brother sexually abused me from the age of 9 to 11. While the abuse was going on at first I was made to think I was a special friend, and when your mum is being a cold-hearted bitch to you, you lap at that, you know. Nothing happens at first, you know, extra sweets, being able to sneak a chocolate bar from the cupboard, and things like that, you know. Then obviously, you know, these arseholes are the hardest to catch because if they make someone feel special why am I going to go and tell my mum that?’*

In terms of neglect, some participants described not being fed, washed or clothed appropriately, and that they went to school looking like ‘*tramps*’. Sarah rarely went to school but on the occasions that she did attend she described herself as withdrawn.

‘*Half the time I didn’t even go to school anyway… and when I was in school very shut down, reclusive, didn’t have any friends, was bullied… and was always sent to school dirty and scruffy and trampy, shoes half falling off our feet, dirty clothes with stains all over them’.*

Leah mentioned not having had the comfort of basic bedding.

*‘We used to have like one blanket and then like you would wake up in the morning with no blanket and when it’s like weather like this and its freezing you have to just cuddle up to yourself because you are so cold. Why the fuck do you not just go out and buy us blankets? Why don’t you go and buy us pillows? I knew what a pillow was but I never used one because she never brought us one’.*

Although many of the participants did provide a relatively in depth description of abusive experiences, there were some who mentioned wanting to forget the details of what had happened. Becky for example stated that she had tried to ‘*blank most of it out’*. For Lucy, she had ‘*buried it’* because she didn’t want to think about it anymore due to the fact talking about it made her ‘*feel like it’s happened all over again’*. It is not possible to code these experiences as ‘unresolved’ without in depth training. However, given the potential level of motivated forgetting and the sense of re-experiencing events when they were talked about, it is likely that this could have been the case in relation to some of the traumatic experiences participants had endured.

Loss

Some of the participants had experienced the loss of someone and the circumstances of which could be regarded as traumatic. A couple of the participants had lost the person who had been their ‘*angel in nursery’.* For Jack, this was the loss of his mother, and for Sarah this was her grandma, the couple who had fostered her, as well as the recent loss of her sister who had committed suicide. Luke’s baby sister had died when he was nine from choking, and he reflected on struggling to comes to terms with it, given the guilt he felt at not having been there to ‘protect her’. Some participants had previously had children removed from their care and although this was not a loss due to a death, it appeared to feel similar for those parents who had been through it. Tracey, for example, described herself as ‘grieving’ for her other children.

Traumatised Behaviour

Self-harm and attempted suicide were the most commonly mentioned behaviours. In discussions with Lucy, she had very nearly lost her life when she had attempted suicide the last time. She did not report finding this traumatic but instead she felt it had provided her with a sense of calm.

 ‘*That was the most peaceful I ever felt in my life, it’s so messed up but stuff I said about self-harm whenever I did it, it wasn’t the pain, the blood leaving my body was the stress leaving my body that’s how I envisaged it.’*

Current Family Dynamic

Most of the participants appeared to have made a conscious decision to not have any contact with their parent aside from Chloe, who had been requested to no longer see any of her family as part of her daughter’s child protection plan. Participants spoke about wanting nothing at all to do with their family or having no feelings for them. Lisa mentioned if she saw her father in the street, she would ignore him and Lucy wished her father would die. For Jack, he no longer saw his father as being connected to him. Leah stated she would no longer allow her mother to be a part of her life. It is possible that deciding not to have further contact with family members may have finally provided them with a sense of control over that relationship, which they appeared to have been lacking during the years of abuse.

Experience of Intervention

**Foster Placement/Assessment Unit**

Anxiety

Most participants expressed feeling anxious at the beginning of their placements, and for some this lasted for the duration. Having to move to somewhere unfamiliar and then be required to live with unfamiliar people tended to be the cause, as well being aware of the continued observation as part of the assessment process.

Becky reported feeling worried about the outcome of her assessment, on a regular basis.

*‘I was on edge all the time because obviously, they had to write their daily reports and I didn’t know what they were going to say, whether they had a problem with my parenting’.*

Sarah’s mind seemed to be quite consumed by wondering what others were thinking about her parenting and she reflected on how this may have ended up impacting on her ability to remain focused on her baby.

*‘I still felt very uptight and oh am I doing the right thing with Lexi here, and am I proving enough in their eyes. I was always trying to second guess what other people were thinking or saying or doing, which took a bit of the attention off of her to a degree’.*

Isolation

In most cases, the allocation of the placements seemed to be based on availability rather than proximity to where participants had previously lived. As such, some of them appeared to struggle with being away from their familiar surroundings and people they previously relied on for support.

Lisa reported this to be her main difficulty at the start of her placement.

*‘I was thinking where the fuck am I? I am in the middle of nowhere. I don’t know anyone, away from my family and the friends I did have’.*

Jack also struggled being in a location that was a three hour journey from his home town.

*‘I felt a bit isolated because I wasn’t near my friends and family and stuff being all the way over in place one. My friends and family have always been my support network, whenever I have been stressed or upset’.*

Time out restricted

At the start of the placements, time restrictions were put in place and participants were allocated a certain amount of time to go outside of the placement. For some, this meant that initially they were not allowed to leave the placement with the baby alone at any point. The idea was that after a period of observation, the social worker would have a clearer understanding of risk and therefore would decide how much time they could have with their baby outside of the placement.

Becky had to wait five weeks before she was allowed time alone with her baby.

*‘I wasn’t allowed visitors at the placement, aside from professionals, I wasn’t allowed to see anyone for the first 5 weeks because I was restricted. I wasn’t allowed out without the carers, I wasn’t allowed on my own even for 10 minutes, everywhere they went I had to go’.*

Sarah also found the restrictions that were placed on her, in relation to not having time with her baby alone, difficult to cope with on occasions.

*‘It was like I am still not getting time to prove myself or have any breathing space away from them with my child. I didn’t really have no breathing space with me and Lexi one on one. I still felt that it had to be me Lexi and someone else, me Lexi and someone else, and that was really frustrating at times’.*

Chloe also waited a number of weeks until she could spend time with her baby alone. Once she was allowed outside of the placement with her daughter, this was only for half an hour and she felt this was too short to manage getting the things she needed.

Balanced Approach

Finding the right balance with foster carers in terms of the support they offered, how they did this, and how frequently seemed to be a contributing factor to participants settling into their placements. Sarah had a particularly difficult experience with her first foster carer and eventually was given a different placement. She felt that the first one was ‘*taking over’* and had tried to raise this with her but reported feeling cautious as she didn’t want to appear confrontational as she was aware this could impact badly on her assessment. When she did try to speak to her, she felt as if she was being ‘shut down’. It got to the point where she felt the foster carer was not letting her feed her baby as she was doing this herself. Fortunately, her child’s social worker was aware of the situation and moved Sarah and her baby to a new placement. Sarah found the second foster carer offered her the right amount of support.

‘*Well foster carer two took a step back and she let me parent and do everything that I needed to do for Lexi. If I needed help or support I could ask her, could you, do you mind helping me with this or that? She let me take all the lead in everything and let me do everything for Lexi. Whereas the first one was too hands on, doing everything for her, and I couldn’t do nothing’.*

Jack also felt that he had been offered an appropriate amount of support when it was required. He also mentioned that the foster carer would tell him when he had done things well and offered him reassurance which he had found helpful.

‘*She was brilliant if I needed advice she would give it to me but she didn’t force anything on you. She let me come to her if I needed her, but at the same time she always said that if I was doing anything that she needed to step in on she would do it straight away, so she was very fair’.*

Luke and Chloe, who were in an assessment unit as a couple, welcomed staff being open with them about their concerns and spoke about the fact that they would be informed about areas they needed to improve on, as well as things they had done well, on a daily basis. Chloe appeared pleased when mentioning how her key worker had said she was *‘really proud’* of her.

 Feeling Cared for

For some participants in foster placements, the support that they were offered by the foster carer appeared to go beyond practical help and provided them with a sense of also having some of their own needs met, which in some cases may have been the first time they experienced this. Those who described this type of care had also remained in contact after the placements had ended.

Lisa spoke at length about the way she felt welcomed and how she was treated like she was part of their family.

*‘As soon as I met the foster carer she put her arms around me and said everything is going be alright. [--] They opened the door and you just feel like you are one of them. I have my cries with her and she listens to me. Everything that they had done everything they could to help me with her they didn’t let me struggle’.*

Tracey found that the foster carer would help her at times when she had difficulty in communicating effectively with the social worker.

*‘If I can’t talk to the social worker but I can talk to the foster carer then the foster carer will put it to the social worker in perhaps a way I wouldn’t have said it but she will say it in a better way’.*

Helpful

At the end of their placements, a number of participants reflected on the ways they had found the placement helpful. This seemed to range from practical skills they had learned for themselves and their babies, as well as a sense of changing personally. Some participants also attributed their successful outcome to the help they had received in placement.

 Becky had her first child removed from her care and felt the difference in her now as a parent was due to what she had learnt in her foster placement.

*‘Where I was put in placement I have learnt that you can’t be like that, you can’t do things like that, and my parenting towards my son is completely different to how I am with Grace because I have been taught that’s not how you act, you have to deal with things nicely and calmly, you can’t just fly off the handle. I got the help and support that I needed when I needed it’.*

Tracey was surprised by the ways in which her placement had benefited her.

*‘I didn’t realise, like I said the help and support would be so beneficial at all, and it’s actually the best thing they could have done’.*

**Therapy**

A small number of participants had received therapy at some point in their past. Only one of them however, who had attended a rehab, facility reported finding it *‘helpful’*. One participant couldn’t identify the exact problem, but reflected on whether her difficulties had been due to the therapist, the type of therapy or the fact she was only offered a few sessions. Another participant found that the therapist she was seeing regularly changed and she felt that she was continually back to square one of explaining how she felt with no progression.

 Initial reluctance/hesitation

All the participants who received parent-infant psychotherapy in this study had attended the sessions at the request of social services and had not wanted to attend. The consensus amongst therapists is often that therapy is more likely to be beneficial to the patient when they have an active desire to attend. Interestingly, despite their reluctance, all the participants who had received parent-infant therapy acknowledged how helpful it had been. All of their interviews contained narratives that had indicated their determination to care for their babies. Therefore, perhaps this contributed to the therapy being a success despite their reluctance to attend.

Initial hesitation to begin the therapeutic work tended to be due to the uncertainty of what it would involve. Sarah was worried about how discussing her past experiences could impact on the decisions being made about her keeping her daughter.

*‘I didn’t really know what to expect. I just hope it isn’t going to affect me not keeping my child that you know regardless of whatever I’ve got to go through that doing this with like… whether it is bringing up a lot of my past’.*

Lucy doubted that it was going to helpful for her and disliked the fact she was going to be asked to talk about things that she had tried to forget. However, she appeared to hope it would work in order to help her keep her daughter.

*‘I don’t think it’s going to be too helpful. It’s not going to heal over things that have happened to me when I was younger. It’s not going to help you feel better about them because I don’t want to talk about them. [--] I don’t, I don’t want to talk about these things, you know, there are things but I just don’t want to talk about, you know, things I want to forget. I know how counselling would work it’s just that it’s never worked on me before because I’ve not had a reason to fight for things’.*

Positive change

During their final interview, all the participants acknowledged the ways in which the therapy had been beneficial. It appeared to have provided an opportunity to talk about their past in, what felt like, a non-judgemental setting, but they also felt able to discuss current issues or struggles they were having. The therapeutic work seemed to provide a place for self-reflection and the chance to develop new ways of being and behaving that would benefit them in several different ways, not just in their relationship with their babies, but also their interactions with social care professionals and other people whom they would spend time with.

Sarah discussed how the therapist had helped her to process the trauma she had experienced in her childhood. She acknowledged that it is potentially not possible to understand why she was treated in that way. However, she had been helped to make links between what she experienced and how she felt afterwards.

*‘I just talk through the problems that I have had really and just get an understanding of them all. I can’t really say an understanding of what’s happened because I don’t think there’s any understanding of what’s happened, it’s just just the occurrence of how many times certain things have happened—um like the pattern’.*

Leah felt she had benefited from the therapist increasing her awareness of how others may perceive some of her behaviours.

*‘I need help with my attitude because things that I say come across a lot ruder than I think it*, *so she helps me with stuff like that. It’s more my state of mind, with my attitude problems, and trying to teach me how to control myself if I was to speak to social services, and how to come across to them and not to get in an argument with them’.*

For Lucy, the therapist was someone whom she could share how she felt and feel listened to and understood. This was something she never felt she had experienced from her own mother. She saw the purpose of their sessions as providing her with ways she could manage those feelings.

‘*She wants me to explain how I feel about things, you know, because when you have got borderline personality disorder you can get really intense straight away, inappropriate, like there is no brakes on that train. If you are sad, you are utterly in despair, you don’t grieve you fall apart. You don’t fall in love, your like head over hills down the hill. Everything is so intense, you know, areas you know. In counselling they will want to teach you tips where you can sort of put a bit of a break on that train, or if you can’t be like that, be a bit like Spiderman and and at least slow the train down a little’.*

Positive Mentalization

One of the aims of parent-infant psychotherapy is to try to increase the parent’s capacity to mentalize. All of the participants reported being more aware of their babies’ needs by feeling better connected to what their baby was communicating and how they might be feeling.

Sarah reflected on how she needed to be able to do this better and how the therapist had helped her.

*‘Sometimes I need an insight into how Lexi sees it in her little mind, and her little eyes, rather than adult eyes and the adult way. Sometimes I need to take a step back and validate it in Lexi’s eyes and what Lexi is going through, rather than as an adult, and that is often what I talk to the therapist about as well’.*

Sarah had three children removed previously from her care due to neglect. She discussed how she used to respond to them when they became unsettled and the difference she now felt with her daughter after engaging in the therapy.

*'I would lose my temper more and feel more frustrated with my child if they were not listening to me, or if I was trying to get something done and they were screaming in my ear I would be like enough, I have had enough, I can’t take the screaming, I would then feel even more anxious. Whereas if she is having a screaming fit, at times, I am much more calmer, relaxed dealing with the issue. Whereas before I would be uptight and anxious and feeding it more into them because they would be picking up my anxieties that I would be picking up off of them, so I am a lot more calmer than I was before’.*

All of the participants had worked with the same parent-infant psychotherapist and spoke very highly of her. Their narratives depicted her as someone who made them feel listened to without judgement, and they all felt extremely grateful for the ways she had been able to help them.

Lucy was pleased with the way that engaging in the therapeutic work could still be beneficial without having to provide an in-depth account of what she had experienced.

*‘It has made me see that talking about my problems it doesn’t mean I have to go back into every single little detail, you know, I can go back to that place but stand on the side of the fence, you know. I know what’s on the inside but we can just sort of work at it from the fence. I don’t have to go right into the middle of the field and to that place to be able to talk about the abuse. I can talk about it from a distance away from the actual situation instead of getting upset about stuff and not talking about the ins and outs’.*

Both Sarah and Lucy discussed what they felt the outcome could have been for them if they had not had the chance to work with the therapist. For Sarah, she felt she would have been able to meet her baby’s needs but would have struggled to connect with her baby’s ‘*way of thinking, her view of the way life is’*. She believed this would have caused them to clash and place a strain on their relationship, whereas now she feels they work ‘*together as a little team’*. Lucy felt that if she had not seen the therapist then things would have easily got on top of her. Once again, she likened her state of mind to a train and described the therapist as halting the breaks on her ‘*suicide train’*, as the therapist appeared to provide an outlet for the stress she was experiencing as an alternative to self-harming.

Relationship with Social Worker

The relationship between a parent and their child’s social worker is likely to consist of a number of difficult and challenging interactions, given that the priority for the social worker will always be to safeguard the child. As such, the parent may feel that their own needs and wishes are not being heard or are being rejected, at which point communication between them may break down and may not be recovered. Given that the focus of this research was to explore influencing factors on the outcomes of intervention, it felt necessary to ask participants about their relationship with their child’s social worker.

The majority of participants reported negative experiences of interacting with their child’s social worker and similar patterns emerged across the data set, regardless of whether the participants were successful in their assessments. These experiences were organized into sub-themes and each of these is listed below for the group who were successful.

Negative approach

There were a number of participants who appeared to struggle with the manner in which the social worker interacted with them, for example some participants described the social worker as ‘*patronising*’, ‘*bossy*’ and ‘*disrespectful*’, and in some cases this had left them feeling angry, isolated and upset, causing them to dislike the social worker from the beginning of their relationships.

 Negative communication

The need for the social worker to communicate with the participant in a way that was understandable to them appeared to be important. This was something that Sarah specifically struggled with in relation to her child’s social worker.

*‘She would try to have a way of explaining it but she would have this level of ermm still being very cryptic of what she said, so I still so I was still none the wiser of it’.*

There were a few participants who at times felt as if they were not being listened to by their child’s social worker and this appeared to frustrate them. For Leah, this frustration crossed over into strongly disliking her.

*‘With my social worker I said to her the other day it just goes in one ear and out the other because you’re not listening to me. I literally told her something and asked her to repeat what I said and she couldn’t because she never listened. You were obviously not listening to me it’s going in one ear and out the other so why am I gonna sit here talking to you, wasting my breath, and she was like whatever. She is so irritating I hate her’.*

Lucy also spoke about feeling as if she was not being listened to in relation to issues she wanted to raise at the core group, but felt she was not given the opportunity as they wanted her to ‘shut up’. Interestingly, both Leah and Lucy had reported having attachment figures who they felt did not allow them to express their feelings and points of view. This may have contributed to the difficulty they had when they experienced this within the social care setting. Another similarity highlighted with Leah and Lucy is that they both had narratives that were initially coded for ‘emergence of worse self’. This related to an awareness of their own negative behaviour that would occur during interactions with their social worker when they did not feel listened to. Examples of this included Leah raising her voice when the social worker did not appear to be listening to her, and Lucy struggling to sit and listen in meetings and not ‘*scream*’ when she had not been allowed to speak. This brings into question, whether if a parent experiences feelings in their relationship with their social worker that resonate on some level with how they felt in their relationship with an abusive caregiver, this could contribute to the ‘emergence of their worst self’.

Lack of transparency

A common theme to emerge from the narrative discussions about their child’s social worker was feeling as if they were not communicated with openly and honestly. Once again, this seemed to cause frustration and then a growing dislike towards them. It appeared that when this was occurring it may have contributed to a break down in the relationship caused by a general distrust, that in many cases the relationship did not recover from.

Sarah, for example, felt that there were a number of things that were not communicated with her, or she was being told something different compared with what was being communicated to the other professionals.

*‘Horrible, I had no relationship with her. She wouldn’t tell me nothing she held information back from me she had ermm a double standard sort of approach to things. She would say one thing to me and then say something else to someone else’.*

Becky felt that they had not been honest with her about the expectations of her mother and baby foster placement when they had been trying to get her to voluntarily agree to attend the placement. When she moved into the placement, the agreement appeared to differ from what she had previously been told.

Having been made aware that Lucy had behaved in a worrying manner towards her baby after giving birth the social care team were concerned about allowing her to return home with the baby. Lucy struggled with the fact that these concerns were not raised with her until the discharge planning meeting and she would have hoped that somebody would have spoken to her about this sooner.

 ‘*He walks into the hospital on the discharge planning meeting and he wasn’t going to let me home and that was the first time I had been told that apparently I had said some really disturbing things, and I was like what you talking about? I have no idea what you’re talking about, talk to me’.*

Becky was one of the few participants who spoke positively about her relationship with her social worker but acknowledged it had taken time. Their relationship appeared to have got to the stage where there was a mutual openness in terms of communication between them.

*‘I think it is good, although, in the beginning everybody’s like I don’t need a social worker I don’t want one, but I think it is quite a good relationship. I can talk to her if I have any troubles and I know she is not going to turn round and say right we are taking the baby. I know she will help me through that and I can talk to her’.*

Conflicting views

The majority of the participants mentioned that they often had disagreements with their child’s social worker in which they would have entirely different opinions. This seemed to create a larger distance between them and a sense for the participants of not feeling understood. During the parenting assessments that they had received, some participants had disagreed with some of the smaller concerns that were raised.

Jack disagreed with the social worker about the best way to care for his son when he gets older.

 *‘She was like how are you going to make sure you know where he is at all times if he is staying out, and I was like unfortunately no matter what I do I am never going to know what he is doing all of the time, which is true, you are never going to know what they are up to 100% of the time, and she tried to tell me that she knew exactly where her kids were all of the time and what they are up to…’*

Leah had been given a bedsit to live in with her daughter after leaving the assessment unit. It was quite dark and cramped with her bed, the baby’s cot and the kitchen all in one small area. Lucy felt that her living arrangements were contributing to her low mood. However, her baby’s social work did not agree.

*‘And my social worker is telling me I was getting depressed for other reasons and I’m like no the only reason why I’m getting depressed is because I’m in here all the time so there is nothing else I can do, but she just keeps saying it’s not the room it is something else, and I know why I am like it’.*

Lucy had also clashed with her daughter’s social worker over issues relating to her mental health and had relied on her therapist to advocate that she was not a risk to her. At times, Lucy felt like she was not being treated as an individual case but rather with a general approach that would be applied to everyone with her diagnosis.

*‘I just want them to realise that, you know, like I said I love my baby and just because I have got mental health doesn’t mean but I can’t put my baby first and they can piss off to be honest’.*

Being given advice from other people when you have a young baby can be difficult for most new parents to tolerate. For some parents, hearing this from their child’s social worker, particularly when they disagreed with it, created conflict within their relationship. Lucy, for example disagreed with the social worker’s view that she was too firm when burping her daughter. The following example highlights the potential subjectivity of the social worker’s judgement, when concerns are not clear cut. Lucy did not feel like she was pressing too hard on her daughter’s back but the social worker did.

*‘I was patting the baby on the back and the way she spoke to me it was like I was going boff (gestures on back). You cannot just, you want the baby to burp, you can’t just go, you have to be a little bit firm and they are babies so if you go on the back it is going to sound like you are hitting them harder than you are, and she was making out that I was like smash, and I felt like saying to her do you want to shut up’.*

In the event that Lucy wasn’t being too firm, the potential judgement voiced here from the social worker, that Lucy disagreed with, could in some way have influenced Lucy’s ability to listen to future concerns, which could possibly be more serious. Therefore, knowing when to raise criticism may be an important consideration within the relationship.

Tunnel vision

Closely linked with ‘conflicted views’ was some participants reporting a feeling that when disagreements did occur, there was a ‘tunnel vision’ approach whereby they did not feel listened to or understood. This may then have impacted on their engagement with the requests being made by the social worker. For Jack, this approach left him feeling unheard and misunderstood.

 ‘*A social worker should have their opinion but also take on board the opinion of the person they are working with, whereas in her position she is right, her opinion is what matters. She is the one who says what happens and the other person does not matter’.*

Lucy struggled with the fact that the social worker’s manager had not met with her before making his decision at the discharge planning meeting. It is likely that this may then have impacted her ability to understand and potentially respect the decisions he had made.

*‘The man based his opinion of me by what the midwives had said, he should have come to me and introduced himself, got a little bit of a first impression’.*

Perfect parent fallacy

The participants were all fully aware that their parenting capacity was being assessed in order for a decision to be made in relation to the long term care of their babies. Some participants at times felt like they were being scrutinised and that the expectations of them went beyond what would be considered the usual behaviour expected from an average parent.

 For example, Lisa disagreed with the social worker’s concern regarding her interaction with her daughter.

*‘I put my daughter on the floor facing that way because, like I said to them, the only reason that I put her on the floor is so she can go and play with toys and they said that’s not interacting with your baby, and I said when you’re here I have to talk to you my daughter is playing with the toys, obviously I am watching her’.*

Lucy described feeling as if the social worker expected her to be *‘perfect’* and this mind set implied there was no clear distinction made in her mind between parenting behaviour that did pose a risk to the child and behaviour that could be considered ‘normal’.

*‘When you go to a parenting course you are told there is no such thing as a perfect parent, but when it comes to social services their ideals of what a perfect parent is if you’re not that then they want to take your children away, so you send us on parenting courses they teach us there is no such thing as a perfect parent but you guys want that from people. You want them to be perfect parents and anything less you make their lives hell you know’.*

Lack of empathy

There were a few participants who at times felt like the social worker was not considering how certain things they said or did made them feel. Once again, this seemed to contribute to a dislike towards the social worker that the relationship didn’t appear to recover from. In most cases, this was likely due to the fact that the participant felt the social worker was unaware of their feelings. In one case, Leah raised this directly with her.

*‘With my social worker I know that she has a daughter so I say put yourself in my shoes and imagine if it was your daughter. Imagine what I’m saying to you about your daughter, how would you feel? And she will say you’re not allowed to talk about my daughter, and I’m saying well put yourself in my shoes and understand where I am coming from before you tell me something, understand that yourself in my shoes, understand every little point that I’m coming from and then say something to me’.*

Sarah struggled with the fact that she had been asked, during a meeting to leave the room whilst the meeting continued, with what would appear no explanation as to why, and no recognition of how that felt for her.

*‘She done things unprofessionally where she would ask me to leave the room but she would have someone that had nothing to do with the case be in the room, and it’s like how dare you have that person in the room talking about me and my child, and I am not allowed to know nothing that is going on’.*

Tracey however was one participant who did feel understood and supported by the social worker, perhaps because she had a sense that she was doing everything she could to help her.

*‘Yeah she understands my needs and my welfare basically, yeah she is good, and I think she is going to go out of her way to help me. I think she is going to over step the mark to help me’.*

Persistent worry/Trauma inducing

The most significant strain on the relationship for the participants may well have been knowing that the social worker could decide that the baby should no longer be in their care. For some, the anxiety they experienced in relation to this was severe and even after passing their assessments for a few of them this did not go away. Some participants were also aware of the affect this had on their physical and mental health.

Leah felt that her mental state was connected to when she was seeing her child’s social worker.

*‘I feel like with them like when I’ve not seen my social worker for a few days I feel happy and I feel I know that I feel okay, and then when I see her I think you know what I don’t want to see this lady right now because I know it stresses me out, and then… I don’t know sometimes I sit there and I think I haven’t got a lot of stress but I’ve got this feeling that I’m then gonna lose her and I just can’t do that’.*

For Lucy, her anxious thoughts appeared to occur daily despite the positive outcome and she felt this affected her in variety of different ways, physically and mentally.

*‘My IBS has definitely got worse due to all of the stress of social services. [--] My hair is falling out I have started to feel suicidal. I have been feeling everything because of yourselves, you guys want me to be a mentally stable capable mum and if anyone in my life has jeopardised that it’s yourselves. [--] I wake up thinking about them, dreading social services. I go to bed thinking about them, like one social worker in particular he is the most evilest man I have ever met in my life he haunts me twenty four seven’.*

Despite passing her assessment Sarah remained anxious about losing her daughter at some point.

*‘I am still very highly critical of myself, and I am still highly stressed and anxious and worried about every given moment at times. Could this all go pear shaped at any given moment?’*

**Chapter 7- Negative Assessment Outcome Themes and Trauma Symptom Checklist**

The following section details the themes that emerged from the interviews with participants who did not pass their parenting assessment, and therefore the outcome at the end of their placement was for their baby to be removed from their care.

Denial

This theme appeared in the narratives of those who explicitly voiced their disagreement for the need for any intervention. They struggled to accept the concerns of the local authorities in relation to their care of their babies and as such they did not believe it was necessary for them to temporarily reside in a placement for an assessment. The participants who had children previously removed from their care prior to this assessment had difficulty providing a comprehensive and clear account as to what had been the cause of this. All the participants who did not have a successful outcome this time, and whose children had been removed, appeared to find it incredibly difficult to accept the decision that had been made. Therefore, the theme of *‘denial’* was present in many cases during the first and final interviews.

Ben had four children removed previously from his care due to neglect. Although he mentioned this as the reason, he was unable to provide any details as to what he had or hadn’t done in relation to his care of them. When prompted, he attributed the main concern to be their budgeting. His narrative was not clear or coherent and he appeared to switch between the concerns in relation to his partner and her family and then his own family.

*‘Well because of her mum and her mum weren’t protected. Well basically her dad done things to her and her brother so that’s why we are here. We didn’t protect our children at the time so basically her mum lost her children, so basically she was protecting him over the other children as well, so that’s one reason, and neglect and all that. I don’t know much about what went on because she made a couple of them I just know that we are here through neglect and that. I do know some because with our past with our other children it was like she said that her dad raped her and I didn’t know anything about that’.*

At the end of his twelve week assessment, Ben disagreed with the concerns that had been written such as that he was ‘*making hot bottles’* and he hadn’t been changing his son ‘*properly*’. He described the assessment as ‘*a load of rubbish’*.

Similarly to Ben, his partner Katie, also found it difficult to provide a clear account of what had been the previous concerns. She also seemed to merge her narrative of her own sexual abuse with the potential neglect of her children.

‘*We had our other four children removed from our care because… obviously I got raped by my dad and obviously that’s why the children were gone from neglect and sexual abuse, and they have given us a chance with Jackson to try and fight for him’.*

Katie could say slightly more about the reasons why two of her children were removed and attributed this to a support worker noticing a stain on her toddler’s top and reporting that she was only feeding them sausage rolls and coke. Katie stated, *‘that’s honestly why I lost them’*. She also mentioned how she struggled to see why moving into the assessment centre was necessary as she had four children and felt she knew what she was doing. During Katie’s post placement interview she was asked what she understood to be the concerns in relation to her care of the baby and she said they did have concerns but they hadn’t really told her what they were. For both Ben and Katie, there was a sense they were not connected to what had happened and as such they did not have a clear accurate narrative of what had happened and an understanding of the reasons for this.

Some participants were able to offer more detail in relation to the concerns of their child’s social worker but appeared to disagree with their level of concern. Emma, for example disagreed with the reasons social services had become involved with her family. Emma felt that by being asked to move into the assessment unit, they were being set up to fail, as she felt they were doing ‘*so well at home’*.

*‘My partner just got drunk on one occasion erm and like we just had Kyle and I was pregnant at the time, no Tommy was quite young like newborn at the time, and he got drunk and had a little fight with me at home and the kids were in the bedroom so they didn’t see anything, but he got arrested that night because he threw something at the wall and then the next day we just got social on the case’.*

There were a few participants who attributed the blame on to others in terms of why they were in the assessment centre. Charlie, for example, felt that he had been asked to come to the assessment centre because of his ex-wife and ‘*the person she was’*. At the end of his assessment he felt that a number of lies had been written about him and stated that he was going to sue the local authority for ‘*perjury*’. Abbey mentioned that her previous children had been removed due to the fact that her mother kept pushing her out every time she had tried to look after her children. During her post placement interview, she stated that there hadn’t been any concerns in relation to her care of the baby, but that the past *‘family issues’* had been the reason her daughter was removed.

Abbey’s partner Kieron was unable to provide an answer when asked what he understood to be the reasons why he was in the assessment unit. He felt the social worker had not explained it to him properly. During his final interview, he appeared to have made sense of the negative assessment outcome by believing that the key worker and his child’s social worker disliked them, he stated ‘*they just had it in for us*’.

There were participants across both groups who had experienced the removal of previous children. However, those whose narratives indicated denial also appeared to have an absence of discussion detailing feelings of guilt., whereas participants who had been successful in their assessments and had narratives indicating ‘*acceptance’* had talked explicitly about the guilt they felt regarding no longer caring for those children.

Low Mentalization

Low mentalization was a theme that was present in all the interviews with participants who did not have a successful outcome. These narratives indicated a difficulty in accurately considering what was in the mind of their baby, and they therefore appeared to struggle to make authentic links between how their baby’s thoughts and feelings could influence their behaviour. This theme was also present for some participants in relation to their ability to mentalize for themselves and others.

Baby

 Low mentalization of baby’s’ thoughts

There were some participants who struggled to know what might be feasibly possible for their baby to be able to think, and in some cases do. To some extent, this seemed to be linked with their knowledge of child development, in which case it indicated how having limited child development knowledge and a difficulty to mentalize could be a potentially detrimental mix when occurring in combination. It is possible that limited child development knowledge could have given rise to the inaccuracies of what the baby could be thinking, both in terms of underestimating this, which was the case in most participants in the group, or over estimating this.

On a few occasions during her interviews, Jenny appeared to overestimate what her baby may have been able to do in terms of his interaction and communication with her. For example, when her baby was two months old, she thought he could understand and respond to her when she asked him to give her a kiss, and that he knew what his name was. She also felt he had communicated to her the name he wanted to be called before he was born.

*‘And I said to him you little man do you want to be called Jack or Billy and I asked what he wanted to be, and I said come on Jack and nothing then when I said come on Billy and bam he kicked. We did that again and again. Yeah when I said Jack he didn’t respond’.*

Whilst this does not mean on those occasions her son was likely to come to harm, it appears worth considering perhaps how the inaccuracy of what he was communicating and his capacity to understand her requests could have had implications later on in his development. For example, if she felt he understood her telling him not to do something, such as putting something in his mouth, when in actual fact he may not have developed the cognitive ability to understand this or why he shouldn’t do it.

Charlie felt that during the time he was being interviewed, his baby, who was eight weeks old, was likely to be thinking about him and when he returned would signal to him by his body language that he wanted him to give him a kiss. Attachment researchers believe that young babies of this age can find kissing quite invasive rather than comforting. At eight weeks old he would not have had the cognitive capacity to recall thoughts in relation to his father, and would not yet have developed ‘object permanence’. This means if he cannot see someone or something he would not think it existed.

Another example of potentially overestimating what was in their baby’s mind and what the baby could do was when Abbey spoke about her six week old daughter and acknowledged that her baby could tell that she didn’t like it when she became upset and said, ‘*she looks at me and then puts her arm around me’*. She felt her young baby had the ability to consciously comfort her. Again, on the surface this does not appear concerning, however if in the future she did not receive this response this could impact on her feelings towards her daughter.

Katie had three sons previously removed from her care due to neglect and seemed to be aware of the fact they had not felt close to her, but appeared unable to connect with the reality of their experience of her care, which may have well have caused them to behave in that way. She hoped that this baby would be equally close to both her and her partner, *‘None of my boys have been close to me. It would be nice if he was in between us both’.*

Unlike the other examples, rather than over estimating what was in their child’s mind, there were a few participants who underestimated what they might be thinking or struggled to consider what they could be thinking. Emma, for example, did not feel that her children had been affected by a domestic violence incident between her and her partner, in which the police were called, as the children had been in their bedrooms.

*‘I don’t know exactly what we are in here for, I think it’s like my partner’s drinking and domestic violence. He has beaten me up twice in the time we have been together, and erm he was just drinking all the time and were just bickering and arguing, but we have never done it in front of the kids, they have been in the bedroom, and they are sitting there saying they can hear, it will affect them, blah blah blah’.*

Holly found it challenging to answer questions that required her to voice what she felt her daughter was thinking and how this connected with her experiences. When asked why she thought her daughter would sometimes throw tantrums, she said, ‘*I don’t know, I don’t know I just I don’t know*’. When asked what she would have wanted her daughter to have learnt by having her as her mother, she again struggled to answer the question stating ‘*Erm a lot really, I don’t know, I don’t know, I don’t know really, I can’t think, erm I don’t know’.*

Low mentalization of baby’s feelings

There were a couple of examples when participants had potentially projected their own feelings onto their babies. This mechanism of projection more often than not did not appear to lead to any insensitive behaviour in the examples that were given. However, these examples do demonstrate the potential blurred line between what they were feeling and what their baby might be feeling and could have potentially led to a response that was incongruent with the actual cause of the babies’ mental state.

For example, Jenny discussed comforting her baby when he woke up and she felt he had had a nightmare about being removed from her care.

*‘And I hold him and look at him and rock him and tell him it’s ok. I say it’s alright they are not going to take you away’.*

Charlie felt that his baby was aware that there was often someone observing them and was concerned he would have known he was in an assessment unit.

*‘Is he satisfied that he realises that we are in a controlled environment, has he realised that there is always a third person all the time or fourth person. All the time there is always someone overshadowing us all the time, and I believe as time goes on Billy will realise this intervention and this is really bad’.*

Katie and Kieron both felt after their placement had ended that their baby, who was three months old, disliked when they had to leave her at the end of the supervised contact session. Katie stated that as soon as she goes to put her coat on, she will start to scream. Kieron also felt that his daughter was now ignoring him when he said her name because of her being placed in foster care.

Participants were asked if they could provide an example of when their baby felt sad or frightened by something. Answering this question relies on the awareness of those negative mental states in the baby, attuning to the cues they are giving, and what could be causing them. There were some participants who were unable to provide an example of a time when their baby had felt sad or frightened, and simply answered ‘no’. Kieron felt this never happened for his daughter, *‘No no she never gets frightened she don’t get sad, she is just always happy’.*

 Baby’s negative persona

Closely linked with the concept of struggling to accurately understand what their baby was thinking were narratives of participants that indicated a negative intention or personality trait of their baby to be the cause of certain observable behaviours. Viewing what could be considered ‘normal’ behaviour of a baby with a potentially negative lens can not only demonstrate an inaccuracy for interpreting their behaviour, but can also increase the likelihood of offering an insensitive or misattuned response.

When talking for her baby, Abbey gave her a voice that implied she felt her baby was being deliberately defiant in her dislike of being dressed and possibly aggressive towards them. The baby’s behaviour may have been due to the fact, like for many young babies, she disliked being undressed due to feeling cold. *‘When I get her dressed she is trying to kick us off saying I don’t want to get dressed I want to stay how I am’.*

Katie mentioned how her son, who was three months old, had responded the night that her partner had left the unit and her narrative implied she felt he was being deliberately challenging. ‘*He played me up that night because he was so used to his dad getting him to sleep and it took me about 2 hours to get to sleep’.*

Emma discussed her son’s difficult behaviour and her annoyance at the fact that she felt he was not going to be able to receive support from CAMHS (Child and Adolescent Mental Health Service) because the social worker believed his difficulties were more likely due to the parenting he had received. Emma stated, ‘*When he was a baby he was just like really bad’.*

A more extreme example came from Charlie, who felt that his son would intentionally punish him or his partner if they had not accurately interpreted his needs. It is not possible to know how Charlie responded to his baby when he felt that he was deliberately punishing him but in some cases this kind of state of mind could impact on parental sensitivity levels.

*‘No matter what you do shake him, walk around, he will cry until he feels he has punished you from missing that cue. Then he will resume sleep, that is his way of telling you I told you but you didn’t listen’ (laughs).*

Self mentalization

The interview questions that required the participants to talk about their past attachment relationships had the potential to provide an insight into their capacity to mentalize. The questions provided participants with the opportunity to connect with past feelings and the reasons why they may have felt this way, together with the impact this had on their behaviour at the time, as well as now as an adult. Their narratives were not scored however if they had been scored using Fonagy *et al.’s* (1998) Reflective Function coding manual they would have received a low score.

Almost all the participants in this group, when asked if they ever felt rejected by their parents responded by stating ‘*no*’ and did not elaborate any further. Under the official coding guidelines this would be considered low mentalizing as it is thought that all of us at some point will have felt rejected in some way by our primary attachment figures. There was one participant who had been raped by her father and her mother had not believed her until he did the same thing to her brother. However, she did not appear to link this with a potential feeling of rejection and answered ‘*no*’ to being asked if she could recall a time she was upset by something. Additionally, this group had been recruited for the study based on the fact they had experienced some form of attachment trauma, and although some of them mentioned this briefly they did not appear to have a narrative of the feelings associated with this experience. This was also the case when it came to being asked if they had ever felt worried or frightened during their childhood, with most participants replying *‘no’*. Once again, it is very unlikely that at no point they felt worried or frightened, particularly when considering what was known about their attachment trauma history.

Charlie’s narrative was slightly different from the rest of the group, in the sense that it was far more detailed. However, he often switched to talking about something that was not related to his thoughts or feelings within his attachment relationships. For example, he acknowledged he was closer to his father, but this was not accompanied by a narrative detailing why this was the case in terms of what his father did in their relationship and how this made him feel.

*‘I was closest to dad to be honest because because it is good for someone to take a risk sometimes because in them days everything was a risk, it’s the same thing as you jump in your car, touch wood and no one is going to say you make it from A to B’.*

Low mentalization of others

When it came to mentalizing for others, being able to accurately consider what other people were thinking and feeling, this was again something that appeared difficult for this group. There were only a few examples of this occurring in the narratives but none of which would have been coded as ‘*convincing*’. For example, Charlie had a diagnosis of narcissistic personality disorder and this may shed some light on why he could have struggled to understand the thoughts and feelings of others, particularly when they were critical of him. He was dismissive of the psychologist who assessed him and attributed her views to her own trauma that he felt she had likely suffered, rather than accepting anything she had written.

*‘For her to portray me, a man of my calibre, in this sort of fashion and for her to recommend that Billy would have a better life if he grew up with a lone parent or one parent. That literally shows to me that she went through the same trauma herself’.*

Holly, however, struggled to answer most of the questions which required her to think about what might be in other people’s minds. On these occasions, she stated that she did not know, but on the few occasions she did answer, she appeared uncertain with minimal narrative, and no further elaboration on why she felt this was the case.

*‘Quite happy I think’.*

*‘Quite well, they were quite pleased I think’.*

*‘Happy and outgoing I think’.*

*‘Upset I think…’*

Negative Talk about baby

For the participants that did not pass their assessments, there were some observable differences in the narrative description of their babies compared to those who had passed their assessments. In general, their descriptions were less detailed, and it felt unlikely that this was not caused by any cognitive or linguistic issues given the fact that other topics were covered over the course of the three interviews, of which there had been more in-depth narrative provided. There were also fewer examples of narratives that indicated a sense of happiness and delight associated with their babies and their developing relationship.

Minimal description

For some participants when it came to describing what their baby was doing developmentally, their narratives were particularly short. They described a couple of things their babies were doing. However, unlike the other group their narratives didn’t move beyond physical description, with examples of when the baby had done something or what they thought they might start to do next. For example, Ben did not elaborate further than the following; *‘Smiling, rolling over from his tummy to his back. Just trying to talk back and he is growing’.*

Abbey and Kieron both described their baby as ‘*perfect*’, but did not provide any detail in relation to what she was doing, why she might be doing it and why this made them feel this way. Interestingly, when asked what age they would keep their baby if they could freeze time, unlike most of the other participants, they both expressed their desire to keep her as ‘*newborn*’. During this stage, the interaction that takes place from the baby towards the parent is somewhat minimal and a sense of their developing personality is less apparent. Therefore, this stood out as an unusual response in comparison to others.

Holly found it very difficult to describe her relationship with her three-year-old and to provide examples of ways she had developed. *‘Erm close erm, I can’t think erm, erm I don’t even know, I’m trying to think, erm, oh my god’.*

In addition, the majority of participants in this group when asked were unable to provide a favourite memory or story of their baby or child.

Jargon

Several participants in this group described having a ‘*bond*’ with their baby. However, they struggled to elaborate on what they meant by this and provide further description around the dynamics of their ‘*bond*’ i.e. the link between what they did, how they felt and what their babies did and may have felt. Therefore, when ‘jargon’ terminology was used with minimal narrative description it implied that, whilst the participants may have acknowledged the importance of these terms, they may not have internalized the extent to which in reality they were present in their relationships.

Ben’s description was brief, and at times didn’t quite make sense.

*‘Good we have a good bond together [--] It’s just bubbly really good bond [--] I talk to him a lot so he has got used to our heartbeats and all that from the bonding, so he knows yeah’.*

Holly also did not elaborate much further when describing having a ‘*bond*’, *‘erm like we have got a great bond, like it’s just an instant bond’.*

Another term that was mentioned and that is heavily used by professionals within the framework of most parenting assessments is ‘*emotional warmth’*. Abbey used this term, not to describe her relationship with her baby but in describing her relationship with her own mother, without elaborating on what she meant by this, and appeared keen to end the description there.

*‘She showed us that she loved us, she gave us emotional warmth so that’s that’.*

Disconnect with baby

There were some participants whose narratives indicated a sense of disconnect from the individuality of their own children. Charlie, for example, on occasions started talking about his baby but then moved on to use quite general terminology such as ‘*the child*’ and ‘*the baby’*, and there seemed to be a loss of narrative about his own son. He also described his son as ‘*my flesh and blood, my future descendant’*.

During the assessment process, Charlie was diagnosed with narcissistic personality disorder and on quite a few occasions, his narrative became more detailed when he switched to talking about himself.

*‘Absolutely because he is going to be big and strong just like I am, and him being a descendant of my family line because we are leaders, we are descendants of the Ottoman Empire. [--] Most importantly you have the skills and confidence in yourself to achieve anything you want to achieve, which are the abilities that I have. [--] I want him to be strong and brave this is it to be honest, myself I am not scared of anything in this world’.*

Charlie struggled to answer questions that were specifically focused on his son, both in terms of present day and his future. However, he would talk at length expressing his opinion on politics and current affairs.

Abbey mentioned how when her baby daughter had been poorly, she had coughed and started to choke so she had to sit her up. When asked how she felt when she was unwell she stated, ‘*I don’t know I don’t feel anything I try and comfort her as much as I can’.* A further example illustrating a potential disconnect was when Emma referred to her son as ‘*someone*’ when describing how she felt her son needs to learn to be less attached to her, and appeared to welcome further distance from him. She stated, ‘*he has got to try and learn to detach from me, erm because he is the worse one for it at the moment, like Kyle was never like it and then you get someone that is’.*

Lack of delight

Compared to the narratives of the other group, there was a noticeable lack of discussion that depicted a sense of ‘delight’ in their babies. For many participants, it was a not case of what they were saying that indicated this, but more what they weren’t saying. However, in Emma’s case she talked at length about the areas she struggled with in relation to looking after her son, with no mention of the positive aspects of caring for him. One of the concerns staff in the unit had raised with her was the fact that she did not interact enough with the children and she disagreed with the amount they felt this was required. Interestingly, she mentioned how this is something she did not enjoy, which could have contributed to the frequency of play she engaged in.

‘*I am exhausting myself, I don’t feel like I am enjoying it. They are like you have got to enjoy it, play with them, but they expect me to play with them like 24/7 a day and if I sit on the sofa just for rest to have a drink they use it against me’.*

There were some participants who appeared to struggle when their child expressed their desire to be with them. Ben, for example, stated that he didn’t want his baby to be attached to him as his son, who was removed from his care, was and it meant he couldn’t go to the toilet. Emma mentioned her difficulty with her son wanting to be with her but didn’t seem to mind it when she felt loved by him. However, she appeared slightly disgusted when talking about when he had a cold and wanted to cuddle into her.

*‘For a one year old, he is just really clingy and it tires me out because he is just a big lump on me, and you got another one. I like it but there are just times when he is so tired and clingy and it is like annoying clinginess. The love clinginess I don’t mind but when it’s the annoying, tired, wipe your snot all over me, I don’t like it, it’s horrible’.*

Relationship is self-serving

There were some participants whose narratives conveyed a sense of what their relationship with their baby did for them. This was not the same as the other group who seemed to have reflected on the way having their baby had positively impacted on their life, but rather how the baby seemed to meet their own needs. For example, Jenny stated how she wanted her son and needed him, and how he was her ‘*rock*’. Holly said that one of the most positive elements of her relationship with her daughter was that she was always asking for and wanted her. Having had four children removed previously Katie spoke about how having another baby would allow her to feel the love she was no longer receiving from her other children. Similarly to Emma who enjoyed the ‘love clinginess’, Katie’s baby seemed to serve as a potentially important source of ‘love’ given her previous losses and this state of mind could have made dealing with the usual challenges of caring for a baby such as long periods of crying, even harder to cope with.

‘*Glad I was having another one because, obviously, where I lost all the other four I thought sod it, at the end of the day it would be nice to have another one and feel that love again, what I lost with all of them’.*

Bizarre description

There were some narratives that were highlighted as being moderately strange in terms of the descriptive content. If the official coding system for reflective function had been used then they would have been coded as ‘bizarre’. For example, Charlie based his assumption on the type of voice his baby was going to have on the sound he made when he cried.

*‘I would say he is a very simple child to look after even his crying is very light, so I think he is going to have a very thin voice that even… so your voice does crack but then that didn’t happen with Justin Bieber’.*

In relation to her son Emma stated, ‘*he makes me bubble, he makes me just get up and dance’*. However, this did not seem to fit with the majority of her narrative, which depicted a state of tiredness and a lack of enjoyment and ‘delight’ when playing with him.

Lack of Factors

There were a few themes that were noticeably lacking in the narratives of this group compared to those in the group that had a successful outcomes. These related to ‘*determination*’, having had an ‘*angel in* the *nursery’* and experiencing ‘*feeling loved and cared for’*. It may be the case that the participant simply didn’t mention these areas and as such the associated narrative did not emerge. However, given the fact that all the participants were asked the same questions that had been designed to focus on potential influencing factors, it is likely they were given the opportunity to be guided into mentioning these areas if they had been present and they felt comfortable discussing them. Although some narratives within the data set were shorter than others, nobody’s presentation communicated they felt uncomfortable answering any of the questions.

Lack of determination

Similarly to other themes for this group, it was more a case of what they didn’t say than what they did say that demonstrated a lack of determination. Unlike the other groups their interviews did not contain narratives that indicated a sense of ‘*determination’* to succeed in the assessment and return home with their baby, or that mentioned the desire to end intergenerational cycles of abuse. In addition, the hopes for their babies often consisted of lists with an overall absence of elaboration, as well as consideration for their future relationship. Perhaps the latter was in some ways rooted in self-protection given the concerns that had been raised by social services, especially for those who had experienced the removal of previous children.

Katie, however, did state that she was going to try her best to try to make sure her son was not removed, but it appeared that the removal of her previous children had caused her to presume this was likely and may well have contributed to a less determined attitude.

*‘Obviously in the past where they have taken my children away, it just it feels like we have come here and now it’s going to happen again. We have had all this time bonding with him and then at the end it’s going to happen again and obviously me and Ben are trying our best to do that for him so hopefully it doesn’t happen again’.*

Abbey attributed the removal of her previous children being due to issues with family members, and during the assessment felt this had once again caused her baby to be removed from her care, rather than it being due to the concerns raised in relation to her parenting capacity.

‘*It’s the family history that has gone against us and it’s not fair, we still doing fighting and all that shit’*.

During his final interview, Ben stated that the assessment was ‘*a load of rubbish’* and expressed his anger towards the social worker at having cancelled his recent contact with his son because they were running late. The local authority appeared to view this as him not prioritising the contact. The theme of ‘*denial*’ may, in this case and for other participants, have fed into a ‘*lack of determination’*, hence why they may not have prioritised arriving on time, whereas for those participants who passed their assessments the ‘*acceptance*’ that their narratives indicated may have increased the likelihood of feeling the sense of ‘*determination’* to now succeed.

Lack of Angel in the Nursery

With the exception of Ben who had a close relationship with his grandmother, who became his primary carer, all of the participants in this group stated they had not had a close relationship with another adult during their childhood. This may have been someone who could have potentially buffered some of the negative effects of the attachment based trauma they experienced.

Abbey discussed how she had not had anyone like this during her childhood. She laughed after stating this, which could also be interpreted as ‘false positive affect’. This was discussed in Chapter Two of literature review in the context of the abused child, but can also be used to describe when an adult presents as being in a positive state to potentially mask or prevent connecting with negative affect states such as sadness, anger, or fear.

‘*No ain’t got no one really, no not really’, (slight laugh).*

Charlie mentioned spending time with his uncle during his childhood and that this had been an important relationship to him. Although Charlie did not regard his parent’s behaviour as physically or emotionally abusive towards him, his narrative suggested this was the case. His narrative in relation to his uncle conveyed a sense that a similar dynamic may have existed in their relationship as was present with his parents in terms of the pressure to achieve. Therefore, he may not have actually offered him a more positive relational experience.

 *‘My uncle was an important person because he was good in certain factors because he would tell mum what I had done wrong and what needs to be prepared for, addressed, you know, I learnt to prioritise and the top of the list was education’.*

Lack of feeling loved and cared for

Most participants in this group did not feel they were loved and cared for by others. They struggled to provide an example of somebody who made them feel this way and the things that they did. Abbey mentioned the staff and the residents in her placement as people who she felt cared about her, and did not appear to have anyone outside of that environment. Holly no longer felt that her partner loved her and that he had gone off her, as he stopped telling her that he loved her, and was not physically affectionate with her anymore. Not feeling loved or cared about may well have reinforced any negative internal working models of the self, such as being unlovable or, unwanted, even horrible. This, in turn, could have contributed to the continuation of behaviours associated with those models such as anger and defiance, both of which were likely to impact negatively on the assessment outcome.

Disconnect with Trauma

Participants were recruited on the basis that social services were aware they had experienced attachment based trauma of some form during their childhood. Whilst the nature of the traumatic abuse experienced within an attachment relationship is entirely individual, one of the aims of this thesis was to explore whether there were any significant differences in the traumatic experiences and the way in which these were spoken about. The most prominent difference appeared to be in the amount of available narrative detailing traumatic events, with a noticeable lack of discussion around the thoughts and feelings associated with those events. Having the ability to mentalize is believed to increase the likelihood of building a reflective framework to view these experiences within and therefore could potentially help to make sense of them. It therefore seems likely that the prevalence of the theme of low mentalization within this group almost certainly interlinks with the minimal narrative descriptions detailed in this section. This will be discussed in further detail in the final part of the thesis.

Relational Dynamic

Rejection

There were only a small number of participants who mentioned having felt rejected by their parents at some point during their childhood. Holly stated that she felt rejected by her adoptive parents, who were her aunt and uncle, as they favoured her siblings who were their birth children. She appeared to struggle to provide any further details around how this affected her at the time.

‘*They always used to put the others first, like before me, they used to treat the others as different. They would get bought nice stuff and I would get crappy stuff really, yeah. There weren’t much I could do really, so let it go over my head basically’.*

Emma discussed how she felt rejection from both of her parents. Her father didn’t really interact with her when she visited him and she didn’t feel loved or cared about by her mother.

*‘My dad was quite violent towards my mum and we went and visited in a court order, like we went and visited every weekend, but he used to live upstairs and never come down and we would be looked after by his partner. [--] My mum used to just work and (inaudible word) with her partner and never really looked after us. [--] Probably like unloved or something because she just didn’t really care about us’.*

As previously mentioned, under the theme of low mentalization, there were a few participants in this group who, when asked, did not recall a time during their childhood that they felt rejected. However, when discussing their attachment experiences, they described incidences that may have been likely to cause them to feel rejection on some level. However, this was not spoken about and did not appear to have been reflected upon. It is important to note they did not seem to have misunderstood what was meant by ‘rejection’ and the lack of connecting with this feeling could possibly have been more closely linked to a disconnect with the feelings surrounding those events. For example, Ben did not associate his mother struggling to look after him and giving him to his grandma, when he was three, and his father being in and out of his life, with any connection to feeling rejection.

Lack of Safe Haven

There were a few participants whose narratives indicated a lack of an attachment figure who acted as a ‘safe haven’ to them. When asked if they remembered being held by either of their parents when they were upset, hurt or ill, they answered ‘*I don’t think so no’*. Emma discussed how she had never had a close relationship with her mother and she hadn’t felt able to share her feelings as sometimes her mother would misinterpret or laugh at her. She also mentioned how she had never seen a photo of her being cuddled by either of her parents. She recalled feeling unsupported by her mother when she was bullied and when she became pregnant at a young age.

*‘When I was getting bullied, erm I tried speaking to mum and she was saying it’s all my fault, then when I got pregnant at the age of thirteen, fourteen, she told me to like go and die basically and not come back and she was trying to kick me out. Erm and like every time I needed her really just like someone to talk to or something she was never there’.*

Charlie agreed with the approach his mother had taken when he had hurt himself, despite the fact that to others it could be considered as relatively harsh and insensitive, as she did not provide comfort.

*‘Oh yeah threatened me, yeah of course, was the whole purpose that’s what made us kind of like… we knew you know. We knew our boundaries, we knew what was right and wrong, we knew what was hot and cold. If you hurt yourself mum would say, good I hope it hurts a lot yes. I hope it hurts a lot I hope it bleeds a lot, see understand the next time you don’t do that yeah’.*

Fear without solution

There were very few participants in this group who provided an explicit narrative that indicated a time when they felt frightened and threatened by a parent when asked. However, given the abuse that they were known to have experienced it was likely that they would have felt both frightened and threatened at some point during their childhood.

Emma’s step mother had called her ‘*fat*’ and she had reacted by slapping her. Emma’s father responded by being aggressive with Emma, and she was fearful of the extent he could have harmed her.

*‘She told my dad after work and my dad pinned me up against the fence and strangled me and said he’s gonna kill me, and my mum drove over because it was time for mum to pick us up, and she saw it, and shouted at my dad and my dad let go, but if my mum weren’t there he wouldn’t have let go’.*

Jenny had been sexually abused by her step-father who she had believed was her real father and her narrative implied a state of fear that was felt by all family members.

*‘I was scared of him yeah, fear of what’s going to happen, everyone used to be scared of him, my mum, brother and me’.*

Traumatic Abuse

There was a similar range of traumatic experiences in childhood recalled by the participants in this group. However, these were noticeably less detailed accounts. Domestic abuse and sexual abuse were spoken about more frequently. Katie recalled being frightened by her dad when he was angered by something.

*‘Erm sometimes, because obviously, my dad used to throw stuff and smash the home and stuff and so sometimes I was because he used to do it in front of me’.*

Emma used to witness her mother being beaten by her father during their disagreements, and on occasions he would self-harm in front of her.

‘*My dad was quite abusive to my mum and my mum was getting beaten up by him, he used to always get like chucked out of the house… erm I and used to cut himself in front of us, so it was quite horrible to remember’.*

For the participants who had been sexually abused, their fathers had been the perpetrator. It is widely acknowledged amongst trauma experts that the closer the person is relationally to the child, for example a parent rather than a distant relative, then the abuse can be more psychologically traumatising. Jenny spoke about how frightened and scared she was and how she still feels disgusting, as well as how he manipulated her by threatening her.

*‘Frightening, sick, you don’t touch your own flesh or blood sexually it’s disgusting. I feel disgusting what he done to me is wrong. I shouldn’t have done it but I was scared and frightened because he was scary, said I’d never see my mum again and things like that’.*

Abbey had been raped by her father when she was a young toddler and stopped seeing him after she was two years old. Katie was raped by her father at the age of fourteen. She did not discuss any of the details around this during her interview. None of them had ever received any form of counselling or psychotherapy previously. Katie was, however, provided with this during her placement.

Charlie was the only participant who spoke about his experiences of physical abuse. However he referred to this as ‘*old school discipline’*. He mentioned his mother finding things to throw at him, ranging from a ‘*slipper*’ to a piece of wood. He recalled a time when his parents had returned from his school parents evening and his mother was angry with him and had scratched his face. He explained that he would feel embarrassed going back into school.

*‘We knew if we push her too far she would snap, she would start shouting and screaming. You knew you would get a beating. I mean, and you come to school like you have a few scratches on your face… you feel small in front of the other kids because you got caught out you know’.*

Charlie was also the only one whose narrative indicated potential emotional abuse, but similarly to the physical example above, he did not view it as this. As previously mentioned during the assessment Charlie received a diagnosis of narcissistic personality disorder. Charlie mentioned several times the pressure he used to feel from his parents to work hard and be successful. Psychologists believe that in some cases this type of personality disorder can develop due to the child experiencing excessive parental criticism. He recalled a time when his mother had told his father that he had been ‘nasty’ and he said the following to him.

*‘What I’m bringing you into this world to hurt me, you are supposed to be supporting me, you are supposed to be my son that’s the whole purpose of you being a son, because you have been put in this world to represent the family. That is your main duty, you have to know who you are and what your abilities are’.*

In terms of neglect, only one participant discussed experiencing this, and mentioned that her mother did neglect her at times but she did not provide any further details. One of the most observable differences between how this group spoke about their abusive experiences was the fact that they provided minimal narratives, but perhaps most importantly minimal reflections within those narratives in terms of discussing what they thought and felt at the time.

Loss

A number of participants had experienced loss that could be regarded as traumatic. For some, this included close family members, and there were quite a few who had children removed from their care who had been subsequently adopted. For Ben, he had lost his grandma who had acted as his ‘*angel in the nursery’*, who he had felt loved and cared for him. The circumstances of her loss were particularly stressful and upsetting for him.

‘*I went to see what the hell was going on and my nan was really my… so I gave her a hug to see if she was all right and she died in my arms so that had a big impact on me because I didn’t know what to do. I didn’t even go to my mum to cry on her shoulder because normally I cried on my nan’s shoulder because I didn’t have that relationship with my mum so that hit me’.*

Holly was a young baby when her mother was strangled in front of her. She remained unsure who was responsible for her death. This had not been discussed with her by any of her family members during either her childhood or adulthood. Katie had four children removed previously and the last one was five days old when he was taken from the hospital. She had placed large pictures of her children on the wall in her room at the assessment unit.

During her placement, Katie spoke about how she often woke in the night feeling anxious about where her son was after her last baby was removed and she woke up forgetting what had happened.

*‘At night time I can’t sleep properly I make sure that he is in his cot all the time because I woke up and James and he was gone and I was waking up Ben to say he’s got to be fed and he was saying no he has gone, and it just keeps going round in my head. I had five days bonding with him and then social services took him from me’.*

Abbey had three children removed previously and seemed to be hopeful that her current baby would look like the others. Although she appeared to view this as being something that she wanted, in reality, if the new baby did look like the babies she had lost, this may have triggered some of the associated sadness.

*‘All I had was that my mind was focusing on her taking after her sisters and that is what she has done. [--] I feel happy because I know for a fact she has taken after them’.*

There were a few participants who when interviewed after their placement spoke explicitly about how they felt following the removal of their children. Jenny had struggled to get pregnant for seven years, she stated ‘*my heart is just broken because I have done nothing’.*  Kieron also described feeling ‘*broken*’ and ‘*ripped apart’*. The fact that they strongly disagreed with everything that had been said to them to explain why social services and the judge felt this was the best option for their child appeared to add further to the trauma of the loss of their child.

Overall, the narrative discussion of traumatic experiences for this group was fairly brief and for some, at times, appeared contradictory, whereby the narrative of the relationship with the primary attachment figure did not appear to join up with what had been said previously. For example, Abbey stated that she never felt rejected by her mother. However, later mentioned that when she turned ten years old, her mother seemed to focus more on her brother. She believed her mother felt ‘*there wasn’t much point in dealing with us’.* Sophie described her mother as being ‘*loving, really kind’.* However, she later added, *‘when I was young or growing up she used to call me nasty names’.* With some participants, there was a sense that they were possibly minimising the impact that certain events had on them. For example, Charlie’s description implied that he felt the violence between his parents was normal.

*‘They would argue and sometimes they would get along well, it’s how some relationships are, a love hate relationship. They never beat each other up, yeah they used to smash plates and throw stuff at each other’.*

Traumatised behaviour

Although only one of the participants discussed difficulties with managing his emotional states, there were a number who had been involved in violent incidences in the past. Ben was the only one who mentioned this and discussed how he had received a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) when he was younger.

*‘I just proper shout anything really a certain thing but not in a violent way just shout, swear, if someone gives me a funny look I will be like what the hell are you staring at, you know’.*

There were two participants who spoke about misusing substances. Ben developed an addiction to speed and Emma started drinking heavily after her first teenage pregnancy when she was thirteen. A few participants also mentioned self-harming. One participant recalled being nine when she first started to take knives into the bathroom to cut herself.

Jenny remained living near to her step father who had sexually abused her. She described the somatic response that continues to occur when she sees him.

*‘I go cold down my body because of the bad experience so I don’t remem… I do remember what happened to me of course I do but I don’t see what happened to me, I just have like a chill down my body, down my spine, that’s it because what he done to me was wrong. I don’t feel, you know, I feel sick that’s it… and cold inside’.*

There were a few participants whose narratives indicated a potential psychological withdrawal from connecting with the reality of events and the emotions associated with traumatic or difficult times. This appeared most obvious when some participants spoke about the removal of their previous children and either minimising the effect this had on them or dismissing what the concerns had been. Interestingly, those whose narrative indicated potential withdrawal did not report experiencing many of the trauma symptoms on the health checklist. Therefore, perhaps the disconnect with these feelings in some way acted as a defence mechanism and prevented the development of the trauma related health symptoms. This defensive emotional disconnect may however have contributed to the potential disconnect with the necessary relational feelings towards their baby, such as delight and enjoyment, which was far less apparent in the narratives of this group compared to those who had a successful outcome.

Current family dynamic

None of the participants in this group reported currently having a positive relationship with their own family. For many of them, the removal of their previous children had caused tension and fall out between them. Despite Katie’s description of her relationship with her mother being slightly contradictory (describing her both positively and negatively), she felt that after losing her children, her mother’s feelings towards her had changed considerably and reported that they were constantly arguing.

Experience of Intervention

**Assessment Unit/Foster Placement**

Anxiety/Stress

One participant spoke about being ‘wary’ when he first arrived. However, in the main participants in this group did not mention experiencing the same levels of initial stress, as was indicated in the narrative of the group who had a successful outcome. The main cause of stress for this group appeared to be due to the constant observations that were taking place in the assessment units, some of which used 24-hour cameras in addition to staff. The only place participants could not be seen or heard was in one bathroom. Some participants reported that the constant observation from staff affected their sense of independence and may also have impacted on their levels of confidence. For Charlie, the cameras seemed to be his main cause of stress. He likened the placement to a ‘*torture chambe*r’. Given his diagnosis of narcissistic personality disorder it is somewhat understandable that this level of scrutiny would be difficult for him to manage, particularly when it led to criticism.

*‘We are under a tremendous amount of stress being under this camera, everyone seeing what you’re saying’.*

Isolation

A number of participants mentioned how they had struggled with being in a placement that was a significant distance from their home. Emma’s sense of isolation appeared to worsen due to the fact she was not allowed to take her children outside of the centre unsupervised, which meant that she could only leave the centre on the days when there were enough staff present.

Helpful

During the first interview at the beginning of their placements, most participants reported finding the staff helpful. This help tended to be focused on practical tasks associated with caring for their babies, feeding, sterilizing, changing, and bathing. Kieron appeared appreciative of the methods the staff used to teach and encourage him.

*‘They have helped me do things, we have charts and all things like that they have done for me. If I do something good I get a star and if I do something positive I get a star, or if I need work they have done me pictures of things… it is good how they are doing’.*

It was apparent across the data set that for the participants who entered assessment units, although they received more intervention than those in foster placements, this intervention was not relationally focused in a way that had the potential to increase parental attunement. Instead, it appeared to focus predominantly on increasing their capacity to complete physical care tasks.

Perfect Parent Fallacy

Similarly to what had been felt by participants within their relationship with the social worker, some participants felt that the expectations from staff within assessment units were beyond that of ‘normal’ parenting. Jenny for example had been told that she was too slow when changing her son’s nappy and she struggled to see why this was concerning to them.

*‘I don’t want him to be scared because some babies if you are doing it fast they get a bit worried, especially when your touching them and you do it quickly, they get upset’.*

Some participants also mentioned how on occasions they felt staff may have said or done something that if they had done this themselves they would have been criticised. For example, when staff were caring for Ben’s son, they had forgotten to remove his oxygen after the recommended time, and if he said if he had done this they would have noted this as a concern. However, he felt they were dismissive of acknowledging this when he raised it with them. Emma felt that a staff member had spoken abruptly to her son, and if she had done the same it would have been listed as a concern.

Controlling

One of the biggest struggles for some participants was feeling that the staff had a high level of control over what they did, how they did it, and the final outcome for the family. Similarly, when discussing the dynamics of the relationship with a social worker, perhaps that controlling element felt within the relationship with staff could have resonated in some way with the feelings of being controlled by abusive parents when younger. Therefore, once again, they may have found themselves feeling as if they lacked control over what was happening to them. If this were the case then, as mentioned previously in the context of the relationship with the social worker, this could have caused the emergence of their ‘worst self’. Ben’s narrative indicated his difficulty with the constant feedback and observation.

*‘Sometimes I feel, you know, I feel, you know, like they are in charge of me sometimes, you know, just let me get a chance with my son, you know’.*

For Charlie, his mind set in relation to what it felt like being in the assessment unit indicated the extent to which it may have been impacting on his mental wellbeing.

*‘You have taken a professional human being and trapped him in an assessment centre, you’re trying to tame a wild animal, which is not easy I can’t be tamed.’*

Switch of viewpoint

Despite some parents noting how the staff in the placement had been helpful during the beginning of their placement, following the news that they would not be leaving the placement with their babies, this viewpoint significantly changed. Participants stated that the staff had been rude, complaints had not been followed up, and that they had felt judged. The environment of the assessment units was described as ‘*bad*’ and ‘*horrible*’, with threatening staff, by the participants who had previously described their experience as positive. Although he was initially very positive about the staff, Kieron appeared keen for others to know about the difficulties he had experienced during his placement.

*‘I am not being funny, it should be published, this should be put in a book for people to understand if they go in residential it’s the worstest place to go into’.*

Perhaps this extreme switch served as the best way to make sense of what had happened in the moment. However, in reality, it strengthened the mind set of ‘denial’ and perhaps weakened the shift towards reflection and acceptance. This, in turn, could have further implications later down the line should they find themselves being assessed with additional children in the future.

**Therapy**

None of the participants in this group had received therapy before. There were however two participants who had been offered it during their placement and spoke positively about their experiences. Ben discussed how he had become more aware of how his mood might affect the baby and therefore he felt that being able to ‘*get all the emotions out’* with the counsellor helped him to concentrate better on his son. For Katie, despite having been raped by her father during her childhood and the removal of her four children, she had not been provided with any therapeutic intervention previously. She appeared to welcome the opportunity to have someone to discuss her thoughts and feelings with.

‘*Now I am getting counselling here, she is helping me through working with my dad and the grief when I lost my other four. [--] Obviously what we’ve been through and how we could work on it to build ourselves up again [--] It’s been nice because obviously, we haven’t had the chance to speak to no one and tell us how our feelings are and stuff, so yeah it’s really nice’.*

Relationship with Social Worker

Within this group, there were some positive comments made about their child’s social worker at the start of their placements. However, once their child was removed from their care, in all cases their viewpoint shifted to a more negative stance. A number of relational issues raised in this group were similar to those of participants who had a successful outcome. The fact that both groups reported difficulties could suggest that some of these concerns may be experienced by other families working with social services. Given that the two groups had very different outcomes, the relationship with the social worker may not be such a key factor in influencing placement outcomes. However, it may still have impacted on the engagement levels within placements.

Initial Positivity

There was a mixed response in terms of the narratives in which participants were asked to mention any positive elements within their relationship with their child’s social worker. Ben, for example, felt that his child’s social worker had listened to him when he had asked for a chance to be allowed to attend an assessment centre with his fifth child. He felt that the previous social workers were ‘*idiots*’. Jenny mentioned that she had felt supported by the social worker who had helped them to purchase a pram and would often give them lifts into the town centre when this was on her way back to the office. Holly reflected on how she found it difficult to trust people, but she did develop a positive relationship with her child’s social worker. This was perhaps helped by the fact that she felt her child also had a positive relationship with her.

 *‘I find it hard to trust people and get on with people, but when she has come to see us I have got on really well with her. I felt like I could talk to her and the first court hearing when she said she wasn’t going to be the social worker anymore I cried, yeah, Annie loved her’.*

 Potential misinterpretation

There were some participants who reported rather extreme responses and reactions towards them from their social worker. Whilst these narrative accounts must be respected, it may have been the case that the social workers responses were misinterpreted. If not, then they would be highlighting a considerable lack of sensitivity shown towards them.

Jenny had described the social worker as being ‘*a bit rude’*. When asked for an example of when this may have been the case, she mentioned how the social worker had responded to her when she had become upset after discussing the potential for her son to be adopted.

*‘I said what if he goes for adoption will I ever see him again? And she went no, and I just bawled out and cried because I am a sensitive person, and she looked at me and smiled.* *She could have said are you ok? She saw me crying and she smiled’.*

After her son was removed, Jenny felt that her child’s social worker wanted him to forget about her. When asked what words the social worker had used, Jenny stated she said, ‘*Billy needs to get less attached to you’*. Therefore, for Jenny, even though the social worker did not explicitly state he needed to forget her, without further elaboration, this is what it felt like she was communicating to Jenny. Similarly to Jenny, Abbey felt the social worker was smiling and laughing at her when they were in court.

*‘She went to court, got the order, and came out smiling and then we are in court she tried to speak to me and I went to jump up and the barrister said no you need to stay calm for this. It’s upsetting because they were laughing’.*

Abbey stated that her child’s social worker could get ‘*a bit nasty*’. When asked for an example of this, she mentioned that before the baby was born, the social worker had been concerned that their house was ‘*dirty*’. This highlights how complex the dynamic between the social worker and the parent can be and how the social worker suggesting what needs to be changed can cause them to be viewed as having a negative temperament or attitude towards the parent. This in turn could then make it harder to agree and understand the need for change. The way in which these suggestions are communicated is perhaps a key factor within the relationship.

Confusion over role

For some participants, they appeared to have expectations of their child’s social worker that possibly centred on their own needs. Therefore, when these expectations were not met this generated negative feelings towards the social worker. Emma, for example, felt that the social worker should have been continually supporting and agreeing with them and became annoyed after a placement review in which the social worker communicated the need for them to make more of an effort to make the changes they were requiring.

‘*She is going against us and says step up or you are going to lose the kids in a few weeks, so she is not on our side, so we feel like she is just listening to everyone else and not us’.*

Similarly, Katie also stated she had wanted the social worker to be on her side, ‘*all the way through*’ the assessment process. A few participants had also been struggling with issues with housing and there appeared to be some confusion over who should be helping them to rectify these. Charlie felt that one of the social workers responsibilities should have been to help him with the problems she had highlighted in relation to his property.

*‘Sometimes I say to them show me what you can do then, let’s see if you are genuinely going to help me or you are not going to do anything at all, just cause more headache for me in the long run, and that is what did actually happen. Even though we’re coming up to the 29th of this month my property still hasn’t benefited from me having a social worker’.*

Following the removal of Holly’s daughter, she accepted the recommendation that she needed to engage with a counsellor. However, she expected the local authority to organise this for her. Given that her daughter was no longer in her care, they may have in fact seen this as Holly’s responsibility.

 *‘Yeah I am still going to do counselling, but they are supposed to be helping me and nobody is bothering. [--] They have just took her and left me to get on with it by myself. They said I need counselling and it isn’t in Annie’s timescale for me to have the counselling’.*

Lack of transparency

Similarly, to the other group, this theme relates to some participants feeling like their child’s social worker was not always open and honest about the potential concerns. This seemed to cause a considerable amount of frustration within the relationship and distrust. Katie said she wished that her social worker would ‘*tell the truth*’ when she felt she had done something wrong and explain what she needed to then do to change this. Unsurprisingly, communication appeared to be key to maintaining the relationship. Emma felt as if the social worker was not communicating honestly and would voice a different opinion to other professionals in the network.

*‘She can be alright to your face but then she goes to someone else and slags us off. [--] Like at our family conference it was really good, apparently it was all positive, she agreed to it, and then she come here and she basically said to the manager of this place that the family conference went crap, but she said to our face that it went good and was really happy’.*

Ben had been asked to leave the assessment unit before the placement had officially ended. He appeared confused by what had been said to him and what was later said in court.

*‘I kicked off a bit and said if you had a problem with me being there in the first place why didn’t you take me away before the three months, but they said we haven’t got no concerns about you but in court they did. They were really contradicting themselves’.*

Trauma inducing

For these participants who had their children removed, the level of distress they experienced within the relationship with the social worker was present in many of the narratives. For some, this was evident during the placement and for others, this theme was more widely present in the final interviews when their children had been removed from their care.

Abbey and Kieron had three children removed previously. They had not received any therapeutic support with this and they both struggled each time the previous concerns were raised in court.

‘*Getting all the court hearings back up again, bringing up the history, you don’t want to keep doing that, like it has stressed him out this morning’.*

Kieron found most of the discussions with the social worker difficult to engage with.

*‘Not having my kids and all that, social workers and all that, what they do to you, everyday really’.*

At the end of her placement, Jenny felt that it had been communicated to her that even if she chose to be a single parent and separated from her partner, this would not improve her chances of keeping her son, as there was nothing they could do to help her improve. This was likely to have left her with a feeling of helplessness, which was particularly difficult to tolerate. Once she had left the placement she reported feeling severely depressed and, at times, suicidal.

*‘They said that nothing would change if I was on my own, they said that nothing will make me better than I am now’.*

Charlie spoke openly about the trauma he associated with his relationship with social services and struggled to understand why his behaviour was not understood from the perspective of what he had experienced.

*‘I think the most traumatising thing for me is being involved with these social workers. [--] Mr Smith’s behaviour is threatening and extremely hostile. How do you expect me to be? You come into my life, intervened in my life, wrecked my life, and you expect me not to be hostile?’*

The feeling of a trauma inducing relationship may also have been present for the participants whose narratives indicated ‘*denial*’, as they felt they had done everything they could in their assessment. Therefore, when the social worker recommended that their child was removed from their care this may have increased their feelings of anger or upset as they felt this judgement was incorrect and the outcome would have appeared extremely unjust, possibly even cruel to them.

Trauma Symptom Checklist

*Figure 1: Trauma Symptom Checklist Scores of 2 and 3*

During the first interview using ‘The Trauma Symptom Checklist’ participants were asked to score and discuss whether they were currently suffering with any health symptoms that are clinically associated with trauma and the frequency of these. A four point scale was provided with a score of 0 indicating they ‘never’ experience it and a score of 3 indicating they ‘often’ experience it.

The narrative discussion surrounding some of these symptoms has featured in the detailed thematic analysis. The table above details the number of participants who scored the trauma symptom on the higher end of the scale at 2 and 3. There was not a clear numerical difference between the symptoms listed by the group who passed their parenting assessments and those that didn’t, therefore the graph refers to the data set as a whole.

The most commonly reported symptoms at the start of the intervention were ‘feeling isolated’ ‘headaches’ and ‘feelings of guilt’. The isolation tended to link directly to the location of placements being far from their home town, and in some cases also limited support networks. For many of the participants, they reported suffering from headaches from a young age. Those who mentioned feelings of guilt most frequently connected this to the removal of previous children, and it was more commonly reported amongst the group who had received a positive assessment outcome and remained caring for their baby.

The second most commonly reported symptoms were ‘flashbacks’ and ‘feeling tense’. Flashbacks tended to relate specifically to abusive experiences, but for some the removal of previous children also entered their minds. As mentioned in the detailed analysis, most participants reported feeling tense about the potential outcomes of their placement, and even those who were successful remained apprehensive once they had returned home.

The reporting of traumatic symptoms did not appear to decrease once the placements had ended. In some cases, those who had children removed from their care had an increase in the number of symptoms they said they were experiencing. The most common was ‘insomnia’ followed by ‘flashbacks’ ‘sadness’ and ‘anxiety’.

**Chapter 8- Discussion of findings**

Introduction

The third and final part of this thesis will examine how the research findings have contributed to answering the research question as well as the ways in which these findings fit with the existing theoretical and research knowledge base. The limitations and generalisability of this work as well as recommendations for future studies will also be discussed. Implications for social work policy and practice will be proposed, and the chapter closes with final conclusions and reflections on the process of completing the research.

Research Question

**What factors affect the parental experience and outcomes of parent-infant intervention?**

The thematic analysis detailed in the previous chapter identified a distinction between themes that were present for participants who had successful outcomes, passed their parenting assessments, and then returned into the community with their children, and those that were unsuccessful and had their child removed from their care. The ‘intervention’ that participants received was either entering a parent-infant foster placement or residential assessment unit, and/or parent-infant psychotherapy. The thesis proposes the themes that emerged from the guided conversations comprise some of the potential influencing factors on the outcomes of these interventions.

What follows is firstly a discussion of the thematic factors that were associated with the participants individual experiences and functioning identified in the participant group who had a successful outcome, and the ways in which these factors may have contributed to this outcome and could be regarded as ‘change facilitators’. This is followed by a discussion of the thematic factors identified in the group that were unsuccessful and how these factors may also have influenced their outcome, and could therefore be regarded as ‘change inhibitors’.

**Individual Thematic Factors for those with a successful outcome**

A sense of *‘Acceptance*’ was evident for this group in terms of their acknowledgement of the concerns that social workers had with their parenting capacity, as well as their agreement to participate and engage in the intervention. This was not present for all of the participants in the group at the start of the placements, as there were a few who appeared to need time to settle and reflect on the placement before this was achieved. Some may question the extent to which their acquiescence was genuine or potentially falsely presented in order to increase the likelihood of passing their assessment. One could never be certain for sure; however, the fact that this factor was only present in the group who were successful may imply that it was in fact a reasonably congruent representation of their state of mind. Jones (2005) states how ‘critical’ she believes it is for those who engage in parent-infant psychotherapy to present with a ‘motivation to work’ and ‘a preparedness to change’. She also believes that an acceptance of previous ‘failures’ is interlinked with increasing the chance of being able to prioritize the baby’s needs above those of their own (Jones 2016). Buczynski (2017) links acceptance with an increase in the ‘window of tolerance’ and believes it is essential when working therapeutically with trauma.

Some form of *‘Acceptance’* may therefore have provided participants with a better chance at engaging with the intervention that was offered and subsequently increased the likelihood of a positive outcome.

‘*Determination’* specifically related to the strength of their conviction that they would pass their assessment and continue to care for their child. A number of participants discussed how they would be prepared to do anything in order to make this happen, in one participant’s case even if this meant risking her own life. Alongside the factor of ‘*Acceptance’*,it could be argued that a narrative portraying ‘*Determination’* may not necessarily be a true representation of its existence. However, as was the case with *‘Acceptance’*,‘*Determination’* did not feature in the narratives of the group who were unsuccessful, and therefore was only associated with a positive outcome. The literature review highlighted how for some parents the start of a new little life can act as a turning point for more positive change (Prachi *et al.* 2010). A new sense of purpose and responsibility may follow after the birth of a child (Pryce & Samuels 2009). Apparicio *et al.’s* (2015) study of teen mothers in foster care reported a theme of ‘*new beginnings’,* which similarly to these findings related to an ‘intense desire to do things differently’. The presence of ‘*determination’* may have provided the participants in this study the strength of mind to continue to engage positively in the intervention, and with professionals. To also continue to be receptive to advice and to cope with the stress that being observed and assessed, whilst living in an unfamiliar environment, was likely to have created.

What is meant by the capacity to mentalize was explored at length during the literature review. A wealth of findings have been able to evidence its impact on the developing attachment relationship (Slade 2005, Meins 2015, Fonagy & Batemen 2016, Shai & Belsky 2017), why in some cases it may not occur (Fonagy & Target 1997, Fonagy *et al.* 2002 Fonagy 2011), and the impact of its absence (Fonagy 2002, Sleed & Fonagy 2010, Fonagy & Batemen 2016, Borelli *et al.* 2017). ‘*Mentalization’* unsurprisingly, was a theme that did emerge from the narratives of participants in the group who passed their parenting assessments. This related firstly to discussions that demonstrated their ability to make accurate connections between how their own thoughts and feelings may subsequently impact on their behaviour, particularly in relation to their past traumatic attachment relationships but also in terms of their current everyday functioning.

Siegel’s (2017a) thoughts on clients’ interactions in therapy suggests that the participants’ ability to have been able to discuss their feelings during their interviews (which was minimal in the other group) may have been due to feeling worthy enough to be seen and the confidence to communicate those feelings. When applied to the therapeutic setting, Siegel discussed how some individuals have an expectation that the therapist will understand them and that they feel they have a right to expect this, and any necessary guidance or help. This stance therefore offers further support for the critical role that self-worth can play in terms of the ability to speak about feelings but also its influence on intervention outcomes as a whole.

Another key dimension of mentalization related specifically to their capacity to mentalize for their child. The narratives in this group indicated they had the ability to view their child as an autonomous individual and accurately consider what they might be able to think and what they were likely to feel. Furthermore, it was evident that their capacity to be able to do this appeared to influence their ability to accurately interpret the cues of their child, which aided them in deciding what would be the most suitable responses. For example, understanding that the baby cries when he becomes aware that his father is not in the room so not leaving until he is asleep, or that the baby is frightened of the hairdryer, so turning it on low to try to get her used to it, or understanding that the unsettled behaviour at night might be due to the pain of teething.

‘*Mentalization’* was also evidenced by narratives that indicated that the participant had been able to link their own mental state and behaviour with how that could influence their child’s. For example one parent mentioned how when she was feeling down, she was aware that this would affect her baby, and the baby would then sometimes be more challenging. Lastly, there were further examples of them connecting with the thoughts, feelings and behaviour of others in relation to their own parents, the interviewer, and their previous children. The capacity to remain connected to their baby’s mind is likely to have significantly influenced the care that they were able to offer them, and therefore is likely to have increased the likelihood of them passing their assessments.

Closely linked with the factor of ‘*Mentalization’* was the presence of ‘*Positive talk about baby’*, narrative discussions where participants in this group spoke warmly and enthusiastically about their babies. This ranged from discussions around their baby’s emotional states, to the ways in which they were able to offer comfort and emotion regulation, as well as detailed discussions around their baby’s developmental milestones. In addition, a sense of ‘delight’, associated with their relationship with their baby was portrayed through narrative details of excitement and pleasure connected with their baby. As well as the participant’s facial expression and tone of voice during these interviews.

Aparicio (2015) reported similar findings from a group of mothers in foster placements whose narratives were themed ‘Love for their children’. They described their eyes lighting up and their posture changing when they spoke warmly about their children. The participants in this group also described how having their babies had positively influenced their lives, and in some cases encouraged them to be the best versions of themselves. Possessing a genuine interest in their baby’s state of mind, as well as their development and feelings of curiosity, positivity and delight in connection with their baby, most likely continued to strengthen their relationships and impact positively on the outcomes of their placements.

The existence of an ‘*Angel in the nursery’* was present for all of the participants who passed their assessments. Therefore, it represents a significant influential factor. Lieberman *et al*.’s (2005) concept of an ‘*Angel in the nursery’* was introduced in the first chapter of the literature review. This theory draws on the work of Fraiberg and her colleagues (1975) who developed the concept of ‘*Ghosts in the nursery’*, to highlight the ways in which experiences with abusive caregivers could interrupt instinctive care giving behaviour. Lieberman and colleagues (2005) discussed how positive attachment experiences amongst those that have been abused provide the individual with a ‘core sense of security’ and ‘self-worth’. They state that these have the potential to interrupt the transmission of abusive attachment patterns. They argue that ‘uncovering the angels’ is as critical to the work of psychotherapy as is ‘exorcizing’ the ghosts.

A number of researchers have also documented the importance of experiencing at least one positive relationship (Werner 2005, Walsh 2008, Narayan *et al.* 2017). In this thesis, a number of the ‘*Angels*’ were identified as grandparents. However, for a few participants, although they had endured an abusive relationship with one parent, the other parent seemed to offer something less threatening. Although this relationship may not have been optimal, and in some cases participants reflected on this themselves, the absence of elements of abuse and/or neglect in that relationship may have still been able to buffer the effects of some of the attachment based trauma that they were regularly exposed to by the other parent.

These relational experiences may have provided participants with some form of internal framework, map, or model of caregiving behaviour that the participants could access and then model their own caregiving behaviour on, and may therefore have contributed to increasing the likelihood that instinctive caregiving behaviour would be able to become ‘switched on’ when required.

Closely linked with the presence of an ‘*Angel in the nursery*’ was an indication that some of the participants in this group possessed an ‘*Internal Working Model’ (IWM)* that was ‘*Intact’.* Despite the abusive attachment experiences they had been exposed to, their mind may not have used the defence mechanism (detailed in the literature review), of internalising that they were deserving of this abuse, or that they were ‘unlovable’ as a means of trying to make sense of it (Lieberman & Amaya-Jackson 2005). Instead, there appeared to be an internal dialogue during their childhood years in which they acknowledged in some way that they deserved better, that it wasn’t the right way for a parent to behave, that it wasn’t their fault. In the case of one participant, this allowed them to feel that they deserved to be rescued by a fairy godmother. Similarly to the function of the ‘*Angel in the nursery’*, this may also have provided them with a better chance at being able to connect physically and emotionally with their baby, as their self-worth and self-esteem was potentially less damaged. Therefore, they had a certain level of confidence they could access and bring to this new relationship, particularly during difficult or unsettled times. In later adulthood, the preservation of the IWM may have been what had driven some participants to seek answers from their abusive caregiver about why they had behaved in the way that they did. This process may well have been key to helping them to start to resolve some of their experiences, and therefore potentially decreasing the likelihood that unresolved memories or ‘*Ghosts*’ from the past would be triggered unconsciously whilst caring for their babies.

‘*Caring for siblings’* was evident in some cases where participants had discussed some of the most extreme levels of abusive behaviour. This links with the theory discussed in Chapter Three that children who have experienced a sense of *‘fear without solution’* in their attachment relationships may seek to gain back a sense of control. One of the ways this is believed to manifest itself is through caregiving behaviour (Liotti 2004). Jones (2005) describes how parents may assume the role of helper and in doing so become a ‘parentified child’ in order to meet their own needs and those of their siblings. Herman (2017) notes how altruistic behaviour of trauma victims can in some ways help to transform some feelings of negativity. Therefore, perhaps caring for siblings could be considered in some way to be altruistic and served as an additional protective factor for participants in this group.

For these participants, there appears to have been an underlying instinct to protect and care for their siblings, and the existence of such an instinct may have provided them with a better chance at offering appropriately attuned and sensitive care giving when they became parent’s themselves. In addition, they may have been more prepared for the physical and emotional demands of caring for a child, which they had managed to do previously within, what was for most of them a highly stressful and abusive environment.

‘*Feeling loved and cared for’* was a factor that some participants in this group were able to provide examples of receiving during their adult years. For some, this came from their current partner, or for those in foster placements or engaged in therapy the intervention itself had provided an element of this for them. Feeling loved and cared for during the placement and assessment process may have increased the likelihood of loving and caregiving behaviour emerging from within them. As stated in the literature review from Jones’ (2010) hypothesis that witnessing somebody taking pleasure in being with them can then increase the parents own capacity to take pleasure in being with their baby. She felt this is key to disrupting ‘malignant projective processes’ that can manifest in parents with an attachment trauma history. If these processes are not disrupted then they could in some way contribute to instinctive caregiving behaviour becoming ‘switched off’. Therefore, experiencing some form of positive emotional connection may have enabled this behaviour to remain ‘switched on’, for these participants, and thus contributed to their ability to succeed.

The final factor, and potentially one of the most influential, was their ‘*Connection to past trauma’.*  The literature review detailed the ways in which being in possession of a narrative surrounding traumatic events can reduce the severity of trauma related symptoms such as those typically associated with PTSD (Post traumatic stress disorder) (Moroz 2005, Main & Hesse 1990, Abrams *et al.* 2006, Walker 2007, Fonagy 2011). The participants were not required to provide detailed accounts of the abuse they had experienced. However, some of them in this group did. Interestingly, they were the ones who were presently receiving therapy, thus highlighting the importance of therapy in creating trauma narratives. Although in most cases this depth of detail was not provided, what did emerge was their ability to make connections between what they had experienced and how that made them feel at the time, behave at the time, and, in some cases, how it may be continuing to affect them. Their capacity to *‘mentalize’* which was also noted in this group, is likely to have contributed significantly to them being able to do this.

Without training and accreditation, it is not possible to use the terminology featured in the literature review that these memories were ‘resolved’ for them, and without therapeutic input it is probable that they are not. However, these memories appeared accessible to participants with some form of narrative surrounding them. This perhaps offered protection from the detrimental ways in which a lack of a connection to their traumatic past could have caused them to be unable to respond appropriately to their child (Lyons-Ruth *et al*. 1999, Jones 2016), due to their baby being lost from their mind (Baradon 2010). It is also likely to have prevented their baby from unconsciously triggering negative emotions connected with their trauma (Cook *et al*. 2003, Walker 2007, Daum 2017) The existence of a connection to those memories and associated feelings may have been what contributed, in some way, to the participants in this group remaining emotionally ‘switched on’ to their own emotions and most importantly those of their babies.

**Individual thematic factors for those with an unsuccessful outcome**

The antithesis of the factor of ‘*Acceptance’* could be that of ‘*Denial’*, and the latter did emerge from the narratives of this group. Ward *et al.* (2014) report that parental denial is common amongst parents within the child protection system. In most cases, the participants in this group disagreed with the necessity of the intervention and the previous and/or current concerns that had been raised by social services. Takaoka *et al.* (2017) documented the influence that having a ‘negative image of help seeking behaviour’ can have on levels of engagement and subsequent feelings of satisfaction with the service offered by children’s social care. Therefore, the underlying causes of this state of ‘*Denial’* are likely to be more complex than just defiance. As discussed previously, in line with Siegel’s (2017a) theory, it could be that these participants did not possess the levels of self-worth to expect to be understood and helped, which diminished the potential of engaging positively and achieving some form of ‘*Acceptance*’. Their previous relationships with social workers, and the likelihood of limited access to resources and effective methods of intervention, may also have contributed to this negative mental state.

Of those participants who had children previously removed from their care, they were unable to provide a coherent and reasonable narrative as to why this had happened. The inability to do so may well have been linked to the trauma associated with the loss of their children, particularly as they did not agree with it. In addition, not being able to reflect, process and understand why this had happened may have given rise to the potentially defensive mind set of ‘*Denial*’ (Stern 1998, Jones 2005). Lanius (2017) notes how difficult it can be for traumatised clients to reach a place of accepting what has happened to them and what needs to change because of the distress associated with this process.

Viewing the mind set of ‘*Denial’* as a defence mechanism is predominantly linked with a psychodynamic model of understanding behaviour. This framework proposes that denial could have served a protective function previously during past traumatic attachment experiences, whilst also then leading to the development of, what was noted in the literature review, as a ‘false self’ (Winnicott 1984). If both of these mechanisms were in operation for participants, then this may have led to difficulties connecting and engaging with the intervention and therefore remaining focused and motivated throughout the assessment process. The psychodynamic model would also suggest that some form of psychotherapeutic support would be required in order to make the client aware of the defensive behaviours in order to attempt to reduce them. There was only one couple in this participant group who received therapy and this ended following the removal of their baby. Jones (2010, 2015) notes that defensive denial can also interfere significantly with the process of change during parent-infant psychotherapy, therefore highlighting its potential influence as a factor impacting on a successful outcome.

Participants in this group produced narratives that indicated low *‘Mentalization’*, with observable difficulties in being able to do this for themselves and their babies. Regarding mentalization of the ‘self’, they struggled to answer questions relating to their childhood emotions such as rejection, fear or sadness. The findings discussed in the literature review implied that this difficulty could have been linked to their trauma history, given that children who experience attachment based trauma are likely to have difficulties making links between their feelings, their behaviour and what has happened to them in the past (Cook *et al.* 2003, Moroz 2005, van der Kolk 2008, Cook *et al.* 2017). In addition, they may be have adopted the defence mechanism of deactivating their capacity to mentalize, in order to defend against the ‘psychic experience of pain’ or other types of ‘overwhelmingly negative affect’ (Fonagy 2010).

In relation to their children, ‘*Low Mentalization’* presented as a difficulty in being able to accurately connect with what was in their child’s mind, what their behaviour may be indicating and what their subsequent needs might be. The previous ‘deactivation’ or potential ‘switch off’ of their capacity to mentalize, due to their own trauma history, may well have been a significant cause of these difficulties. The notion that attachment trauma could cause someone to become stuck in progressing through the developmental stages of menatlization was discussed in the literature review. Fonagy (1999) proposed that as children these individuals are unlikely to have transitioned beyond the stage of ‘*psychic equivalence’*,causing information to be processed in a very literal way. The implications of this in parenthood could be that the parent only focuses on the basic needs of the baby and fails to consider the deeper complexity of their feeling states. Jones (2005) believes that it is unlikely that a parent would be able to transition beyond the ‘*teleological mode’,* whereby links between thoughts and feelings are based solely on actions rather than mental states, towards a more ‘*relationally reflexive mode’*, without receiving therapeutic support. The findings of this study do support this as the parents who received parent-infant psychotherapy in their final interviews spoke openly about the way it had helped them to understand the minds of their babies better, and what was required from them, as well as making links between their own mental states and their past experiences.

It was also observed that some parents may have, on occasions, projected their own feelings onto their baby, in relation to feelings of anxiety about removal or sadness at the end of a contact session. It was noted in the literature review that attachment researchers have discussed the importance of viewing the baby as ‘autonomous’ and that the absence of a mentalized approach can cause the parent to view their child as a ‘narcissistic extension’ of themselves (Bernier & Dozier 2003). Jones (2005) states that the defensive process of ‘projective identification’ is the result of the birth of their baby arousing unexpected difficult feelings and the parent uses this defence mechanism when negative feelings occur causing the baby to become caught up in this process, as these feelings become displaced onto them. The likely outcome being further difficulty in accurately attuning to their baby’s needs, which was evident in the analysis of these findings.

Perhaps one of the more salient ways the struggle to mentalize emerged was through narratives that inferred that their young babies (all under 3 months) had deliberate negative intentions towards them such as wanting to kick them, punish them, or deliberately behave in a more challenging way. These findings link with those of other attachment researchers who have evidenced the occurrence of these types of thoughts amongst parents who struggled to mentalize (Meins 2001, Lieberman *et al.* 2005). This could have then decreased the chances of them offering a more appropriate caregiving response to whatever the baby was in fact trying to provide a cue for. If an inappropriate or non-attuned response was given then this may have been noted by staff observing the parent and could have caused concern. The potential lower level of the capacity to mentalize in this group compared with this ability in the group who had a successful outcome supports the previous well established findings that its existence is of considerable importance (Fonagy 1994, Slade 2005, Ensink *et al.* 2014, Fonagy & Batemen 2016). The participant’s capacity to mentalize is likely to have impacted not only on the decisions made within the assessment process but also on the wider context of the developing attachment relationship.

The presence of ‘*negative talk about baby*’ offered a further distinction between the two groups, and linked with the capacity to mentalize. Whilst many caregivers might discuss the challenging elements of taking care of a baby, these are often then counterbalanced by comments detailing the emotionally positive aspects that caring for a child can also provide. Unlike the other group, for these participants there was a marked absence of detailed descriptions, both in terms of the babies’ emotional and physical development. This perhaps indicates that they struggled to view their infants as ‘sentient’ and ‘intentional’ (Tomas-Merrills & Chakraborty 2010), and struggled to remain ‘empathically connected’ (Jones 2005) to their babies.

There also appeared to be a marked absence of a sense of ‘delight’ that was noted in the other group. What emerged instead for some participants was a sense of disconnect and/or bizarre comments, as well as the notion that the baby might have a self-serving purpose, to help them feel, loved, wanted, and in one participants case, more emotionally stable. Jones (2016) notes how the *‘unconscious wish’* for their baby to fill a potential emptiness due to past attachment based trauma with ‘*unconditional love’* means that these babies are ‘doomed to disappoint’, and in the event that these babies are removed from their care then this emptiness is exacerbated, and shame and the defensive process of rage may emerge.

There also appeared to be an absence in this group of what was noted in the other group as the ability to provide some form of self-talk at times when the baby was distressed, such as going through the motions of what had been offered to the baby in order to work out what could be the problem. Jones (2005) refers to this as ‘*internal self-talk’* and proposes that it serves a function of enabling the parent to soothe themselves whilst soothing their baby. If they feel emotionally stable then this increases their ability to offer a more appropriate response during times when the baby is distressed. The process of emotion regulation was discussed in detail during the literature review and for these parents who may not have received it themselves, their ability to ‘self-regulate’ may have been severely compromised (Brazelton *et al*. 1974, Schore 2010, Cozolino 2017). The diminished capacity to self-regulate is likely to affect the ability to provide yourself with this necessary ‘*internal self-talk’*.

The presence of all of the dynamics discussed above may well have interfered considerably with the likelihood of the parents offering optimum caregiving responses and thus inevitably impacted in some way on their placement success.

The *‘Disconnect with trauma’* that was present within this group has the potential to be one of the most significant influencing factors and supports previous theories linking it with *‘Low mentalization’* and subsequent *‘Negative talk about baby’* (Liotti 2004, Fonagy 2011, Allen 2012). Another likely significant influencing factor is being less able to mentalize in relation to your attachment trauma which can impact on how invested you feel in your pregnancy, cause less positive feelings towards your baby (Ensink *et al.* 2014), and contribute to a more detrimental attachment style (Berthelot *et al.* 2015).

Despite their known trauma history, the participants in this group struggled to produce a coherent account of their traumatic experiences or provide any details, aside from in some cases stating that they had been neglected or abused. As detailed in the literature review, a difficulty in narrative recall is common amongst individuals whose trauma is deemed to be ‘unresolved’ (Hesse & Main 2006, Holmes 2001, Out *et al.* 2009). The development of Alexithmia, as a result of attachment trauma, was also mentioned in the literature review, and causes an individual to struggle with finding the words to name their feelings. It could be that the participants in this group may have been suffering with this. Fosha (2017) notes how disturbing and disorganizing it is to feel something but be unable to explain or describe it. However, what will be argued later in this section is the notion that participants in this group may not have even been at the stage of feeling the things they didn’t have the words for.

It is important to note, that there was no refusal to enter into these discussions about their past or any hostility displayed in relation to answering the questions. What was perhaps more likely was that they had trouble accessing these memories, due to a difficulty in storing, retrieving and most importantly integrating them (Cozolino 2002, van der Kolk 2014, Siegel 2017b, Lanius 2017).

The field of neuroscience has provided evidence that indicates why this can occur. Firstly, during traumatic incidences the Broca’s area of the brain, that is responsible for processing speech and organising thoughts and feelings into words, can go offline, causing difficulty with recalling events (van der Kolk 2014, Cozolino 2017). As detailed in the literature review, trauma can also impair the functioning of the hippocampus, which is primarily responsible for processing and storing memories. Sigel (2017a) refers to this area as responsible for ‘weaving a puzzle of facts and lived experiences’. Cozolino (2017) adds to this by describing the hippocampus as the brain’s ‘Etch A Sketch’. Therefore, the lack of words to start to construct a narrative and the likelihood of the memories not being stored in an accessible format are likely to have contributed to the difficulty that these participants had with recall. In the absence of any previous therapeutic support, a narrative may not yet have even been formulated and no opportunity for integration had taken place.

Most significantly these participants appeared disconnected with the feelings associated with the abuse, unable to access and narrate memories of sadness, fear and rejection that had likely occurred, given their brief comments about their family dynamics. In addition, there were some participants, who despite their trauma histories, reported virtually no symptoms on the ‘Trauma Symptom Checklist, even common symptoms that we all might experience at some point such as headaches, tiredness, sadness. Their narratives indicated the likelihood that their experiences had not yet been resolved.

Trauma experts and neuroscientists have provided both theoretical and empirical evidence to offer an explanation for this potential ‘shut down’ or ‘switch off’ of when connecting with feeling states in the self and other. The literature review detailed how exposure to trauma can cause individuals to either become hyper-aroused whereby their brain operates with hyper vigilance to all stimuli, even that which is neutral, or they may become hypo-aroused, which is more closely linked to a dissociative state. Within hypo-aroused states, the nervous system is believed to shut down (Levine 2017). Porges (2009) ‘Polyvagel theory’ has been influential in understanding the ways in which the various branches of the vagus nerve can be impacted by trauma, in particular when a sense of ‘fear without solution’ occurs, causing a potential ‘shut down’.

Van der Kolk (2014) offers insight into why some participants in this group reported none or very few trauma health symptoms. He has documented how his trauma patients often report feeling very little and/or a general numbness, both emotionally and physically. He discusses how a number of patients struggle to identify objects when placed in their hands when their eyes were closed. Or during sensory therapy, once their eyes were closed, becoming panicked, not knowing where the therapist was despite the fact she had her hands on the client’s feet. McFarlane (2010) observed the same phenomena in his patients with PTSD. Therefore, some participants in this group may have been experiencing a disconnect with their physical selves, perhaps adding further difficulty in connecting with their babies physical self, increasing the likelihood of neglect.

Pat Ogden (2017) has been a pioneer of sensory therapy for traumatised individuals and she believes that working therapeutically with the body is one way of ‘fostering resilience’. She uses a quote from Aristotle to support this notion which is *‘we are what we reportedly do’*. She has also previously stated how she believes that an individual’s connections with their sensory state needs to be worked with prior to engaging in interventions that are narrative focused (Ogden & Fisher 2014). Other expert therapists in the trauma field, such as Dianne Fosha are in agreement that language based therapy may not be enough particularly in cases of chronic hypo-arousal (Fosha 2017), which may have been the case for some participants in this group. The reality of course for them was that there was an absence of any form of significant therapeutic intervention.

The insula area of the brain is believed to be connected to management of feelings and attachment trauma has been found to potentially compromise the functioning of this area (Teicher *et al*. 2016). This means that feelings are still present but they may lack a ‘structure or base’ (Damasio 2017) from which to be understood, processed and become connected to. Damasio (2017) states that ‘connectedness is a biological imperative’ and trauma can interfere with the occurrence of ‘reciprocal connectedness’. Cozolino (2017) discussed how trauma can interfere with the ability to relate to others and remain connected in a meaningful way. The absence of such ‘connectedness’ is likely to impact significantly, not only on the individual’s ability to form positive meaningful connections with others, but its impact on the developing attachment relationship is of particular significance to the findings of this research. Jones (2016) highlights how a baby’s distressed cries may fall on ‘deaf ears’ that ‘need to be deaf’, in order to defensively not feel their babies sense of distress. For these participants who may have been predominantly operating within the defensive state of hypo-arousal, disconnect with their own feelings, but most importantly those of their babies, offers a plausible explanation as a contributing factor in the outcome of their assessments, bearing in mind that the main concern for these parents was potential neglect. When asked how she feels when her baby cries, one participant said ‘*I don’t know, I don’t feel anything I try and comfort her as much as I can’.* It would seem that this absence of feeling is likely to have a significant impact on parental sensitivity, and attunement. A focus on the inclusion of a detailed trauma history has not featured in many studies of sensitivity and mind-mindedness, most likely due to the fact that the majority have used quantitative data, but could be useful in future research.

Bowlby (1979) discussed the importance of traumatised patients ‘knowing what you are not supposed to know and feeling what you are not supposed to feel’, as being key to beginning some form of healing. Van der Kolk (2017) stresses how important it is that people feel safe enough within a therapeutic environment to be able to do this and that the therapist is then able to increase the client’s awareness of their mental states and what is going on inside themselves and what therefore ‘comes up’. The defence mechanism of hypo-arousal that may have served to protect these participants from the trauma they had endured by shutting down their connection to their own feelings, may have been the cause of an impaired activation of their instinctive caregiving behaviours, as mentioned in Chapter Three (Walker 2007, Cook *et al*. 2003, Cook *et al.* 2017). Siegel (2017a) states that these kinds of hypo-aroused dissociative states are ‘curable’ and he feels it is a privilege to be alive during a time in which it is possible to help people to become integrated. As previously stated, none of the participants in this group were offered any substantial therapeutic treatment. Therefore, the likelihood of this disconnect continuing to impact them and their attachment relationships with future children is likely to be high.

Within the results section, the ‘*Lack of factors’* highlighted the absence of some of the themes that presented in the other group, namely ‘*Determination’*,the presence of an ‘*Angel in the nursery’*,and *‘Feeling loved and cared for’.* The absence of these within this group strengthens the potential connection between these factors and a more positive outcome, as seen in the other group, as well as highlighting the influence that previous and present positive attachment experiences are likely to have. The absence of ‘*Determination’* within this group could be linked with the presence of ‘*Denial’*,as remaining focused on succeeding in passing the assessment may have been difficult when they disagreed with the necessity of it. The fact that there was also an absence of narratives that linked with the ideas associated with an ‘*Intact IWM’,* (Internal Working Model)may add further strength to a connection between the ‘*Angel’* and an ‘*Intact IWM’,* in the sensethat the latter could not exist without the former and the majority of participants in this group were unable to clearly identify an ‘*Angel*’. In addition, the preservation of the IWM was likely to be reliant on a connection with the sense of self, in terms of what was thought and felt at the time. As discussed in the literature review, the attachment experiences of these participants could have compromised the healthy development of their sense self (Cook *et al.* 2005, Fonagy *et al.* 2007, Cook *et al.* 2017). Frewan *et al*. (2008) have provided neurological evidence to support this concept further. Their research indicated that trauma victims who struggled to connect to their feelings had less activity in the areas of the brain relating to the sense of self.

As discussed previously, this group appeared to have difficulties connecting with their thoughts and feelings, both in relation to past and present contexts, which may have further limited the chances of the integrative processes that are required for an ‘*Intact IWM’* to take place. Instead, thoughts about the self are likely to be fragmented, disjointed or, as previously discussed, disconnected. Dianne Fosha (2017) who is regarded as an expert within the field of trauma focused psychotherapy, claims that her AEDP (Accelerated Experiential Dynamic Psychotherapy) model offers the chance to alter the IWM. Her work has been praised for its links with present neuroscience research, in particular findings relating to neuroplasticity. However, some therapists have noted that despite the potential for a new IWM to be formulated, the old model never fully disappears and is likely to re-emerge at times of emotional stress (Hodges 2016).

This concludes the discussion of the individual factors identified in those participants who had a successful outcome and those that did not. This appears to have been the first piece of research to have identified these factors within the context of social care interventions such as foster placements, residential units, as well as those receiving parent-infant psychotherapy. In addition, the existing literature has very few interviews with fathers, and no known studies that have included parents who have had an unsuccessful placement outcome.

Similar findings to these have been documented by Berman *et al.* (2014) who interviewed mothers who had experienced previous attachment trauma. Although the theme of *‘Acceptance’* was not made explicit, she states how the women in her study all acknowledged how their past trauma had impacted on them, and that in order to be a ‘good mother’ there needed to be some form of healing, but that this would ideally take place before the birth of their child. This need for healing in relation to past trauma was captured by one of the themes titled ‘Forgiving and Forgetting’. The findings also linked with the factor of ‘*Determination’*, with one theme depicting that the mothers were ‘Pregnant with Possibility’ in terms of what they wanted for their future. Berman *et al.* (2014) state how many of the women in their study were ‘determined’ to provide a more stable life for themselves and their family, and that this sense of determination was ‘intense, uncompromising, and unrelenting’. This also links in with the sub-heading detailed in the results section of this thesis titled ‘*Determination at any cost’*. In addition, Berman *et al.* (2014) notes how their pregnancies seemed to serve as ‘a catalyst for change’, also linking with the findings discussed in this study in relation to ‘*Determination to end the intergenerational cycle of abuse’.*

Aparicio *et al*. (2015) conducted a qualitative study to explore how teenage mothers in foster care experienced motherhood. Once again, they did not title the theme ‘*Determination’,* but discussed the participants ‘intense desire’ for things to be different, resulting in a theme of ‘Glimpses of light in the darkness’. Another similar theme to this study relating in particular to determination to change things for their own children was that of ‘New Beginnings’*.* They stated how some participants appeared to accept the need for therapy. They also noted, similarly to the concept of ‘*Angels*’, the positive influence that ‘other mothers’ had. These were other family members or foster carers who had provided them with a model of supportive parenting.

Jones (2015), a lead consultant parent-infant psychotherapist, has theorised what she terms ‘Red’ and ‘Green lights’ that she had begun to identify amongst her patients who received parent-infant psychotherapy, but this has yet to be tested within a research framework. Similarities do exist between the findings of this thesis and her theory. The ‘Green lights’ she discussed were firstly the existence of an ‘angel in the nursery’, which was a strong theme identified in the group who had a positive outcome. Secondly, comparable to the theme of ‘*acceptance’*, she highlighted the importance of parents acknowledging they need help. Thirdly, she discussed the positive influence that she believes being able to evoke feelings of love and kindness from others can have, which was similar to the theme identified here of ‘*Feeling loved and cared for’*.

There were also some similarities in relation to Jones’s (2015) ‘Red lights’, which she associates with a decreased chance of therapeutic success. Firstly, she discusses the role of mentalization, but refers to an ‘extreme’ low level, and by this she likens it to that which you would expect to see from a parent who is significantly maltreating their child. The majority of the narratives for this group would be unlikely to be coded as indicating extremely low levels of mentalization. However, low levels in general did feature as a prominent theme for those who were unsuccessful. The fact that they weren’t classified as extreme could have increased the chances of parent infant psychotherapy being successful if this was something that had been given to this group. The second red light was ‘Withdrawal’. Although this was not a specific theme that emerged, links could be made between a state of withdrawal and the hypo-aroused disconnected state that has been discussed above in the group who did not pass their assessments. A final similarity was Jones’s (2015) red light of denial, which was a prominent theme amongst this group as well. The potential key additions that featured from the findings of this thesis are the influence of ‘*Acceptance*’, ‘*Determination*’, and an ‘*Intact IWM’,* as well as specific positive or negative talk about the baby.

**Experience Factors**

In addition to factors that were present within the individual, narrative analysis also took place of factors that related to the participants experiences of the relationship with their child’s social worker, and the intervention. Considering the vast numbers of parents that are asked to engage with social workers and attend placements, there is a relatively limited amount of research that has collected data detailing the parent’s experiences of both of these.

Forrester *et al.’s* (2007) paper was one of the first to highlight the lack of research on how social workers interact with parents. Their extensive review of literature revealed that since 1985 only three studies had interviewed parents working with social services in the UK. Perhaps this may be in part due to the difficulty in recruiting this client group, which was also documented in the methodology section of this thesis. Although Forrester *et al.* (2007), (2008), did add to this work and their findings will be mentioned below, their research involved interviewing social workers and using vignettes to create practice discussions, or simulations, rather than direct discussion with parents.

Hall and Slembrouck (2009) state that although there is literature that details what constitutes as ‘good practice’ and the necessary ‘communication skills’, there is very little work that has documented the interactions that take place between professionals and parents in their home. Analysis from serious case reviews has prompted an interest in ‘resistant’ families or families labelled as ‘troubled’. This has increased some of the focus on research involving the perspective of parents (Fauth *et al.* 2010).

Ferguson (2016) also notes that social work research has not got ‘close enough to practice’. He has sought to improve this by conducting research that has included the use of an ethnographic approach, following front line practitioners and observing their interactions with families. He notes how important it is to gather evidence that represents ‘real time’ practice (Ferguson 2017). His research will be discussed in more detail in the following section, as he has focused a great deal on practice, but this has not included documenting interviews with parents about their relationships with social workers.

In light of this information, the following section of findings, although taken from a small sample, do appear fairly unique as they involved direct discussion with parents about their experiences, in the majority of cases over a period of six months.

**Relationship with social worker**

Regardless of the post intervention outcome, both groups reported predominantly negative relational experiences with their child’s social worker. There were two main shared themes identified across the data set. The first was a ‘*Lack of transparency*’,whereby they did not feel the social worker was communicating openly and honestly. They also believed information was not communicated as soon as it should have been, or in some cases, that it had not been mentioned directly to them at all. Forrester *et al.* (2008) highlights the challenge that some social workers face in terms of wanting to be honest but equally wanting to avoid ‘hostility’. If this was the case in these scenarios, then in actual fact it appears the ‘*Lack of transparency*’, may have increased feelings of hostility. Ward *et al.’s* (2014) review of the research on parental capacity to change also notes the importance of honesty around the reasons for and expectations of change. Wiffin (2010) discusses how fear and distrust, particularly with ‘resistant’ families could in some cases be reduced by a more honest approach to communicating concerns.

The second similarity amongst both groups of participants was a ‘*Trauma inducing’* element felt within therelationship. For the group who were successful, this related more to the anxiety associated with the fact their child could have been removed from their care, and for the other group it related more to the fact that their child was actually removed from their care. However, some of the general processes of engagement with social services carried a sense of trauma associated with them. Similarly, Wiffin (2010) mentioned that participants described their involvement with social workers as ‘difficult’ and ‘traumatic’ and, at times, caused them to feel vulnerable. Dale (2004) found that some parents described specifically the process of attending child protection case conferences as ‘traumatic’. If assessments are unsuccessful and removal of children does take place, then this is understandably associated with feelings of ‘profound grief and loss’ (Ross *et al*. 2017).

Additional themes that emerged from the group that passed their assessments were concerns with ‘*General* *communication’* from the social worker that they felt was unclear, abrupt, or left them feeling misunderstood. They also felt there had been a ‘*Tunnel vision’* approach when it came to listening to them and understanding them. Similar findings have been evidenced by Manij *et al*. (2005), who noted that in some cases parents felt that practitioners had ‘narrow preconceived ideas’ about the problems that were present. Not feeling listened to also features within other studies. For example, Forrester *et al.* (2008) noted ‘low levels of listening’, from social workers. Maiter *et al.*’s (2006) Canadian study states that 38% of participants did not feel listened to by their child’s social worker. In addition, Ross *et al.* (2017) titled their research with families whose children were placed into care ‘No voice, no opinion, nothing’, indicating reports of similar feelings.

This sense of being misunderstood was further exacerbated for participants who also felt the social worker had been operating on the basis of what they perceived to be a ‘*Perfect parent fallacy’.* This theme described the way they felt the social workers expected standard of care that they should be providing exceeded that which they felt an average parent is achieving.

The Social Care Institute for Excellence (2004 p.1) states that ‘Good communication is at the heart of best practice in social work’. However, Forrester *et al.* (2007) noted that there appears to be a lack of guidance on what constitutes as ‘good communication’, with minimal input by theoretical or empirical means to define what the required skills are. Therefore, it may ultimately rest with the individual social work practitioner (Forrester *et al.* 2008), or their manager and team that they work with to set the expectations of ‘good communication’. When investigating this themselves, Forrester *et al.* (2007) reported that the majority of the questions social workers asked were ‘closed’ and they often mentioned concerns, with a lack of discussion around any positives. Their later study noted a ‘very confrontational and at times aggressive communication style’ from the social workers that they interviewed (Forrester *et al.* 2008 p.1). They were concerned by the frequency of these observations and the likelihood that this could in fact be a ‘systemic issue’ within social work. Previous research from Dale (2004) details that parents described the communication from social workers as ‘arrogant’, ‘snotty’, and ‘bossy’. Therefore, this implies that the reported communication style in this thesis has not occurred in isolation, and is potentially a wider issue that needs addressing.

Forrester *et al.* (2008) conclude that there has been an ‘insufficient’ focus on the ‘micro skills’ required to safeguard children and that this should be an ‘urgent priority’ for future studies. It would appear that not a great deal more work has been added to these findings that were published almost ten years ago.

A ‘*Lack of empathy’* was a prominent theme to emerge from the narrative interviews. This included examples which indicated that consideration for the parent’s mental state did not always occur during communication on visits, and in meetings with professionals. Maiter *et al.* (2006) similarly reported issues with perceived empathy levels as they found that 44% of parents described the social worker as ‘cold and uncaring’. Dale’s (2004) participants wanted social workers who appeared more ‘human’. In addition, Wiffin (2010) states how important empathic communication can be, as well as having an awareness of how it feels to ‘be on the receiving end of the child protection system’, particularly when working with resistant families.

Forrester *et al.* (2008)highlights the challenge that social workers may face in knowing how to show empathy without ‘colluding’ with concerning behaviour. Fauth *et al.* (2010) advise practitioners of the need to be empathic but with an ‘eyes wide open, boundaried, authoritative approach’. Perhaps some practitioners, such as the ones working with the families in this thesis, are finding it hard to achieve this balance.

Forrester and his colleagues have been the main contributors to providing data on levels of empathy in social work. Their research evidenced low levels of empathy amongst the social workers they interviewed, and they noted that empathy had the most significant impact on the responses that came from their ‘simulated client’ (Forrester *et al.* 2007). They also reported that social workers were either not taking parents views seriously or empathising with them (Forrester *et al.* 2008). The social workers that demonstrated empathy encountered ‘less resistance’ and obtained more information directly from clients. Behaving in an empathic way did not impact on their ability to identify concerns and discuss these with parents (Forrester *et al.* 2007). Therefore, this highlights how empathic interactions do not necessarily compromise safeguarding abilities, but rather to the contrary behaving in such a way is likely to help the worker to gain more information and a clearer picture on what is happening within the family. Forrester *et al.* (2007) note that increasing social workers empathic communication skills when discussing child protection concerns should be a ‘priority’. Mentalization based interventions are connected with empathy, but providing this type of training to staff could be time consuming and costly. An alternative could be that the interview process for qualifying courses included some of the standardised tools that currently exist to assess levels of empathy in social work candidates such as ‘The Empathy Quotient’ (Baron-Cohen (2011). The degree to which answers were based on what candidates presumed to be desirable would need to be explored.

Lessons can also be learnt from experts within the field of trauma and psychotherapy as understandably the role of empathy in forming a positive therapeutic relationship is key. The final chapter of the literature review discussed the concept of ‘Epistemic trust’ and its relevance to social work. It details the importance of feeling understood by a professional, as without this someone might hear what is being said to them, but they won’t actually be listening (Fonagy 2015). Behaving in an empathic manner is therefore likely to communicate that on some level you do understand them. Siegel (2017b) states that the worker doesn’t need to try to place themselves in the shoes of the client and think ‘what if that were me’, but they do need to connect with how that person is feeling. He adds that being able to differentiate in this way is important in preventing ‘burn out’.

Additional themes for the group who did not pass their assessments included ‘*Potential misinterpretation’* of the social worker’s communication. This led them to feel they were being ‘rude’, or in some cases that the social worker was smiling or laughing at them when they felt distressed. Chapter Two of the literature review discussed neuroscientific findings that suggest children who have been abused may interpret neutral behaviours as hostile (Schmid *et al.* 2013). Additional evidence that supports this hypothesis does exist (Kempes *et al.* 2010, Young & Widom 2014, Cuadra *et al.* 2014, Carr 2015). Therefore, given the trauma history of the participants, it could be that they may have been more prone to misinterpreting behaviour that to others may have appeared fairly neutral. However, the fact that Forrester *et al.* (2008) raises considerable concern for the ways social workers may be interacting with parents, suggests that perhaps some of these behaviours did occur, and rather worryingly were in fact accurately reported in the interviews.

The narratives of all of the participants highlighted the ways in which the relationship that the parent enters into with their child’s social worker has the potential to cause the emergence of their ‘worst self’. All of the participants had some form of traumatic attachment history, characterised by abuse and/or neglect, during which they were all powerless to stop it and therefore had no control over it. Entering into the relationship with a social worker in some ways may have felt similar due to the fact that, once again, they found themselves in a relationship where the other person seemingly had all the power, all the control. Although the social worker should not be abusive, they may still say things that feel critical and are upsetting or hurtful to hear. They may also insight a feeling of fear, particularly in relation to the potential outcome for their child.

Ward *et al.’s* (2014) review of research notes that there may be more resistance to the involvement of social workers than to the notion of change, particularly when there is an absence of perceived support. Instead, they may feel social workers are ‘exercising power over them’. Fauth *et al.* (2010) review of the literature states how several studies identified a power dynamic where participants felt that practitioners had been using power ‘over them’, rather than ‘with them’. Wiffin (2010) notes how one parent said that social workers had become more of a ‘social police force’, and there was sense of fear towards the ‘all powerful’ social worker. Mamj *et al* (2005) also documented a feeling of ‘fear’ surrounding whether the system would be working in the best interests of their children. Ross *et al.*’s (2017) thematic analysis of interviews with parents titled one of the themes ‘Power and Inclusion’ and documented the ‘disempowerment’ that some parents experienced within the child protection system. This potential battle for control is considered, in some cases, to cause both the social worker and the family to be less focused on the actual concerns (Dumbrill 2006).

Feeling misunderstood, and feeling as if your voice is unheard may also resonate, on some level, with the experiences you endured in your childhood years. Therefore, the very nature of what this relationship may represent could trigger feelings of anger, sadness, fear, or in some cases, disconnect, during which the behaviour that follows is associated with the ‘worst self’, and could quite easily contribute to the negative outcomes they were trying their best to avoid. Jones (2016) notes how interactions with parents who have mental health difficulties can trigger ‘defensive responses’ in professionals, with more supportive responses being at risk of ‘becoming over or under-activated’. This hypothesis has been evidenced by practitioners either behaving in an avoidant manner or over identifying with the parents (Stanley *et al.* 2002, Laird 2013, Tuck 2013). The extent to which the child protection system is operating with traumatic past and present behaviours in mind will be discussed in more detail in the final chapter.

The ‘*Lack of empathy’* and additional concerning themes of communicationidentified here and in other studies no doubt increases the likelihood of the emergence of the ‘worst self’. Forrester *et al.* (2008 p.32) note that in some cases, social worker’s interactions with families may be contributing to relationship difficulties by creating and reinforcing patterns of behaviour such as ‘denial, non-engagement and even threatening behaviour in clients’. A vicious cycle may then be created whereby the social worker’s interaction with parent’s increases hostility from the parent, and this in turn decreases empathic responses in the social worker and increases confrontational ones. A cycle which also creates what they refer to in counselling theory as ‘roadblocks to listening’ (Gordon 1970, Miller & Rollnick, 2002), and may also increase the likelihood of ‘Epistemic freezing’ defined as ‘a complete inability to trust others as a source of knowledge’ (Fonagy *et al*. 2014 p.1). This could increase the potential risks to the child, as it could prevent the parent from listening to the concerns and more importantly acting on the advice of the social worker.

One participant who was interviewed in this study had difficulty accepting what professionals had told her regarding the impact that her abusive relationship with her partner was having on her children. This example featured in the analysis of findings under the theme of ‘*Low Mentalization’* and provides an example of where, if she felt understood herself, she may have been better able to reflect on their concern.

 ‘*I don’t know exactly what we are in here for, I think it’s like my partners drinking and domestic violence, he has beaten me up twice in the time we have been together, and erm he was just drinking all the time and we were just bickering and arguing, but we have never done it in front of the kids, they have been in the bedroom, and they are sitting there saying they can hear, it will affect them blah blah blah’.*

Fauth *et al.’s* (2010) review of ‘resistant’ families details some of the issues that were raised by parents. A common concern was feeling as if they had not received the help they felt they needed. Families were described consistently across studies as displaying types of behaviour that could be deemed ‘worst self’ behaviour, which included a lack of engagement, avoidance, hostility or violence and denial. Therefore, feeling that social services has the ability to offer you the opportunity to make the necessary changes could be key to reducing ‘worst self-behaviour’, but this is only likely to be possible if families are offered more intensive forms of intervention. This will be discussed in more detail later in the final chapter.

 Interestingly, the relationship with the social worker did not appear to impact on the outcome of the assessments, as both groups reported relational difficulties. However, for the group who were successful, regardless of the turbulent relationships, being more connected with their babies, being able to ‘*Mentalize’* for them, and hold onto their own sense of ‘*Determination’* may have enabled them to stay focused, ensuring their ‘best self’ emerged more frequently. If the social worker were to adopt the ‘ideal traits’listed by participants, such as for them to be ‘*understanding’,* ‘*compassionate’* and ‘*open’,* then this may also increase the likelihood of the ‘best self’ assuming a more dominant presence. Additional studies have also listed these traits as the ones parents have stated were most important to them (Dale 2004, Wiffin 2010).

The last ten years has seen a rise in systemic approaches being implemented in social work, with techniques such as motivational interviewing and other strengths based forms of working with families being adopted by some local authorities. These client focused approaches may offer the chance at increasing the emergence of the ‘best self’ and will be discussed later on in this chapter. Remaining focused on the client’s strengths is also a feature of many of the therapeutic approaches to working with families, particularly those who are involved with social services. Abel (2016 p.93) states how demonstrating an appreciation of the client’s strengths can increase the opportunities to raise any concerns in relation to the care of their babies in a more ‘genuine way’.

The participants in this study listed ‘*compassion*’ as something they felt was important in a social worker. The previous section discussing trauma detailed how important neuroscientists and psychotherapists feel the process of ‘integration’ is in order for trauma victims to function optimally. Siegel (2017b) notes that ‘integration made visible is kindness and compassion’. Buczynski (2017) adds to this by expressing that having a healthy relationship can be a ‘catalyst for healing’. Therefore, *‘compassion’* should be an essential element required for all social workers and this research, as well as the work of others discussed here, sadly highlights that this may not always be the case. Another element that can be important to include, where possible is some form of choice. In her therapeutic work with clients Pat Odgen (2017a) highlights the importance of subtle gestures such as asking a client where they would like to sit. Therefore, offering parent’s small subtle choices could help improve their relationships with social care practitioners. Lastly, John Norcross (2011) has been conducting research over the past decade on what works and what doesn’t in psychotherapy. Siegel (2017) notes how John has concluded that central to the relationship between the client and the therapist is the therapist seeking feedback about how they feel the relationship is going, as well as being open to the fact that things may not be going that well, and then being open to adjusting things. All of these approaches, although situated within the domain of therapy, if applied within the social care setting, have the potential to improve relationships between families and their allocated worker.

It would appear that adopting a more therapeutic approach to working with families in child protection could in some cases provide an increased opportunity for, less hostility and resistance, and more reflection and positive change.

**Experience of Intervention**

The central findings of this thesis suggest that the potential influencing factors on the outcomes of the placements relate primarily to internal processes and subsequent capacities of the individual. However, there were clear themes that did emerge from the narrative data regarding the participant’s experiences of the interventions, and it seems important to highlight and summarise within this discussion chapter what these were. Particularly when the literature review highlighted a significant lack of research in this area.

*Foster Placements*

One of the most important aspects for parents in these placements appeared to be the need to achieve the right balance in terms of support and responsibility of care tasks. For some participants, they felt that the foster carer was taking over too much of the care of their babies. Therefore, clear expectations of the parent and foster carer may need to be made more explicit and agreed by both parties, alongside the social worker, at the start of placements. Aparicio *et al*. (2015) reported similar findings with some foster carers trying to do too much in relation to the care of the babies. Adams and Bevan’s (2011) research interviewed foster carers and so offers the foster carers perspective. They reported that foster carers also felt that clarity around their role contributed to placement success. They also noted the impact that foster carers believed ‘good social work practice’ had on the success of placements in terms of the planning and the support that was offered.

All cases will present with their own individual concerns and there is likely to be some risk management involved within these placements. However, it would seem that remaining focused on supporting and strengthening the developing attachment relationship, as well as the parent’s sense of self-efficacy which is likely to be low (D’Andrea *et al.* 2012, Ogden 2017a) is important. For most participants, they were required to wait a number of weeks before being able to leave the placement with their baby, and on most occasions they were allowed out for a very short period of time. These restrictions were likely to have been put in place, understandably, for safeguarding reasons. However, they may have caused increased levels of stress, which may then have, at times, compromised their capacity to ‘*Mentalize*’ given the established connection between stress and mentalization (Fonagy 1999, Hawkes 2011, Nolte *et al.* 2013). For those who had a successful outcome their *‘Determination’* similarly in the case of helping to manage their interactions with the social worker may also have strengthened their capacity to manage this stress and continue to do what was necessary for their baby to achieve a successful outcome.

These placements appeared to offer the opportunity for a more nurturing experience in comparison to residential settings. The support came predominantly from the foster carer. Therefore, the person offering advice was consistent, which may have helped with understanding and accepting it. There was also considerably less observation, which may also reduce the stress levels. Most importantly, in the majority of cases, these placements offered the parents the opportunity to feel cared for themselves, to be the recipient of kindness and provided them with a model or (reminder for those with an ‘*Angel in nursery’*) of what nurturing care can look and feel like. Aparcio *et al.* (2015) reported similar findings that foster carers ‘modelled supportive parenting’, whilst operating as ‘other mothers’ to the parents.

This may then have positively contributed to the ‘switching on’, or in some way provided an electrical supply, for their own caregiving behaviour. Jones (2010) documented her thoughts on the ‘parental love’ that can be experienced by a parent with their therapist during parent-infant psychotherapy. This, to some degree, supports this notion of an emotional ‘switch on’, whereby somebody witnessing someone taking pleasure in being with them increases their capacity to take pleasure in their infant, which is key to disrupting the ‘malignant’ projective processes that were discussed earlier in this chapter.

The reality is that parents deemed high risk will most likely be placed in residential assessment units where this risk may be more easily managed. However, preventing these parents from having the opportunity to experience something more nurturing could also, in some ways, be contributing to their difficulties and the subsequent outcome.

*Residential Assessment Units*

The levels of observation within these placements was far more frequent and arguably more intrusive. Particularly for those participants who were recorded on cameras positioned in every room aside from where the toilet was. Most people, regardless of their attachment history and capacity to tolerate stress, would have found this difficult to manage and cope with. Participants had likened the experience to feeling as if they were in prison or a caged animal. This level of stress may also have increased the likelihood of the emergence of the ‘worst self’, particularly when the relationship with the social worker was also turbulent. In addition, given the likely connection between stress and a lower capacity to mentalize (mentioned above), this environment may also have impacted significantly on caregiving behaviour. In some high risk cases when there are concerns around potential physical or sexual harm, this level of supervision may be the only way to safeguard the child. However, concerns associated with all of these participants who were placed in residential settings did not relate to imminent risks of harm but rather historical and/or potential issues of neglect.

Understandably, participants in these placements also had restrictions placed on them in terms of being able to leave the unit alone with their babies. Of those who did not pass their assessments, none of them had been allowed to leave the units with their babies alone for any period of time during the twelve weeks of their placement. One parent who had four children removed previously, due to neglect, mentioned how nice it was that one of the staff members let her push the buggy when they were allowed out together. Whilst some of these restrictions may have been deemed necessary from a safeguarding perspective, it is likely that this could also have contributed to a feeling of disconnect with their babies and a lack of self-efficacy and confidence, weakening their ‘*Determination’* to succeed.

The intervention that was offered from all four of the residential placements within the study appeared to be similar. It tended to be focused on practical care tasks such as, feeds, nappy changes, baths and the majority of participants enjoyed acquiring this knowledge. In addition, practical support in areas such as cooking and budgeting was also provided. Although all of this support may have been required it was unlikely to increase the chances of developing any of the factors that were identified in the group who had a successful outcome, in particular ‘*Mentalization*’ and a *‘Connection with past trauma’*. For example, in the case of the parent who had to be prompted to feed her baby during her interview and missed his hunger cues, such as sucking on his hands, starting to squirm, cry and not settle, providing her with practical support in terms of a clear time table around feeding times, did not help her to connect with her baby, to become attuned to him, or to develop a curiosity for what was in his mind. However, those who received parent-infant psychotherapy were therapeutically supported with this.

Casanato *et al.* (2017) conducted the first pilot study to test the efficacy of the attachment and mentalization based intervention VIPP-SD (Video Intervention Positive Parenting-Sensitive Discipline) with a sample of mothers at risk of significant maltreatment, who were placed in residential assessment centres. They reported that following the intervention there was a significant decrease in dysfunctional methods of discipline, and the intervention offered the mothers a supportive relationship and created a ‘holding environment’. Although their sample size was small, they felt this study demonstrated the value of using this type of intervention in a residential care setting. Repetition of this study on a larger scale, and further studies applying attachment based interventions in residential assessment settings therefore appears beneficial.

Although the trauma history of participants in this thesis was often acknowledged by social services and the residential units as being the potential cause of their parenting difficulties, in most cases, none of the participants received trauma focused support. The one couple who did receive counselling sessions spoke positively about how they felt this was helpful for them. However, in the absence of an intervention that could also offer the chance to connect and ‘*Mentalize’* with their baby, these sessions were likely to have not been enough. A comparison between the overall experiences reported here from participants who attended the residential assessment units with other similar research findings is not possible due to the absence of research that has been carried out in this area. Therefore, it appears incredibly important that more is done to understand the experiences of parents who attend these types of placements, given that they can cost the local authority between £32,000-60,000 per family, and in one case £127,000 (Munro *et al.* 2014), and may in fact be providing limited intervention. In some cases, they may also consist of environments that are traumatising or at the very least highly stressful, with no opportunity for repair.

Munro *et al.* (2014) have been the first to provide the Department of Education with a research report that explored the ‘uses, costs, and contribution to effective timely decision making’ of residential parenting assessments. The Childhood Wellbeing Research centre (CWRC) was commissioned to conduct this study following the Family Justice Review, which questioned the value of residential assessments in relation to their cost and lack of identified benefits. Their research was however fairly small scale and consisted of 33 cases. They reported that just over half of the mothers had experienced attachment based trauma and just under half (48%) were reported to be suffering with mental health problems. Their findings centred on numerical facts associated with placements, rather than an in depth exploration of what was being offered to parents during their placements. They acknowledge themselves that further research that includes interviewing the parents would be beneficial, as their findings were based mainly on factual information they received from local authorities. They also highlighted the need for an understanding of what assessments were offering parents and the frameworks that were informing their practice. The findings of this thesis support the necessity for this, which appears yet to be explored in depth.

 *Parent-Infant Psychotherapy (PIP)*

The findings indicated that for those participants who received parent-infant psychotherapy, it provided the opportunity to increase factors such as the capacity to ‘*Mentalize*’, as well as a safe containing place to improve their ‘*Connection with* past *trauma’.* Participants were encouraged to consider what goes on in the minds of their infants and how an understanding of their baby’s behaviours may offer the opportunity to become more tuned into their states of mind, and therefore better meet their needs. The participants all spoke very highly of their relationship with their therapist. Not only did it offer them an experience of *‘Feeling Cared For’* but also the chance to feel understood. The therapist’s capacity to mentalize for them offered them the chance to know how it feels for someone to understand their thoughts, feelings, behaviours and subsequent needs. This may have further increased the participants’ capacity to do this for their own baby.

In relation to their trauma, the therapist seemed to provide them with an opportunity to discuss the details of the abuse they had suffered, at their own pace, and on their own terms. She also appeared to aid them in the process of making links between their attachment experiences and how this impacted on them as a child, as an adult and most importantly as a parent. The therapist’s approach to working with these participants, the compassion and kindness, certainly created a sense of ‘epistemic trust’, which is likely to have enabled the work to be meaningful and most importantly provide a pathway towards healing, and an integration of their past trauma.

It is not possible to make a comparison between the findings in this study and others that have also focused explicitly on parents who were working with social services and receiving PIP due to the absence of similar studies. However, there have been a few studies that have reported parent’s positive feedback to being offered some form of therapy (Manji *et al.* 2005) or being worked with in a therapeutic way (Dale 2006). The minimal amount of data of this kind most likely reflects the limited amount of therapeutic intervention that is offered to parents working with social services.

The majority of research on PIP has been quantitative and focused on the effectiveness of the intervention rather than the experiences of the clients. Similar qualitative findings were however noted from Barlow & Kirkpatrick (2007), whose participants felt this form of therapy was ‘unique’ and was important in making improvement in themselves, as well as their relationships with their babies. Haimovici (2016) is the only other person, to date, who has conducted thematic analysis of client’s experiences of PIP. The themes identified suggested that they found PIP to be a ‘nurturing’ ‘humanising’ and ‘transformative’ experience. The findings state how valued this work was by the mothers who took part and that PIP has the powerful potential to be a ‘vehicle for change’.

To conclude this chapter, in light of the findings of this thesis establishing clear thematic distinctions between those who were successful and those who were not, it seems appropriate to make links with the body of research relating to ‘Resilience’. ‘Resilience’ is regarded as a ‘keyword’ within the social work literature (Garrett 2015). Some argue that with limited resources available to help families an interest in this area has grown, as people have become more invested in wanting to know more about the ways resilience can be promoted (Luthar & Zelazo 2003).

Norman Garmenzy (1971) is considered a pioneer of research into resilience, a clinical psychologist, whose initial research interests were with adult schizophrenic patients. However, he was intrigued by discovering that despite the risk of psychopathology some children of mental health patients were appearing to follow a healthy trajectory themselves. During the early 1970s, he focused his attention on research with children who were at risk due to their parents’ mental health needs, in addition to other socio-economic risk factors. This research programme was referred to as ‘Project Competence’ and marked the start of the detailed study of resilience.

Specific definitions of resilience appear to vary from one study to another (Herman 2017). Most definitions include the notion of overcoming adversity by some form of ‘positive adaptation’ (Luthar *et al.* 2000) ‘struggling well’ (Walsh 2008) or ‘beating the odds and changing the odds’ (Hart *et al.* 2013). Variance also exists in relation to the terminology used when referring to resilience such as ‘hardiness’ ‘reserve capacity’ and ‘a positive coping style’ (Treisman 2017 p62).

Criticisms have been raised in relation to the notion that resilience is representative of a trait that you either have or you don’t have (Masten & Powell 2003, Newman 2011, Harrison 2013). Experts within the field of trauma appear to be particularly passionate about this, with van der Kolk (2017) stating that, ‘To define the world in terms of people who are resilient and those who are not is offensive’. He strongly believes that any person who has been exposed to trauma is resilient because they have survived it. Ogden (2017b) stresses that resilience is something one can learn to develop by therapeutic means. Relying on ones presentation in order to categorise somebody as resilient also has its pitfalls. Treisman (2017) highlights that some children who could be viewed as ‘resilient’, such as a child who has been the victim of sexual abuse who appears to function appropriately may be regarded as a ‘fighter and strong’ but others could interpret this as being more closely linked to ‘denial and/or dissociating’. In addition, as mentioned previously in the literature review, the development of a ‘false self’ (Winnicott 1984) may also impact on assumptions made regarding resilience.

Crittenden (2014) has also developed a theory of ‘false positive affect’, which is a component of her Dynamic Maturational Model of Attachment (detailed in the first chapter of the literature review). She believes that some children will display false depictions of positive behaviour as a defence mechanism or ‘self-protective strategy’ to attract more positive attention.

The existing literature indicates that resilience is a complex and multidimensional phenomena that cannot be reduced to a personality trait. A more optimum way to understand resilience appears to be to view it as a ‘dynamic, developmental process’ (Masten & Powell 2003).

In line with the findings of this thesis, the majority of research that has added to the work of Garmenzy has concluded that the experience of positive relationships is most influential to fostering resilience (Masten2001, Luthar & Zelazo 2003, Werner *et al.* 2005, Narayan *et al*. 2017). Fosha (2017) states her therapeutic work with clients has revealed that resilience develops from a sense of ‘being understood and existing in the mind and heart of a loving attuned and self-possessed other’. Jaffee *et al’s.* (2007) research led them to propose a ‘Cumulative stressors model’, of resilience whereby they note that exposure to multiple family and neighbourhood stressors impacted on children’s levels of resilience. Particularly when those children had strengths that, ordinarily under less stressful conditions, served to protect them from the detrimental effects of maltreatment. The advantage of this study was that it was conducted whilst these individuals were still children.

The participants in this thesis were adults and those that could be deemed ‘less resilient’ in the group who were unsuccessful appeared unable to describe the potential stressors they may have experienced in detail. Therefore, it is not possible to make a link between their experiences of cumulative stressors. However, some participants in the group who could be seen as ‘more resilient’ due to having a successful outcome did detail what could be regarded as multiple stressors, e.g. abuse, housing issues, financial difficulties, problems at school. Therefore, perhaps their ‘*angel in the nursery’,* that the majority of them identified, was able to in some way reduce the accumulation of stressors, thus evidencing once again the significance of experiencing some form of positive relationship.

Genetic research tentatively suggests that genes may also have a role to play in relation to resilience. The first chapter of the literature review discussed the potential influence that genes such as the DRD4 7- repeat allele, (Bakermans-Kranenburg & van IJzendoorn 2006), MAOA (Caspi *et al.* 2002*)* and the glucocorticoid receptor (Meaney 2001, Weaver *et al.* 2004) could have on the functioning of those who grow up in abusive environments. Kim-Cohen *et al.’s* (2004) study was the first to demonstrate that resilience has both genetic and environmental elements to it. However, it was focused on socio-economic factors rather than specific attachment trauma. The growing field of ‘epigenetics’, also mentioned in the literature review, adds a further dimension to consider within the field of resilience. It has evidenced how the alteration of genes in positive ways due to positive environments and negative ways due to negative environments could impact on levels of functioning and associated resilience across generations.

Research into resilience has provided opportunities to become more knowledgeable about what could contribute to its development. However, criticisms have been made that not enough analysis of how potential factors or traits could have been influenced by wider societal issues has taken place (Harrison 2013). Bottrell (2009) questions the amount of adversity that people who are considered resilient should have to experience before social intervention is targeted instead of the individual. Many critics fear too much emphasis is placed on the responsibility of the individual to self-navigate their way through their own adversity (O’ Malley 2010, Bottrell 2013, de Lint & Chazal 2013, Friedli, 2013), when in fact the body of research that exists on resilience should be used to influence the development of necessary social support (Bottrell, 2013, Harrison 2013, Schmidt 2015), in particular ‘targeted intervention’ to improve the individual’s chances of optimum functioning (Luthar & Zelazo 2003).

Hart *et al.* (2016) propose that it is time for a ‘new wave’, of research that combines our knowledge on ‘resilience’ and ‘practice development’ with ‘social justice’. This thesis supports the necessity of such a proposal. Two significant reviews of resilience research however note that the ‘scientific rigour’ of this work does need increasing (Masten & Powell 2003), particularly if it is going to be used to try to influence social policy.

**Chapter 9- Limitations, Future Research, Implications and Conclusion**

Limitations of the research and directions for future research

The sample of participants was not selected at random and was reliant on volunteers. This is common practice in qualitative research, where the emphasis is different from the representational accuracy within quantitative designs, which is needed to make comparisons to a wider population or sub-population. Given the reliance on volunteers, it could have been that a certain type of person was more likely to agree to take part, for example someone who was ‘*Determined’* or someone who was in ‘*Denial’.* Additionally, the ethical requirement of ‘informed consent’ means that there is unlikely to be any other way of avoiding this predicament. Again, the aim of the research was to explore participants’ experiences; it was not to make inferences about the distribution of sample means to the population from which it was drawn.

It has been proposed that the participants who were unsuccessful in their placements may have been experiencing some form of ‘dissociation’ or ‘hypo-arousal’ as a result of their own attachment based trauma. This may have resulted in them being disconnected from their own feelings in addition to those of their children. A group that may have therefore been missing from this sample could be those whose trauma has left them in a more ‘hyper-aroused’ state. As discussed in the literature review, this is more closely associated with a ‘hypervigilance’ to potential threats, and may lead in some cases to an increased distrust in others. This may have impacted on the likelihood of these individuals volunteering for this type of study.

Another potential limitation is that the parents were the only participants and their child’s social worker was only briefly spoken to at the beginning and end of the placement. Therefore, there may have been additional information in relation to concerns from social services that the parent themselves did not wish to raise in the interviews. Neither did observations of them with their babies feature within the data collection process. Instead, their parental capabilities were analysed on the basis of their discussions in their interviews. However, the fact that the outcome of their assessments was known appeared to be enough to aid in the formation of clear thematic distinctions between the groups. Therefore, additional information from the social worker or observations of the babies was unlikely to alter those established themes. Requesting their permission to also interview their child’s social worker may have dissuaded some participants from taking part. The fact that this study was focused solely on them and their experiences, told through their voice, most likely increased the likelihood of people being willing to take part. It may have provided them with an opportunity to talk openly and honestly without feeling like they were being assessed or that what they were saying could have impacted on their assessments. Bringing in the element of interviewing their child’s social worker could have in some way compromised that feeling and reduced the sample size further.

Participants were only followed up to the point at which they had left their placements and returned back into the community, due to the timescale restrictions of this thesis. Therefore, for those participants who had successful placement outcomes, things could have changed at a later date, and removal of their baby could have taken place but this would not have been known. A potential suggestion for future research could be to repeat the research design but include a follow up interview one year after the end of placements.

Despite the fact that ‘saturation’ of data was reached with an acceptable level of homogeneity, it may be useful if this study was replicated on a larger scale. A more even distribution of participants who received the different intervention types would be helpful, as only a small number received parent-infant psychotherapy (PIP), all of which possessed factors associated with a successful outcome. In addition, all of the participants who did receive PIP were seen by the same therapist. Whilst this was helpful in terms of increasing the likelihood of them all receiving a similar therapeutic style, it does impact on generalisability of wider service experiences. Given the implication of these findings on the current functioning of the social care system and the suggestions that are going to be made in the following section, replication with an increased sample size is likely to be useful and strengthen potential recommendations.

The literature review and the findings of this research indicate that further research is needed on a larger scale that focusses on the experiences of parents working with social services, in particular those who attend residential assessment units. The fact that the majority of participants reported concerning interactions with the social worker and the similarity between these findings and those that have been referenced indicates that there are still problems with the ways in which social workers are interacting with families. Despite Forrester *et al*. (2008) stating that they believed this to be a ‘systemic issue’ that should be an ‘urgent priority’ for future research, very little progress appears to have been made in gathering more in depth data. This does need to be addressed as, although the findings of this research reported predominantly negative interactions with social workers, there is data that suggests more positive interactions do take place (Platt 2001, Manji *et al.* 2005, Dumbrill 2006, Wiffin 2010). Therefore, the need to gain more insight into the prevalence of both kinds of interaction is important for professionals and families existing within the current and future social care system.

In order to further investigate the influence of the thematic factors that were identified and to add further to the argument of the necessity of more intensive therapeutic intervention being offered to parents, it would be useful to repeat this study with a larger sample size, with all parents receiving parent-infant psychotherapy (PIP). This may increase the chances of being able to observe whether the same distinctions between ‘change facilitators’ and ‘change inhibitors’ were made at the start of the therapy, and whether following treatment even those presenting with ‘change inhibitors’ could shift to the more positively associated ‘change facilitators’ such as, ‘*Acceptance*’, ‘*Determination*’, ‘*Mentalization*’ and a ‘*Connection with past trauma’*.

The extent to which these themes could link up with the field of neuroscience is a bold but potentially worthy additional direction for future research. As referenced in Chapter Two of the literature review, the field is making progress to overcome some of the criticisms in relation to improving its statistical methods, Craig Bennetts ‘Dead Atlantic Salmon’, mentioned previously, highlights the necessity to do so. Despite the contribution of neuroscience to improving our understanding of human behaviour, the field has yet to develop detailed analysis on high risk cases of parents working with social services. Therefore, it could be potentially useful to repeat the study on a larger scale and if the same thematic distinctions emerged brain scans such as fMRIs could be used to scientifically evidence the ‘hypo-aroused’ states in those who were unsuccessful. In addition, using EEGs whilst participants were interacting with their babies adds another dimension to evidencing this. It is important to note that this type of research would not be used to penalise or vilify these parents, and would certainly not to be used to aid in the process of removal of their children, but instead to demonstrate how the current limited forms of intervention, most of which are not therapeutic, are very unlikely to bring about the changes that are being expected of them, particularly when these difficulties essentially may relate to the neurological functioning of the parent.

Future research could also include a genetic element to add further to the existing studies on the influence of certain genes such as the DRD4 7- repeat allele, (Bakermans-Kranenburg & van IJzendoorn 2006), MAOA (Caspi *et al.)* and the glucocorticoid receptor (Meaney *et al.* 2001, Weaver *et al.* 2004). It could be worth testing whether these genes were present in the group of participants who were unsuccessful, but more importantly if they are given the right kind of targeted therapeutic intervention, such as trauma focused CBT, EMDR, or PIP, whether the presence of these genes may actually be irrelevant.

Implications for social work policy and practice

Gregory and Holloway (2005 p.51) acknowledge that there is a ‘dynamic interface between policy and practice, and social work as a profession should never cease to question, expose, challenge and reframe’. This thesis investigated and analysed the experiences of parents that were requested to engage in some form of social care intervention in ‘real time’. As such, the findings and subsequent analysis can be considered relevant to current policies and procedures used within children’s social care.

The research sought to bridge the gap between the field of social work and the field of psychology by applying established psychological theories and research to the analysis of the findings. Viewing the findings from this perspective has hopefully evidenced how useful it could be to apply this type of attachment and trauma informed understanding to assessment and intervention in social care. Ward *et al.‘s* (2014) review of current research on parental capacity to change states that it is not yet clear what motivates parents to want to change. The use of the word ‘want’ implies that it is a conscious decision and perhaps does not take into account the complexities that can contribute to the parent’s capacity to change.

Processes in children’s social care begin with a referral, and, if deemed necessary an assessment. The findings may then form the basis of either a ‘child in need’ or ‘child protection plan’. The family is then expected to make the necessary changes and adhere to this plan. They will also be reminded of the objectives of the plan when visited by a social care practitioner, or when a meeting is held with other professionals and the plan is reviewed. This process, in the absence of offering tangible support and intervention, could lend itself to the sense of the social work role being to check up on families, and perhaps increases the perception of the social worker being an authoritarian who assumes a ‘social police’ type persona that families in this and other studies have reported.

In the case of child protection, excluding when there is a risk of imminent harm, if the objectives of the plan have not been met over a period of time then the case may meet the threshold for the process of a ‘Public Law Outline’ (PLO). This is where the case will be observed under legal guidance and could then escalate to court proceedings if deemed necessary. Given the likelihood of parents who work with children’s services having experienced some form of attachment trauma themselves (Fonagy *et al*. 1994, Dorsey *et al*. 2008, Bentovim 2009) this approach may not be the most effective method for trying to bring about change. Reviewing action plans and objectives may work in business, but the business of social services is ‘behaviour’ and as such a simple request to make changes is not accounting for the psychological complexity of why that behaviour may exist in the first place. It is not ‘normal’ to neglect or abuse your own child and most abnormal behaviours are treated under the guidance and intervention of mental health services, yet access to this kind of service is not standard procedure for parents with a child on a child protection plan. Some parents may receive adult mental health support, but this is likely to be those who already have a diagnosed condition. When considering the parents who were unsuccessful in this thesis however, none of them had a diagnosable condition or had ever received mental health support, yet an assessment of them from an attachment and trauma perspective could reveal the potential hypo-aroused state that could account for a number of their parenting difficulties.

When considering the process of assessment of families who have been referred to children’s services the standard assessment tool used is ‘The Common Assessment Framework’ (CAF). The CAF is considered a ‘mandatory’ part of processing referrals (Daly 2016). However, what is absent from the criteria included in the assessment is the consideration of the capacity to mentalize, which could offer a better understanding of why there might be some parental difficulties within the categories that feature under the heading of ‘*Basic Care’.* These include ‘*Ensuring safety’, ‘Emotional Warmth’, ‘Stimulation’,* and ‘*Guidance and Boundaries’.* A detailed understanding of the individuals trauma history is also absent as although ‘*Family History and Functioning’* does feature the questions that can be asked in this section appear largely down to the individual social worker. The use of the Adult Attachment Interview (AAI) in this thesis proved useful in providing information about the participant’s experiences and most importantly the sense they had made of them. The use of open questions and adopting skills associated with counselling such as, active listening, were all likely to have increased the depth of information that was provided. As long as practitioners were not using the AAI to attempt to categorise attachment style, which was its original purpose, its application, or something similar that could be devised specifically to use whilst discussing their history, could be useful for gaining a better understanding of the parent.

The absence of mentalization and a detailed trauma history within social care assessments is also reflective of the business type model of working with families. The CAF might highlight the issues that exist, and therefore need to be addressed with a plan but the underlying cause of those issues could be almost entirely missed. If acknowledging the reasons why parents could be having difficulties linked to their capacity to mentalize and a detailed trauma history did feature, then this would be likely to have implications in terms of making recommendations for targeted intervention. Perhaps this explains why access to therapy for families with a child on a child protection plan may occur in sporadic pockets depending on where you live but is by no means standard protocol. In addition, the potential for assessing and understanding risk is also likely to diminish when the capacity to mentalize and a detailed trauma history is missed or not assessed in enough depth during the assessment process.

When considering the process of intervention, the methods, models and programmes that are offered to families appear to be extremely varied across the country. The Department for Education (2016) paper titled ‘Putting children first: our vision for excellent children’s social care’, appears to imply that a child protection plan is a form of intervention, by stating ‘there has been a significant increase in the number of families needing the most intensive forms of intervention through child protection plans’. The findings of this thesis combined with the work of others suggests that unless that plan offers specific access to services that will provide intervention to improve parenting capacity such as the capacity to mentalize and/or offers some form of therapy, then a plan listing expectations of the changes parents need to make is unlikely to offer an ‘intensive’ form of intervention.

The Department for Education (2016) paper also states that ‘social workers know how to affect change’. Greenwood (2016) notes that whilst practitioners are ‘often highly skilled at spotting dangers’ they are often not adequately resourced with methods of intervening. Cooper (2018) notes how social workers wishing to work therapeutically are reliant on using themselves ‘as a resource’. Identifying risks without being able to access the kinds of resources that are most likely to help families is likely to impact on job satisfaction and incidences of ‘burn out’ that have been reported (Mor Barak *et al*. 2001, Kim & Stoner 2008, Hussein 2015).

 Andreadi and Smith (2016) discuss the merits of being able to offer ‘Interventive Assessment’ within the clinical field, particularly in ‘edge of care’ cases, where gathering information about a family is important but so is offering them opportunities to start to address the concerns. An assessment process that is able to offer valuable intervention would also be useful for front line social workers and benefit families, as essentially producing an assessment without any substantial form of intervention most likely weakens the assessment and limits the opportunities given to families to change.

In terms of intervention, there appears to be no shortage of government papers and research reviews that detail the importance of providing families with the necessary types of intervention. Ward *et al.* (2014) state there is a need for a ‘multi-faceted approach’ integrating a number of services for the family. The ‘1001 critical days’ (2013) government manifesto makes a number of recommendations that the findings of this thesis support such as vulnerable families who are having difficulties being given access to ‘specialist services’ designed to improve parent-infant interaction, such as video based intervention and parent-infant psychotherapy (PIP). It states that every woman with past or present mental health difficulties should be given access to specialist support. Lastly, it also recommends that as standard procedure practitioners working in the health sector and with early years families should be given ‘high quality’ training on infant mental health. The Department for Education (2016) acknowledges the importance of ‘identifying the sorts of intervention that really work to make lasting change happen for children on child protection plans, and prevent the need for children to become looked after’. In the event that they are placed into foster care it is also widely acknowledged that these children should also receive therapeutic support (Cuthbert *et al.* 2011, Kerr 2016, McCrory 2017), which may also help prevent the continuation of traumatized ways of functioning in relationships, as well as intergenerational cycles of abuse. It is difficult to comprehend how, despite a judge from the family court accepting evidence that a child has been significantly maltreated and therefore subsequently granting a care order, these children are not automatically given access to therapy when the timing is right for them.

Whilst all of this acknowledgement of the need for therapeutic intervention is extremely positive, the reality is that many of the recommendations such as those in the 1001 critical days manifesto, have not become firmly integrated into public policy and service provision (Abel 2016). The findings from this thesis, although on a very small scale, do evidence this, as despite three participants receiving PIP this was only due to the fact that they live in the one area in the UK that has a dedicated NHS department for perinatal infant mental health. The rate of re-referrals of cases back into social services who had been previously worked with in 2010-2011 was 54.5% during 2015-16 (Troncoso 2017). This figure is not surprising when considering the limited types of intervention, particularly therapeutic, that are likely to be offered to families.

Another area of intervention which is currently outside of the remit of social care practice, and therefore policy, relates to parents who have had a child removed from their care. At present, unless the parent was already being seen by community mental health services, which is unlikely, then they will not receive any therapeutic support following the removal of their child. Given that children’s social care is an organization that is focused on the child, it is understandable that once this child is permanently no longer in the care of the parent, this service does not have a duty of care towards the parent. However, this effectively means that these parents, many of whom may have their own attachment based trauma history as well as the trauma of dealing with the removal of their child, are left to process and make sense of this alone. Broadhurst and Mason (2013) highlight how there is a ‘marked absence of discussion within mainstream policy circles’, concerning these parents and as such she refers to them as ‘welfare outcasts’.

If these parents become pregnant again, in the absence of any form of therapeutic support, the chances of them finding themselves back in the same position with the loss of another child could be particularly high. Some of them, as was the case for one participant in this study, may have been informed during the court proceedings that one of the reasons the care order has been granted is due to the fact that the parent needs therapy, and engagement with this is not possible in the timescales of the child. The final care plans in the case of adoption may even include that support should be provided to parents. However, statistical data indicates that in practice this is not happening, which is in part contributing to the removal of subsequent babies (Obi-Ezekpazu 2014). Without some form of policy and procedure to implement these services then a ‘catch 22’ scenario may inevitably occur (Tickle 2016). The financial implications of which will feature in the discussion below.

The absence of mainstream service provision to work with families following the removal of their child has led to some charities stepping forward to offer help to parents in these situations. However, as is the case with many forms of intervention, access to services is dependent on where the families live. The charity ‘Pause’, for example, is a voluntary programme for women who have experienced repeat removals of their children or are at risk of experiencing this. Mothers receive 18 months of intensive support tailored to meet their psychological, emotional and behavioural needs. In order to receive these services, the mothers have to agree to reversible forms of contraceptive during the 18 month period of intervention. McCracken *et al*. (2017) conducted an evaluation of the programme and improvements noted in some cases were: (i) more secure housing, (ii) lower rates of drug and alcohol use, and (iii) an increase in coping mechanisms and processing of past trauma. However, the evaluation took place over an 18 month period, and it would be beneficial to produce longitudinal data in order to measure its effects once participants do become pregnant again, and whether engagement in this programme can decrease their chances of subsequent removals.

The financial implications of not offering service provision to families that are trauma and attachment focused is likely to be significant. The final chapter of the literature review discussed how the costs of investing in the right kinds of therapeutic intervention may be far less than the billions of pounds spent each year on services that are dealing with the results of traumatic attachment experiences such as social care, mental health, hospitals, and prisons (Moroz 2005, Chowdry & Oppenheim 2015). The average cost of court proceedings per family is £15,000 (Broadhurst & Mason 2013). The cost of one child in foster care during 2016-2017 is estimated to have been £33,708.28 (Curtis & Burns 2017). The average cost of reunification for one family during 2016-2017 is estimated to have been £8648 and the cost of adoption per child, on average is £27,000 (Curtis & Burns 2017).

To be clear, there are of course some cases where the risk is high, or abuse has taken place on a scale of which it would never be safe for that child to be cared for by their parent, in which case therapeutic provision should be put in place for that child. However, after removing the extremely high risk cases, the reality is that a private therapist on a high rate could cost £100 an hour. If these parents was offered one session a week, that is £5,200 a year, even two would amount to £10,400 compared to the total cost of proceedings and a foster placement for a year, on average, based on the figures above, being £48,708.28, or £75,708.28 if the child spends a year in foster care before being adopted. Although this is of course simplified, the cost benefit analysis is clearly visible. The government has pledged to provide £200 million during 2014-2020 for the ‘Innovation Programme’ which is trialling different approaches to children’s social care. However, only one of these programmes ‘Pause’ (mentioned above) involves access to therapeutic intervention for parents and this is only available after the removal of their child.

At the end of 2017, The Science and Technology Committee, situated within The House of Commons, launched an inquiry to examine the strength of evidence linking adverse childhood experiences with long term negative outcomes. The inquiry aims to review the evidence base and its use in policy making, as well as support for research in this area. They are currently receiving submissions and are yet to publish their findings. This inquiry has sparked criticism from academics from within the social work and sociology fields. They appear critical of the scientific findings that claim to establish links between abuse and adverse childhood effects (ACE’s) and feel that this line of enquiry is failing to take into account the impact of complex social issues. Given the aim of this thesis has been to explore influencing factors on placement outcomes for parents who experienced attachment trauma, it is beneficial to briefly detail the viewpoints that these critics have wished to express to the government.

Edwards *et al.* (2017) submitted a paper for consideration of the committee that was titled ‘The Problem with ACEs’. They feel that the evidence for ACE’s and interventions to reduce them remains ‘unresolved’. They also state that a more critical analysis of these findings is required for three reasons. Firstly, they believe that evidence could be skewed given that many of the intervention programmes are evaluated by people with a vested interest in their success. Secondly, they question the validity of results in establishing a causal relationship due to the potential for a number of confounding variables to influence results. Thirdly, they question the statistical power and transferability of these findings due to the difficulty with replicating randomised control trials and small sample sizes. A number of academics have echoed these concerns (Bywaters 2017, Gillborn 2017). For example Morris (2017) notes that this level of scrutiny over findings is required in order to prevent development of policies that could be ineffective or even damaging.

Edwards *et al.* (2017) believe that ‘viewing social issues through the prism of ACE’s is inhibiting a response to identifying and responding to people’s needs. Once again, they are supported by academics who have also expressed the view that ACE’s findings and associated interventions are failing to acknowledge the effects of social adversity such as poverty (Pykett 2017, Reay 2017, Eubanks 2018) and limited housing (Bywaters 2017, Eubanks 2018). Edwards *et al.* (2017) also raise concern over the extent to which this body of research is excluding the ‘power of the human mind’ to interpret experiences in different ways.

The literature review and findings of this thesis support the notion that adverse experiences in childhood can affect the individual in a number of ways later in their lifetime, particularly when they become a parent. This thesis also supports the need to focus on the individual’s interpretation of those experiences, evidenced by the themes concerning the participant’s ability to talk about their trauma. Acknowledgements of the limitations of some areas of research have been discussed, as well as the individuality and complexity concerning outcomes. Exploration of social adversity was not explicitly covered, given the fact that the interview questions were informed by attachment and trauma frameworks. These fields would most likely acknowledge that, whilst social issues such as poverty and housing may increase stress levels they are unlikely to be the main cause of incidences of traumatic abuse and subsequent difficulties. Needless to say, a more idyllic approach to intervention and policy development perhaps would seek to address both psychological and social adversity.

The need for therapeutic provision for social care practitioners is another area for consideration, as they are working within complex interpersonal environments, many of which are permeated by trauma. The literature review has evidenced that a large number of parents whom social workers are interacting with are likely to have experienced some form of attachment based trauma, which may result in parents displaying increased levels of hostility, anger, and emotional distress towards them. The impact of this has been documented by a number of researchers. For example, Ferguson’s (2017) study titled, ‘How children become invisible in child protection’, states that ‘emotional intensity and complex interactions’ are causing social workers to ‘experience emotional and sensory overload’ which is contributing to them becoming disconnected from the families they are interacting with. Not surprisingly, social care practitioners may also be vulnerable to the effects of secondary trauma (Abel 2016**,** Treisman 2017, Cooper 2018). Therefore, some form of therapeutic supervision that allows time for emotional reflection, rather than just action, appears paramount.

Bion’s (1962) theory of ‘containment’ is not only relevant to the parent-child interaction but has also been applied to the needs of social workers (Cooper 2012, Ferguson 2017). This concept relates to the necessity to feel that someone is available to help you offload difficult feelings, which opens up a reflective space to process and manage such feelings. Practitioners are likely to need to be able to address their own emotional responses to their work within a supportive system that allows them to feel ‘held in mind’ (Ferguson 2009, Grayton *et al.’s* 2017). The need for ‘emotionally informed thinking spaces’ (Ruch 2007a), ‘emotional listening’ (Ruch 2007b) and ‘reflective supervision’ (Cooper 2018’ are likely to be key elements of this type of provision. Without this kind of support being available, social workers might be vulnerable to some of the defence mechanisms that have been documented in parents in this thesis such as denial, withdrawal, and even dissociation. This could result in behaviour such as joking about clients, keeping an emotional distance and behaving in a way that increases ‘the gap between us and them’ Treisman (2017). Without appropriate provision to reflect on the ‘emotional experience’ and reduce the ‘sensory overload’ (Ferguson 2017), the mechanisms of projection and transference may further impede practice, whereby the emotions associated with one family may become displaced onto others. In addition, their capacity to mentalize for clients and interact empathically may also be compromised. They may defensively experience an emotional shut down or ‘switch off’ similarly to that observed in participants in this study. This could account for some of the concerning interactions with social workers that were mentioned by participants during their interviews.

In order for social care practitioners to engage fully in meaningful practice that encourages parents to connect with their emotions, be reflective and aims to increase their capacity to mentalize, it seems vital that social workers are given the time, and space to have someone offer this approach to them. Offering families the much needed opportunity to feel ‘held’ is not likely to be possible without social workers feeling ‘held’ themselves.

There have been some social work models such as Hackney’s ‘Reclaiming Social Work’ and the ‘Focus on Practice’ approach that have employed family therapists to offer social workers consultations on their cases. Whilst evaluations have recommended that this level of support should continue (Cross *et al.* 2010, Cameron *et al.* 2016), it appears this provision is mainly providing case advice, rather than a dedicated focus on the practitioner’s emotional responses and reflections.

Therapists and counsellors are asked to undertake a certain number of hours of therapy themselves before qualifying. This could also be a beneficial requirement for qualifying social workers, given that their work has the potential to trigger emotions associated with their own attachment experiences, and having an awareness of potential triggers may be particularly useful for their practice.

Finally, to conclude this section, Munro’s (2011) review of child protection stated that ‘successful engagement with parents is a key contributor to effective helping’ (para.2.24). The concept of relationship based practice is believed by many to be central to that success, and during the past five years it seems to have become more widely discussed within the field of social work. However, it is not a new concept with authors discussing its application in social work during the 90s (Howe 1998).

Interestingly, under the umbrella of ‘relationship based practice’, discussions have taken place in the literature that support the notion that an inclusion of knowledge from the field of psychology could deepen practitioner’s understanding of service users and strengthen relationships. Bryan *et al*. (2016) emphasise the importance of understanding the ‘psychodynamics’ of these relationships. Ruch (2009 p.350) states that ‘fundamental’ to relationship based practice is being able to understand the individual from both a psychological and social perspective ‘as neither the individual nor the context make sense without the other’. Turney (2012 p.151) also discusses the use of psychodynamic theory to improve relational practice, and states that central to this concept is the ability to manage the ‘tension between the inner and outer, intra-psychic and social/political worlds’, and to understand how these two connect. The findings of this thesis support these perspectives and contribute on a very small scale to evidence detailing why relationship based practice that is rooted in psychological understanding is likely to be beneficial.

Munro’s (2010-2011) review of child protection also recommended an increase in ‘evidenced based’ ways of working with families, and there has since been a rise in the number of models of social work being formulated, trialled and evaluated. The ‘systemic’ approach appears to have become popular at present, particularly within London boroughs. Systemic practitioners have criticised social care practice as focusing too heavily on problems and past histories (Andreadi & Smith 2016). Instead, they aim to focus on how the risks can be better understood, worked with, and reduced by an approach that includes reflexivity and providing parents with regular clear feedback. (Greenwood 2016).

Currently, one of the most widely used systemic models is ‘Signs of Safety’ produced by Munro, Turnell & Murphy (2016). The title of their three year review ‘You can’t grow roses in concrete’, is reflective of the way in which the systemic approach acknowledges that expectations of families can be too high and that providing strengths based intervention increases the likelihood of change. Figures from their review suggest that families are responding well to this approach, with 82% of parents feeling listened to and understood, 85% said they felt the social worker was clear about the concerns, and 81% felt that their social worker cared about the family resolving the problems. This appears positive, particularly when considering the absence of parents feeling this way having been recorded in the findings of this thesis, and the other studies mentioned.

Based on the findings of this thesis, perhaps a model that draws on the main systemic principles of engaging with families, with the addition of understanding families from an attachment and trauma perspective, as well as giving consideration to potential ‘change facilitators’ and ‘change inhibitor’s’ would be beneficial.

Research Originality

The findings of this thesis have sought to provide a unique contribution to social work research. It is argued that this has been achieved by interviewing participants within one study who received various forms of social care intervention, such as being requested to attend parent-infant psychotherapy and/or were placed in either a foster care or a residential placement with their baby. The research has moved beyond previous studies that simply focused on the participants’ experiences of these types of interventions to include data about them as individuals, their past and present experiences, and their state of mind in relation to parenting. This has provided the opportunity to gain further insight into the ways in which both parental experience factors and individual factors could contribute to the final outcomes for families. In addition, using theoretical knowledge and research predominantly from the field of psychology to analyse this data is not something that often appears in the social work literature. The level of narrative detail that was achieved from this sample group over a period of six months, during three interviews, inclusive of those who had an unsuccessful outcome, has also greatly contributed to the originality of the findings. Finally, the identification of the ‘*change facilitators’ and ‘change inhibitors’* offers a unique focus for consideration within social care assessments and intervention.

Key messages for practical application

* This research has highlighted the potential benefit of using both an attachment and trauma lens when working with families who require the support of social services. In particular, when considering the ways in which their past attachment based trauma can contribute to a ‘hypo aroused state’, which may impact significantly on parenting capacity. At present, the procedural protocol and format of standard assessments in social care does not lend itself to this approach.
* A focus on identifying ‘*change facilitators’* and ‘*change inhibitors’*, at the family assessment stage, could help to inform the types of interventions required, such as those that focus on diminishing the ‘*inhibitors*’ to change. This approach may therefore provide families with an increased likelihood of making the desired improvements. However, this would be dependent on local authorities being able to access these types of therapeutic resources.
* The concerning nature of the themes that emerged from participants regarding their relationship with their child’s social worker, which occurred regardless of which local authority they came from and the outcome for the family, implies that social workers would benefit from provision that is more trauma focused and therapeutically led. It is hoped this would improve relationship based practice by increasing the capacity for empathy and epistemic trust with families, as well as a reduction in ‘burn out’.

Dissemination of findings

The findings have recently been presented to social care practitioners whilst I have been delivering attachment and relationship based training. The findings were also presented to my local child protection team. Further plans for dissemination include presenting at a team meeting for the perinatal mental health service where participants received parent-infant psychotherapy. I plan on contacting the local authorities that provided me with participants to also offer them a presentation during their team meetings. The findings are also scheduled to be presented at The Adolescent and Children’s Trust conference in October, additional relevant conferences will continue to be explored. It is hoped that a journal article detailing the key findings could be accepted for publishing by journals such as Child and Family Social Work, Qualitative Social Work or The Journal of Social Work Practice.

The participants will receive feedback via telephone contact to, once again, thank them for their participation and inform them that the research project has ended. The key findings will be described, and how these have contributed to the discussion of what may be beneficial for families and social work practice in the future.

Concluding Comments

On the 14th of May 2017 I attended an International Attachment Congress event and during the final question panel, I summoned the courage, in front of 1,200 people, to ask Dr Dan Siegel what his thoughts were on the need for provision within social care to be more attachment and trauma focused. His response included a statement that fitted perfectly with what I had been feeling myself during the past five years of this academic journey, and also in my practice with families. He began by stating:

‘*The sign of a civilised society is how we take care of our most vulnerable members’.*

This perspective also echoes the thoughts of John Bowlby (1952 p.84) who famously expressed ‘*If a community values its children it must cherish their parents’.*

This thesis has begun to explore ways in which current social care intervention may not be providing ‘vulnerable’ parents the opportunity to feel cherished, and most importantly the opportunity to heal and to change. It has been argued that understanding neglect and maltreatment through the lens of attachment and trauma provides valuable insights into the necessary factors that can enable parents to succeed. In addition to the factors that could inhibit success and should therefore be targeted with effective intervention that focuses on the parent’s capacity to mentalize, and the opportunity to therapeutically reflect and process their past attachment trauma. Offering this type of therapeutic intervention should not be seen as a ‘magic’ solution, as this undermines the complexity of trauma. However, it certainly has the potential to provide families with an increased opportunity to stay together. To offer these forms of intervention may not only makes sense on a financial level, as evidenced by the figures discussed earlier, but could also be regarded as a move towards achieving social justice, particularly when you consider the vast array of attachment and trauma therapies that do exist, of which access for families working with social services appears minimal.

The findings offer some insights into the research question by outlining distinguishable themes associated with the intervention outcomes. The application of attachment theory and the expertise and evidence from the field of trauma highlights the potential complexities that can exist for parents who find themselves working with social services. Those participants who were successful appear to have been fortunate enough to have experienced some form of an ‘*angel in the nursery*’ which may have helped ensure their IWM remained ‘*intact’* and provided some basis for developing the capacity to ‘*mentalize*’. For those who were unsuccessful in their assessments and there was an absence of these themes, what seemed more prevalent was the existence of defence mechanisms such as denial, projection, dissociation and hypo-arousal. The present social care system arguably does not appear to operate with a solid focus on these and, as such, the support and intervention that is offered may be unlikely to affect change and in some cases could be causing further trauma to families, as well as impacting on the ability to effectively safeguard children.

This thesis has attempted to bridge the gap between the fields of psychology and social work. If the business of social work is focused on people and trying to assess and effectively intervene, then integrating theory and research from this branch of social science appears to be of importance. It has been argued that this would enable more detailed assessments, both in terms of identifying immediate risks and recommendations for intervention, the success of which would be reliant on the most effective therapeutic forms of intervention being made available. In addition, understanding the emotional challenges and complexities faced by social workers from a psychological perspective indicates that they may also be in need of being given access to therapeutic support, in order to continue to practice in a confident and meaningful way.

Reflecting on the research process

Cooper (2009) notes that ‘the test of whether something really is practice-near research might be whether or not the researcher felt themselves to be changed as a person in the course of the work’. I do feel that completing this research has brought about a number of changes in me both professionally and personally. Like many people working in the field of child protection I have always been driven towards wanting to help others. However, engaging in this research has provided me with an increased level of determination. During one of my interviews with the mother who had had four children removed previously due to neglect, had experienced emotional abuse from her own mother, and sexual abuse from her father, I thought to myself ‘I don’t want to simply be one of the people asked to do an assessment of her and having to recommend she cannot care for future babies. I want to be part of a process of change that would, rather than observe and record her, offer her an opportunity to connect with her baby and to heal in the ways that I now know other mothers have done’.

Given the fact that I had been working in the field of child protection prior to engaging in the research process I underestimated the impact that continuously reading literature on trauma, hearing detailed first-hand accounts of experiences in the interviews, then transcribing and analysing them would have on me. On occasions, I had absorbed some of these feelings of sadness, anxiety, and despair, and sometimes found myself projecting them onto how I felt about the PhD process as a whole. At one point, I briefly engaged in some counselling sessions and this further increased my belief in how incredibly valuable the right therapeutic support can be.

Finally, I have been pleased that my research was able to identify distinguishable ‘*change facilitators*’ and ‘*change inhibitors’* associated with the outcomes for families. Although this project was completed on a small scale, it has been able to contribute to the wider question of why some parents might be able to succeed and others are not. Most importantly, it begins to highlight some of the key ways in which an application of attachment theory and research relating to attachment trauma has the potential to produce more accurate assessments, more effective intervention, and practice that is fundamentally relationship based.

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Appendices

Appendix A- Trauma Symptom Checklist

**Trauma Symptom Checklist – 40**

*(Briere & Runtz, 1989)*

*How often have you experienced each of the following in the last month? Please circle one number, 0-3.*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | ***Symptom*** |  |  | ***Never - - - - - - - - - - - Often*** |  |
|  |  |  | **0** |  |  | **1** |  |  | **2** |  |  | **3** |  |
|  |  |  |  |  |  |  |  |  |  |  |
| 1. | Headaches |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 2. | Insomnia |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 3. | Weight loss (without dieting) |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 4. | Stomach problems |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 5. | Sexual problems |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 6. | Feeling isolated from others |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 7. | “Flashbacks” (sudden, vivid, distracting memories) |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 8. | Restless sleep |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 9. | Low sex drive |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 10. | Anxiety attacks |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 11. | Sexual overactivity |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 12. | Loneliness |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 13. | Nightmares |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 14. | “Spacing out” (going away in your mind) |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 15. | Sadness |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 16. | Dizziness |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 17. | Not feeling satisfied with your sex life |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 18. | Trouble controlling your temper |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 19. | Waking up early in the morning |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 20. | Uncontrollable crying |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 21. | Fear of men |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 22. | Not feeling rested in the morning |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 23. | Having sex that you didn’t enjoy |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 24. | Trouble getting along with others |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 25. | Memory problems |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 26. | Desire to physically hurt yourself |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 27. | Fear of women |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 28. | Waking up in the middle of the night |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 29. | Bad thoughts or feelings during sex |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 30. | Passing out |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 31. | Feeling that things are “unreal” |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 32. | Unnecessary or over-frequent washing |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 33. | Feelings of inferiority |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 34. | Feeling tense all the time |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 35. | Being confused about your sexual feelings |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 36. | Desire to physically hurt others |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 37. | Feelings of guilt |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 38. | Feeling that you are not always in your body |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 39. | Having trouble breathing |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 40. | Sexual feelings when you shouldn’t have them |  |  |  |  |  |  |  |  |  |  |  |  |  |

Appendix B- Participant Information Sheet (Local Authority)



**Research Participant Information Sheet**

 **Influencing Factors on the outcome of parent-infant placements**

***Purpose and Background to the Research***

There has been very few studies that have explored the experience of the parent and followed their journey from the start of being placed in either a residential unit or mother and baby foster placement. This study seeks to explore and understand the parents’ experiences of their placement and whether there are certain factors that impact on the outcome and recommendations made for them and their child.

***What will I have to do if I take part?***

If you agree to take part then you will be asked to meet with the researcher a maximum of three times. These meetings will take place at your placement.

* There will be two meetings at the start of your placement. You will also be asked some questions about your relationship with your child and then asked to complete a health symptom checklist. Finally you will be asked about your thoughts and feelings in relation to the placement. It is estimated that this initial meeting will take between 1 hour and 1 hour 30 minutes.
* The second meeting will take place a week later and you will be asked a set of questions about your close relationships and experiences during your childhood and adult life.
* The third meeting will take place 6 months after your first placement. During this meeting you will be asked to answer the same questions about your relationship with your child and asked to complete the health symptom checklist again, as well as an interview about your placement experience.

***What do my child and I get from it?***

Taking part in this study will give you the opportunity to express anonymously your thoughts and feelings about your placement. You will also be part of a research project that is hoping to improve the experience of parents who find themselves in a similar situation to you.

***What are the possible risks and disadvantages of taking part?***

You will be asked to discuss your early family experiences as well as any difficult experiences you may have encountered and for some participants this may be distressing. The researcher is experienced and trained in administering these interviews, however if you agree to take part and you find yourself upset or distressed following any of the meetings with the researcher then you will be advised to contact her.

***Do I have to take part?***

No – **taking part in this study is voluntary.**

* If you would rather not take part in the study then you do not have to and you do not need to give a reason for this.
* If you agree to take part and then change your mind this will **not** affect your involvement with children’s services.
* You can withdraw from the study at any point.

***Confidentiality***

All of the information you provide will be **anonymous and confidential** and used only for the purpose of this study. However if during any of your meetings with the researcher they observe, or you discuss, anything that could cause you, your child or anyone else harm then this information would be passed to your child’s social worker.

The data for this study will be collected and stored in accordance with the Data Protection Act 1998. Children’s Services will not have access to any of your data from this study. Due to the fact that this study is part of a PhD project the overall findings are likely to be published, none of which will identify the participants involved and all data will be securely destroyed by March 2018.

***Further Information***

* All of the interviews with the researcher will be recorded using a Dictaphone and will be deleted after they have been transcribed.
* You will have one week to take this information home with you and decide whether you would like to take part. Whilst making this decision you may have further questions so please use the contact number below. You may however wish to meet with the researcher in person before agreeing to take part in this study and so they will schedule a meeting with you for you to discuss any questions you might have.

**If you have any questions or if you would like to talk this through prior to agreeing to take part then please contact the researcher (Alice Cook)**

Researcher: Alice Cook

Contact: 07776291001

THANK YOU VERY MUCH FOR YOUR HELP

Appendix C Participant Information Sheet (NHS)



**Research Participant Information Sheet**

**Influencing Factors on Parent-Infant Psychotherapy**

This study seeks to explore and understand parents’ experiences of parent-infant psychotherapy.

***Purpose and Background to the Research***

There has been quite a large amount of research showing how effective parent-infant psychotherapy can be, however the reasons why and under what circumstances it can be effective has yet to be investigated. This study will consist of 20 participants who are parents due to receive parent-infant psychotherapy and have one or more children registered on a child protection plan.

***What will I have to do if I take part?***

If you agree to take part then you will be asked to meet with the researcher a maximum of three times. These meetings can take place at the usual venue where you receive the parent-infant psychotherapy or, alternatively, you can be seen at your home, if you prefer. The date and time of the meetings will be scheduled to suit you.

* The first meeting will take place at the start of your Parent-Infant Psychotherapy sessions. You will be asked some questions about your close relationships and experiences during your childhood and adult life. You will also be asked some questions about your relationship with your child and then asked to complete a health symptom checklist. Finally you will be asked about your thoughts and feelings in relation to starting the Parent-Infant Psychotherapy. It is estimated that this initial meeting will take between 1 hour and 1 hour 30 minutes.
* The second meeting will take place about 9 months after you have been taking part in Parent-Infant Psychotherapy. During this meeting you will be asked to answer the same questions and asked to complete the health symptom checklist again. Depending on how long this takes, you will then be asked some questions about your experience of the therapy (or a third visit will be scheduled to discuss these questions). Two hours are likely to be needed for the second meeting if you would rather not schedule a third visit. However if you feel 2 hours could be too long for you a third visit will be scheduled at your convenience and is likely to last approximately 30 minutes.

***What do my child and I get from it?***

Taking part in this study will give you the opportunity to express anonymously your thoughts and feelings about this therapeutic intervention. You will also be part of a research project that is hoping to highlight the need for more readily available services to support other parents who may be in a similar position to you.

***What are the possible risks and disadvantages of taking part?***

You will be asked to discuss your early family experiences as well as any difficult experiences you may have encountered and for some participants this may be distressing. The researcher is experienced and trained in administering these interviews, however if you agree to take part and you find yourself upset or distressed following any of the meetings with the researcher then you will be advised to contact your assigned perinatal psychotherapist who will be able to offer you further support.

***Do I have to take part?***

No – **taking part in this study is voluntary.**

* If you would rather not take part in the study then you do not have to and you do not need to give a reason for this.
* If you agree to take part and then change your mind this will **not** affect your enrolment with the therapeutic service or your involvement with children’s services.
* You can withdraw from the study at any point.

***Confidentiality***

All of the information you provide will be **anonymous and confidential** and used only for the purpose of this study. However if during any of your meetings with the researcher they observe, or you discuss, anything that could cause you, your child or anyone else harm then this information would be passed to your assigned perinatal psychotherapist and your child’s social worker.

The data for this study will be collected and stored in accordance with the Data Protection Act 1998. Children’s Services will not have access to any of your data from this study. Due to the fact that this study is part of a PhD project the overall findings are likely to be published, none of which will identify the participants involved and all data will be securely destroyed by March 2018.

***Further Information***

* All of the interviews with the researcher will be recorded using a Dictaphone and will be deleted after they have been transcribed.
* At the start of the study you will be assigned a participant number and therefore the information collected from your interviews will be anonymous. However it may be helpful for the clinical team you are working with to have access to the discussions relating to your past family relationships and current relationship with your child but this will be your choice and you can still take part in the study if you don’t consent to this being shared.
* Your GP and your child’s social worker will be informed of your involvement in the study.
* You will have one week to take this information home with you and decide whether you would like to take part. Whilst making this decision you may have further questions so please use the contact numbers below. During your next parent-infant psychotherapy session your assigned psychotherapist will read through this information with you again and you will be given a consent form which will be read through with you to sign if you agree to take part. You may however wish to meet with the researcher in person before agreeing to take part in this study and so they will attend your next parent-infant psychotherapy session in order to answer any questions and you will then be requested to make your decision.

**If you have any questions or if you would like to talk this through prior to agreeing to take part then please contact the researcher (Alice Cook) or Consultant Perinatal Psychotherapist Amanda Jones.**

Researcher: Alice Cook Consultant Perinatal Psychotherapist: Amanda Jones

Contact: 07776291001 Contact:  0300 555 1119 or 1182

THANK YOU VERY MUCH FOR YOUR HELP

Appendix D- Participant Consent Form



Participant Identification Number:

**CONSENT FORM**

**Influencing Factors on the outcome of parent and baby placements**

Name of Researcher: Alice Cook

 **Please initial box**

1. I confirm that I have read and understood the participant information sheet for this study and I have been given the opportunity to ask questions.
2. I understand that my participation is voluntary and that I am free to withdraw at any time.
3. I understand that taking part in the study or withdrawing will not affect my involvement with Children’s Services.
4. I am aware of and give consent to the Dictaphone recording of my discussions with the researcher.
5. I agree to the publication of the results of this study and I understand that I will not be identified in any publication.
6. I agree to my child’s social worker being informed that I am participating in this study.

1. I agree to take part in the above mentioned study.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 Name of Parent Date Signature

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 Researcher Date Signature

Appendix E- Interview Schedule

|  |  |
| --- | --- |
| **Interview 1** | Trauma Symptom Checklist, Initial interview guided questions, Working model of the child interview.  |
| **Interview 2**  | Adult Attachment Interview |
| **Interview 3** | Trauma Symptom Checklist, Final interview guided questions.  |

Appendix F

First Interview Guided Questions

1. Can you tell me a bit about what has led you to become involved with children’s services?
2. What are your thoughts and feelings about being in this placement/therapeutic treatment?
3. Do you feel you can benefit from what the placement/therapy can offer? Which areas of your parenting do you feel you may need help with?
4. What is your understanding of how the placement/ therapeutic support will work?
5. What outcome are you hoping for?
6. How are you feeling about working with your therapist/ your foster carer/residential staff?
7. Can you talk about your relationship with your child’s social worker?
8. Have you been offered any other form of therapy before for yourself or you and your baby/child? What was your experience of this like?
9. Is there an adult who you can identify from your childhood with whom you had a positive relationship? What was positive about this relationship, can you provide an example of a memory with this person?
10. Do you feel love and kindness is shown towards you from others? If yes from whom and what do people do to show you this?

Appendix G

Final interview guided questions (question nine omitted if a negative outcome was known)

1. Can you tell me about how things have been going for you since we first met? Thinking mainly about any experiences that have been stressful?
2. Can you remember what your thoughts and feelings were about taking part in the therapy/placement at the start?
3. What would you list at the positives/negatives of this experience?
4. Do you feel the intervention has impacted on your relationship with your baby, if yes in what way, if no why might this be?
5. Can you discuss any differences you have observed in your baby since the start of the therapy/placement?
6. Are there any differences in how your baby experiences you now compared to before the therapy/placement.
7. Can you describe your experience of working with the therapist/foster carer/residential staff/ child’s social worker?
8. Can you describe your overall experience of the therapy/placement? Overall what do you feel you have learnt?
9. Do you feel you have gained what you were hoping for?

\*Number 9 was omitted for participant’s whose babies had been removed from their care at the time of the final interview.

Appendix H

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Thematic Factor**  | **Participant 1** | **Participant 2** | **Participant 3** | **Participant 4** | **Participant 5** | **Participant 6** | **Participant 7** | **Participant 8** | **Participant 9** |
| Acceptance  | ✓ | ✓ | ✓ | ✓ | ✓ |  | ✓ | ✓ | ✓ |
| Determination | ✓ |  |  | ✓ | ✓ | ✓ |  | ✓ | ✓ |
| Mentalization | ✓ |  | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Positive Talk about baby  | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Angel in the nursery  | ✓ | ✓ | ✓ | ✓ | ✓ |  | ✓ | ✓ |  |
| Internal Working Model intact | ✓ |  |  |  | ✓ | ✓ |  | ✓ | ✓ |
| Caring for Siblings | ✓ | ✓ |  |  | ✓ | ✓ |  |  |  |
| Feeling loved and cared for | ✓ | ✓ |  | ✓ |  | ✓ | ✓ |  | ✓ |
| Connection to trauma  | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Denial  |  |  |  |  |  |  |  |  |  |
| Low Mentalization |  |  |  |  |  |  |  |  |  |
| Negative Talk about the baby  |  |  |  |  |  |  |  |  |  |
| Disconnect with trauma  |  |  |  |  |  |  |  |  |  |

*Distribution of thematic factors for participants who had a positive outcome.*

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Thematic Factor**  | **Participant 1** | **Participant 2** | **Participant 3** | **Participant 4** | **Participant 5** | **Participant 6** | **Participant 7** | **Participant 8** |
| Acceptance  |  |  |  |  |  |  |  |  |
| Determination |  |  |  |  |  |  |  |  |
| Mentalization |  |  |  |  |  |  |  |  |
| Positive Talk about baby  |  | ✓ |  |  |  |  |  |  |
| Angel in the nursery  | ✓ | ✓ |  |  |  |  |  |  |
| Internal Working Model intact |  |  |  |  |  |  |  |  |
| Caring for Siblings |  |  |  |  |  |  |  |  |
| Feeling loved and cared for |  | ✓ |  |  |  |  | ✓ |  |
| Connection to trauma  |  |  |  |  |  |  |  |  |
| Denial  | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Low Mentalization | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Negative talk about the baby |  |  | ✓ | ✓ |  |  | ✓ | ✓ |
| Disconnect with trauma  | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |  |

*Distribution of thematic factors for participants who had a negative outcome*