

**Middlesex University and
Metanoia Institute**

**MOTHERS' EXPERIENCE OF PARENT-
INFANT PSYCHOTHERAPY: A
QUALITATIVE ANALYSIS**

Yasmine Haimovici

submitted in partial fulfilment of the degree
of

**Doctorate in Counselling Psychology
and Psychotherapy by
Professional Studies (DCPsych)**

Word count: 43,312

Acknowledgements

'Interesting, unique, scary, challenging, sharing, improving, seeing, playing, helpful, encouraging, improving, motherly, supportive, bonding, loving, healing.'
Participants' words to describe their experience of PIP

I would like to thank:

The mothers that had the generosity to share their inspiring stories with me;

Giuliana, my psychotherapist who brought to our sessions her determination that I would move this research forward without any space for incertitude;

Vanja, my university supervisor who enabled me to wander without allowing me to get lost;

Marsha, my clinical supervisor who brought

Michael into my life, an angel who had the kindness and generosity to hold my hand through this journey. My gratitude to him goes beyond what I can express here;

My parents who gave me confidence and faith in myself and others;

My friends who smiled at my ever changing research ideas;

And finally Thomas, my beloved husband who, out of our twenty-five years together, has made room for my fifteen years of never ending student's excitement and despair,

And my two beautiful children, Solal and Nima, who made my experience of being a mother such an extraordinary journey – a journey that fuelled my research curiosity.

From deep in my heart, thank you.

Abstract

Aims: This research investigates how mothers experience parent-infant psychotherapy (PIP). The study uses a collaborative exploration of mothers' lived experience and the meaning they attach to it. The intention is to develop insights into mothers' variety of experience of PIP and how their subjectivity impacts their perception of the therapeutic process. Using their in-depth descriptions, this study develops an understanding of the themes inherent in the experience of women in motherhood. **Design:** This research uses phenomenology, hermeneutics and idiography as a philosophical base, and applies interpretative phenomenological analysis methodology, drawing upon Jonathan Smith's concept of experiential qualitative research in psychology (2009). This approach was chosen in order to develop an understanding of the insider perspective by engaging directly with mothers' own descriptive accounts of PIP. **Method:** Seven women, aged between 27 and 43 years old, voluntarily participated in this study. The volunteers were recruited from among the participants of a group of PIP course delivered by a National Health Service (NHS) clinic. In-depth semi-structured interviews were conducted to develop an understanding of participants' lived experience and their meaning-making processes. **Findings:** Three master themes emerged from across the participants' accounts: (1) from a negative to a positive experience of motherhood, (2) PIP as a nurturing experience, (3) PIP as a humanising experience, and (4) PIP as a transformative experience. The findings highlight the significant change in mothers' perception of motherhood (their state of being a mother) – from a sense of inability, detachment, isolation and depression to feeling different, competent, maternal and relationally attached – which they attribute to their experience of PIP. It gave them a different vantage point from which to feel, behave, think, understand and engage with themselves and the world. **Conclusion:** PIP is valued by mothers as a potentially powerful therapeutic intervention and vehicle for change for themselves, their children and the generations to come. The mothers, psychotherapists, the group setting are all essential to the success of the therapeutic encounter. Mothers should be given the opportunity to access such treatment at this precious and formative time in their and their children's lives.

Contents

Acknowledgements	3
Chapter 1: Introduction	9
1.1. Prologue	9
1.2. My relationship to the field.....	11
1.3. PIP and the perinatal mental health context in the UK	12
1.4. Structure of this thesis.....	17
Chapter 2: Review of theory and research	19
2.1. The Importance of the early parent-infant relationship.....	19
2.1.1. The need for relationship.....	19
2.1.2. How early interaction shapes the self	20
2.1.3. The quality of early interactions: affect-regulation and mentalisation	21
2.1.4. The Social Brain	22
2.2. Parent-infant psychotherapy (PIP).....	23
2.2.1. Historical and theoretical perspectives.....	23
2.2.2. PIP and parental reflective functioning.....	26
2.2.3. Concluding thoughts	27
2.2.4. Towards a unified model of parent-infant psychotherapy	28
2.3. Maternal and infant mental health research.....	29
2.3.1. Maternal mental health and the parent-infant relationship.....	29
2.3.2. Infant mental health as a predictor of adult mental health.....	29
2.3.3. Maternal mental health and its impact on parenting and child development.....	29
2.3.4. Disrupted attachment – a major risk factor.....	30
2.3.5. Mothering psychological processes – a mediator	31
2.3.6. Maternal representation of the child and her self.....	32
2.4. Early interventions research	32
2.4.1. Home visiting interventions	33
2.4.2. Relation-based early family interventions	34
2.4.3. Attachment-based interventions.....	34
2.4.4. Relationship psychotherapies.....	36
2.5. The importance of the client’s view in counselling psychology and psychotherapy	40
2.6. The rationale and value of the research project.....	42
2.7. The research question	43
Chapter 3. Methodology	44

3.1. What kind of knowledge I aim to create	44
3.2. My epistemological and ontological assumptions	45
3.3. My role as a researcher	46
3.4. My reflexive stance.....	47
3.5. My philosophical stance.....	48
3.5.1. Phenomenology.....	48
3.5.2. Hermeneutics.....	49
3.5.3. Idiography	50
3.6. Methodology: Interpretative Phenomenological Analysis.....	51
3.7. Methods.....	53
3.7.1. Recruitment of participants.....	53
Table 1. Participant Characteristics.....	56
3.7.2. Ethical considerations.....	58
3.7.3. Gathering data	62
3.8. Managing data using HyperResearch – a choice	65
3.9. Process of analysis.....	66
3.9.1. Reading and re-reading	66
3.9.2. Recording initial notes	67
3.9.3. Developing emergent themes	67
Table 2. Coding an Excerpt of a Transcript	68
3.9.4. Consolidating to form superordinate themes.....	69
3.9.5. Cross-case master theme formulation	69
3.10. Evaluation.....	70
3.11. Initial assumptions of the research	72
Chapter 4. Findings.....	76
4.1. Overview of findings.....	76
Table 3: Themes from the Analysis.....	77
4.2. Overview of participants’ experience of PIP	78
4.3. Reflections on the research process	79
4.3.1 Reflection on the recruitment and interview process.....	80
4.3.2. Reflection about the analysis process	81
4.4. Master theme 1: From a negative to a positive experience of motherhood	83
Table 4. Superordinate Themes of Master Theme 1	83
4.4.1. From a negative experience of motherhood.....	84
4.5. Master theme 1: To a positive experience of motherhood	90
4.5.1. Difference.....	90

4.5.2. Competency/Ability	90
4.5.3. The maternal self.....	92
4.5.4. The bonding experience	93
4.6. Master theme 2: PIP as a nurturing experience.....	94
Table 5. Superordinate Themes of Master Theme 2	95
4.6.1. PIP as a good experience.....	95
4.6.2. PIP psychotherapist as a good object.....	97
4.6.3. Maternal function/mothering mothers	99
4.6.4. Learning process.....	101
4.7. Master theme 3: PIP as a humanising experience	103
Table 6. Superordinate Themes of Master Theme 3	103
4.7.1. Talking.....	103
4.7.2. Sharing	105
4.7.3. Normalising.....	106
4.7.4. Sameness and togetherness.....	108
4.8. Master theme 4: PIP as a transformative experience.....	110
Table 7. Superordinate Themes of Master Theme 4	110
4.8.1. Willingness to change.....	110
4.8.2. Transformative experience.....	112
4.8.3. New perspectives	114
4.8.4. Reflectiveness	115
Chapter 5. Discussion	118
5.1 Reflections on the journey of understanding and interpreting.....	118
5.1.1. How assimilated theoretical concepts and personal experience created anticipation with regards to the findings.....	118
5.1.2. Why so much convergence.....	120
5.1.3. An overly positive view of PIP and its inevitable limitations.....	122
5.1.4. Holding the maternal self in mind.....	123
5.2. Going beyond the findings	125
5.2.1 Psychological pain as a key feature of clients' experience of motherhood	125
5.2.2. On humanising the pain through relationships	129
5.2.3. PIP as a Relational-Transformational space.....	136
5.2.3.1. <i>The meaning mothers ascribed to changes – a transformation</i>	136
5.3. Contribution of this study	141
5.3.1. Practical implications	141
5.4. Limitations of this study and considerations for future research	143

5.4.1. Linguistic perspective	143
5.4.2. Anthropological perspective	144
5.5. Impact the study had on me	145
Chapter 6. Conclusion.....	148
References	150
Appendix 1 – Coding an Excerpt of a Transcript	178
Appendix 2 – Data Analysis – Case Analysis 6	179
Appendix 3 – Superordinate themes showing presence by interview	208
Appendix 4 – Consent Form for Participants in Research.....	210
Appendix 5 – Participant Information Sheet	211
Appendix 6 – Interview Schedule and Topic Guide.....	214

Chapter 1: Introduction

1.1. Prologue

In 1940, Sigmund Freud had already identified the cardinal importance of the parent-infant relationship and its early experience, describing it as 'unique' and 'the prototype of all later love-relations' (1940, p. 188). Traditionally, this earliest period of human existence was examined retrospectively, reconstructed in analysis. But in the 1960s, many eminent psychoanalysts like Anna Freud, Melanie Klein, John Bowlby and Donald Winnicott turned their interests towards the observable parent-infant relationship. This shift was followed by fascinating discoveries in infant observations and research, attachment theory, developmental psychology and neuroscience. This multidisciplinary convergence of interests led to an even greater appreciation of the importance of the earliest mother-infant relationship and its impact upon the infant's development and mental health.

The mother's sensitivity to her child, and her capacity for good mothering, is embedded in her own experience of being parented. But even more importantly, it is underpinned by her capacity to make sense of and represent these early (good or bad) experiences (Main & Goldwyn, 1985/1991; Main, Kaplan & Cassidy, 1985; Zeanah & Barton, 1989). The ability to develop a coherent narrative of one's relational experiences has even won out over historical truth as the stronger predictor of mothers' relational style with their infant (Fonagy, Steele, & Steele 1991a). The presence of unresolved conflicts in the mother's mind takes the form of ghosts in the nursery (Fraiberg et al, 1975) and comes back to disrupt the mother's relationship with her infant.

The acknowledgement of the importance of the early parent-infant relationship, with its potential disturbances and pathologies, has opened the door to a large body of prevention- and early intervention work under the form of parent-infant psychotherapy (PIP). In the past twenty years there has been an enormous growth of interest worldwide in PIP, which has led to great progress in

conceptualising methods of intervention (Baradon et al, 2005; Stern, 1995; Pozzi, 2007).

The efficiency of this type of early intervention has been researched, with a few studies examining the process and outcomes of PIP (Cicchetti, Toth & Rogosch, 1999; Cooper et al, 2003; Lieberman et al, 1999; Salomonsson & Sandell, 2011; Slead, Baradon & Fonagy, 2013; Robert-Tissot et al, 1996; Kennedy & Midgley, 2007). Various models have been shown to have positive outcomes. However, it is interesting to note that with the exception of Barlow's research (2007) exploring parents' perspectives on the value of PIP for themselves and their babies and Kitson's research (2008) that qualitatively explored parents' experiences of a parent-toddler group, there is an absence of PIP qualitative research.

To date, there are some well-established theoretical models conceptually articulating how PIP works, as well as some evidence that PIP is valued by clients and leads to measurable change. However, there is a paucity of research focusing on clients' subjective experiences and developing an understanding based upon participants' insights.

The purpose of this research is therefore to explore mothers' experience of PIP, using subjective, qualitative and temporal lenses, to extend our understanding of PIP processes and outcomes through the client's subjective experience. Mothers' experience of PIP starts before the first session and does not end with the last session. Like any other significant experience, it remains alive inside one's self. This study seeks to understand what it was like for a mother to embark on a therapeutic journey with her child – a journey that starts by being suggested to her, and that she has to make her own in order to engage with it. It gives mothers the opportunity to reflect upon that journey and the impact it has had on them, focusing on their mental states (expectations, wishes, desires, feelings, thoughts) and their meaning-making processes.

The aim of this research is to contribute to a rounder understanding of PIP

where quantitative, qualitative, conceptual and experiential perspectives are integrated into a working model. Ultimately, the intention is to apply these insights to PIP practice so as to improve the quality of service delivery.

1.2. My relationship to the field

My sister, being born severely prematurely (at six months) in the 1960s, spent the first few months of her life in hospital. At that time, parents were not allowed to stay with the infant. I believe this early separation from mother, amongst other things, had an impact on her sense of self and her future struggle with attachment relationships. She battled with it until she ended her life aged 24, on our mother's birthday. I was 16 at the time.

This tragic story left me with a terrible sense of guilt, an experience of emotional pain and a strong desire/need to understand others and myself. Following years of analysis, I managed to develop a narrative around my family life that enabled me to regain the vitality, freedom and enthusiasm necessary to enjoy my existence in a meaningful way. I did not completely rid myself of guilt, but I found an acceptable compromise by becoming a psychotherapist.

Becoming a mother unsettled my equilibrium. I was petrified of losing my child like I had lost my sister. I struggled to see him for the gregarious baby that he was, and rather lived with the constant fear of his death, which disabled my capacity to contain him. I could only love him knowing that his life was going to be short; I could not educate him, as he had no future. This powerful personal experience alerted me to the phenomenon of 'ghosts in the nursery' (Fraiberg, 1975) and directed my professional interest towards the mechanism of psychic transmission between generations.

My personal experience of motherhood and its potential pitfalls coincided with my professional experience in a parental mental health service, working with mothers suffering from mental health disorders and struggling to adequately mother their children. My psychotherapeutic work with them consisted partly in working with their internal baby self, their experience of being mothered and the

impact it had had on their capacity to mother and engage with their real baby. Interestingly, many mothers brought their real babies to our individual sessions, which gave me the opportunity to witness and work with the co-creation of their relationship based upon the interactions of their intrapsychic and interpersonal worlds. It triggered my interest in relational interventions for parents and their children and I went on to work in several perinatal psychiatry and psychotherapy services, learning about and offering parenting assessment and PIP. In PIP, as with my work with individuals, I have been fascinated by clients' different experience and use of the psychotherapeutic frame.

1.3. PIP and the perinatal mental health context in the UK

Becoming a mother is an event of major psychological significance for women (McCourt, 2006). It is culturally assumed that childbearing brings joy and happiness; however, the reality can be much darker, with women experiencing ambivalent feelings and various difficulties (Chodorow, 2003). Research has revealed that women's greatest lifetime risk of developing a mental illness comes in the months surrounding the birth (Kendell, Chalmers & Platz, 1987).

The severity of the disorders varies greatly from minor baby blues, antenatal/postnatal depression (PND) and anxiety disorders, to major puerperal psychosis:

- Mothers have higher scores on the Edinburgh Postnatal Depression Scale during pregnancy than postnatally (Evans et al, 2001).
- Maternal antenatal stress and anxiety can have a lasting effect on the psychological development of the child, and may be linked to premature labour (O'Connor et al., 2002).
- Epidemiological studies consistently show the prevalence of PND to be about 10%, with the effects of the illness potentially posing risks to the mother-infant relationship (Cooper & Murray, 1998) and long-term adverse effects on the cognitive and emotional development of the child (Cooper & Murray, 1997).

- Two out of every 1,000 women who have delivered babies are admitted to psychiatric hospital with puerperal psychosis (Oates, 2003).
- The Royal College of Psychiatrists (2000-2002) suggests that another two out of every 1,000 women who have given birth will be admitted because of a relapse or recurrence of a pre-existing condition, such as a severe, chronic or enduring mental illness, predominantly schizophrenia. In addition, women who have a history of psychotic disorder have an increased risk of stillbirth and neonatal death.
- The report from the Confidential Enquiry into Maternal Death (2004) found that psychiatric disorders contributed to 12% of maternal deaths and that, when suicides identified by the record linkage study are taken into account, deaths from suicide are the leading cause of maternal death (Royal College of Obstetricians and Gynaecologists, 2001).

From a public health perspective, the perinatal mental health of women is a major concern due to the adverse psychological outcomes for the mother, baby and the whole family (Almond, 2009). Parental mental health disorders can prove a pernicious influence on childhood mental health (GB National Study, 2006). Children of mentally ill parents are at high risk of developing a range of emotional, behavioural, cognitive and social difficulties (Leverson, 2003).

Considering the importance of the early mother and child relationship, and its drastic consequences for the psychobiological development of the child, protecting such a relationship and preventing adverse events in the perinatal period appears to be essential (Tremblay, 2010). 'A preventive approach assumes that each individual has the capacity for a particular, personally optimal, course of development, and that health care is directed to maintaining that course or returning that person to his or her natural trajectory of development' (Goldberg, in Kendrick, Tylee & Freeling, 1996). A model of prevention can be applied to the perinatal field to include 'primary prevention (to prevent pathogenesis and include health education and promotion), secondary prevention (early identification of problems and intervention to prevent their progression) and tertiary prevention (preventing the development

of complications for patients with established conditions)' (Kendrick, Tylee, & Freeling, 1996, p.xiv).

Current perinatal mental health policies reflect this shift away from *mental illness* models towards the maximisation of *mental health and wellbeing*, of mothers, children and their families:

- The National Service Framework for Mental Health (Department of Health [DoH], 1999) only briefly mentions PND as an area of service improvement and investment.
- *Perinatal Maternal Mental Health Services* (Council report CR88, 2002) made recommendations for the provision of services for childbearing women. They take into account developments in national health policy – including new commission arrangements, clinical governance and the National Service Framework (NSF) for mental health – as well as the findings of key reports including the *Confidential Inquiry into Maternal Deaths* (Why Women Die, 1998) and *Fatal Child Abuse and Parental Psychotic Disorders* (1996). They recommend that every health authority has a perinatal mental health strategy that aims to provide adequate services for women. This new council report updates and replaces the CR28 (published by the Royal College of Psychiatrists in 1992), and a report published in 1996 in conjunction with the Department of Health.
- *Women's Mental Health: Into the Mainstream* (DoH, 2002) is the first evidence of a proactive approach that recognises the significance of women's perinatal mental health. It acknowledges the need for local specialist perinatal mental health services for women.
- The Royal College of Psychiatrists Perinatal Special Interest Group's opinions vary about the best approach for the provision of these services. They range from a traditional integrative approach of strengthening existing generic community mental health teams and other services, to standalone specialist services to address the specific needs of perinatal women (Royal College of Psychiatrists [RCoP], 2003).

- *Antenatal and postnatal mental health: Clinical management and service guidance* was issued by the National Institute of Clinical Excellence (NICE) in 2007. This guide is the first of its kind to make specific recommendations on the identification, treatment and management of all mental health disorders during the perinatal period. It also provides advice on the care of women with existing mental disorders who are planning a pregnancy and on the organisation of care during the perinatal period.
- *The Child Health Promotion Programme: Pregnancy and the first five years of life* (Department of Health, 2008) places a greater emphasis on the emotional health and wellbeing of the child and mother, and on the importance of early identification of mental health problems.
- 'Improving Access to Psychological Therapies' (IAPT) published *Perinatal: Positive Practice Guide* (2009), which provides guidelines for commissioners to ensure that the needs of people with perinatal mental health problems are met by IAPT services.

The current organisation of perinatal mental health services in the UK, based upon those guidelines, is underpinned by a patient-centred care philosophy. In principle, the treatment and care offered should take into account the women's individual needs and preferences. The detection and diagnosis of maternal mental health issues/risks should take place at a primary care level, with depression being screened throughout the perinatal period. Psychological treatments should ideally be available to women within four weeks of their referral (and certainly no later than three months from that date). Self-help strategies, non-directive counselling delivered at home and brief cognitive behavioural therapy (CBT) or interpersonal therapy is recommended for the treatment of mild to moderate depression within the perinatal period.

However the reality of perinatal mental health services available to new families is very different from what is recommended, with shocking disparities between geographical areas; more than 40% of English health board areas have no perinatal mental health service provision at all, leaving vulnerable mothers

uncared for. Dr Gregoire, chair of the Maternal Mental Health Alliance (MMHA) which collected these figures, said the lack of dedicated services was ‘an embarrassment for the NHS [National Health Service]’ (2014). The Alliance is a coalition of UK organisations committed to improving the mental health and wellbeing of women and their children in pregnancy and the first postnatal year. They are motivated by the current shortfall in quality, availability and accessibility of antenatal and postnatal mental health care, and by the lack of knowledge about the issue amongst health and social work professionals and the wider public. The Alliance is focused on three routes to improvement: awareness, education and action. A key vehicle for this joint effort is the *Everyone’s Business* campaign. Funded by Comic Relief, it will provide key information and tools to support commissioners and service providers in making the necessary changes.

As part of their *Everyone’s Business* campaign, the Alliance commissioned a study on the costs of perinatal mental health problems. They found that that:

‘the costs of mental health problems among women in pregnancy are far greater than previously thought; the cost to the public sector is five times greater than the cost of providing the services that are needed throughout the United Kingdom:

- Perinatal depression, anxiety and psychosis together carry a total long-term cost to society of about £8.1 billion for each one-year cohort of births in the UK.
 - Nearly three-quarters (72%) of this cost relates to adverse impacts on the child, rather than the mother.
 - Over a fifth of total costs (£1.7 billion) are borne by the public sector, with the bulk of these falling on the NHS and social services (£1.2 billion).
 - Other costs include loss of earnings/impact on someone’s ability to work and quality of life effects.
 - There is clear guidance from the National Institute for Health and Care Excellence (NICE) and other national bodies on the treatment of mental illness during and after pregnancy. Yet the current provision is best described as patchy, with significant variations in coverage around the country.
 - About half of all cases of perinatal depression and anxiety go undetected and many of those, which are detected, fail to receive evidence-based forms of treatment.
 - Specialist perinatal mental health services are needed for women with complex or severe conditions, but less than 15% of localities provide these at the full level recommended in national guidance and more than 40% provide no service at all’.
- (Brauer et al, 2014, p.4)

It is interesting to note that PIP is not included in the NICE guidelines, despite the acknowledgement of maternal mental health as a priority. It may be due to the limited evidence on PIP in this era of evidence-based practice.

1.4. Structure of this thesis

So far, this introductory chapter has provided a theoretical, contextual, reflexive context for the motivation for this research.

The second chapter situates this work within the perinatal field by presenting the theoretical background and founding principles of PIP, introducing various PIP models within historical and conceptual perspectives and concluding with an integrated model that highlights the common factors. It then reviews the relevant literature to identify what is already known and what would benefit from further investigation, accounting for the present choice of research questions and methodology. Finally, the chapter will anticipate this study's contribution to the field of counselling psychology and psychotherapy.

The third chapter provides a description of the methodology employed in this study as well as its underpinning epistemological and ontological position and philosophical stance. It includes a detailed description of the planning, recruitment, interviewing and analysis processes within a theoretical and experiential perspective.

The fourth chapter presents the findings of this study, outlining the main themes emerging from a subjective engagement with the co-constructed data. The findings are located within the relevant psychological theories and literature, reflecting upon my subjective research journey and how that subjectivity interacted with the construction of the findings.

Chapter five will link back to the original research questions through a discussion of the findings. It will articulate how the findings provide informed

answers to these questions, consequent to the new understanding of PIP that emerges from the research.

Finally, in chapter six, I will briefly review my research journey, reflecting upon my personal experience of it and reiterating my contribution to the field.

Chapter 2: Review of theory and research

In this chapter, the research is located within the current debate and existing literature. It begins with theoretical support for the importance of the parent-infant relationship – and therefore the importance of psychotherapeutic interventions that attend to its dysfunction. It then presents PIP from an historical, conceptual and research perspective, looking at the current evidence base from which the research rationale and questions emerge. Finally, it articulates how this research will contribute to the field of counselling psychology and psychotherapy by deepening the current understanding of PIP processes and outcomes.

2.1. The Importance of the early parent-infant relationship

Child development theories strongly support the idea that early experiences shape the development of the child. These theories are based on analytic reflections (Winnicott, 1947; Klein 1932, Bion, 1962), clinical observations (Bowlby, 1969; Stern, 1985,) and neuro-scientific research. Psychological theories (of the mind) are now integrating with scientific theories (of the brain) with the concept of the social brain and its experience-dependent plasticity (Cozolino, 2006). In other words, the development of the brain does not depend only on genes, but ‘occurs in the context of a relationship with another self, another brain’ (Schore, 1994, p.40) and ‘influences from the social environment are imprinted into the biological structures that are maturing during the early brain growth spurt, and therefore have long-enduring psychological effects’ (Schore, 2003, p.24). Neurobiology, then, backs up psychoanalytical ideas, fulfilling Freud’s wish for a ‘scientific psychology’ (1954).

2.1.1. The need for relationship

In early psychoanalytic thinking, the relationship between a baby and its mother was understood as a means to an end, with the baby using the mother to satisfy its primary needs such as hunger and thirst. Its early environment was relevant

only in its instrumentalisation in satisfying the infant. Bowlby (1969) challenged this conceptualisation of the relationship by introducing the idea that an attachment between mother and baby is a need in itself. A baby needed its mother to ensure its physical and emotional survival. The actual relationship between them was seen as an evolution-based necessity.

Similarly, Winnicott looked at the baby's early environment and acknowledged its importance. He famously said that 'there is no such thing as a baby...a baby cannot exist alone, but is essentially part of a mother' (1947, p.88).

Psychological theories shifted from the sole existence of the baby's internal world to its complete symbiosis with mother, with the baby conceptualised as one with the mother before gradually going through the process of separation-individuation (Malher, 1967). Here again, the inter-relatedness of the mother-baby encounter was missed.

The innate relatedness and capacity of the infant to communicate was only truly grasped with the theoretical shift of the inter-subjectivists (Lichtenberg 1983; 1989; Stern, 1985; Beebe & Lachmann, 1988; Emde, 1988) coupled with the findings of infant observations (Beebe & Lachman, 1998, 2014) . It framed the mother-baby relationship very differently: both partners were understood as mutually influencing the co-created relationship. This theoretical evolution had important clinical implications: a baby could not be understood outside of its relationship with its mother, and any relational intervention needed to involve both partners as they both actively shaped the relationship and its potential disturbances.

2.1.2. How early interaction shapes the self

Early experiences and relationships are important because one remembers and generalises them; they come to shape one's vision and belief about oneself, others, and ultimately about the world. This mental representation of early experiences (or internal working models of the self-in-relation-to-others) is a

central tenet of attachment theory (Bowlby, 1969; 1973). Similarly, Stern talks about representation of interactions that have been generalised (RIGs) (1985). They are averaged and represented pre-verbally, like a memory without words (Bruner, 1969). You can find variation of this phenomenon in object relations theories (internal object), cognitive theory (schemata) or systemic theory (event scripts); phenomenon by which early interactions are internalised, generalised and used as the template for future interactions. The overarching idea is that the infant's sense of self emerges from its interactions with its caregivers (Stern, 1985).

At this point, it should be noted that within these frameworks, interactions are understood as concrete and observable events between two conscious minds. However, there should be a space here for more psychodynamic thinking within the mother-baby relationship; this would include the real, but also the imaginary and fantasmatic, baby (Lebovici, 1988) in the mother's mind as well as her own fantasies and unconscious representations about herself – the interplay of intrapsychic and interpersonal worlds at a conscious and unconscious level.

2.1.3. The quality of early interactions: affect-regulation and mentalisation

The mother-baby relationship is mutual yet asymmetrical. The baby's immaturity leaves it unable to manage its physical and emotional life. Psychological theories about this early relationship propose the idea of a mature human being (the mother) supporting an immature human being (the baby), with the physical being and the psychological being very much intertwined. Bion (1962) suggested that a mother contains the unmanageable emotional experience of her baby by bearing it, processing it and re-presenting it to her baby in a more manageable form. Such containment takes place at the level and in the language of physical care. Winnicott (1965) talked about the mother's holding and handling of the baby bringing together the physical and emotional care. The mother processes what her baby cannot, she models how to do it but also offers her own mind as a mirror wherein baby can find its own (Winnicott, 1971, Fonagy et al, 2002). By acknowledging her child's intentional stance

(Dennett, 1987), the mentalising mother fosters what will become the child's own mentalising capacity. Such emotionally attuned mirroring is critical to the child's development. It is the foundation of its capacity to experience itself as a feeling, desiring and mentalising individual (Fonagy et al, 1995). Parent-infant psychotherapy provides an opportunity to work with these complex dynamic processes between mother and baby as they emerge outside and inside the session.

2.1.4. The Social Brain

From a neuroscientific perspective, the mind is the product of the brain's activity. From this vantage point, the attachment relationship is seen as an immature brain being regulated by a mature one. There is no real paradigm shift, just a reading in biological terms as opposed to psychological. Within the attachment relationship (regulation of the infant's affect by an attuned mother), the infant (immature brain) uses its primary caregiver (mature brain) to organise its own process (learns to self-regulate). Attachment can be redefined as the interactive regulation of emotions (Schorre, 1996), and the internal working models as encoded strategies of affect-regulation that operate at a non-conscious level. As the brain is experience-dependent, early interpersonal affective experiences directly influence the maturation of the early brain's developing regulatory system. 'From a basic biological perspective, the child's neuronal system is shaped by the parent's more mature brain. The attunement of emotional states provides the joining that is essential for the developing brain to acquire the capacity to organize itself more autonomously as the child matures' (Siegel, 1999, p.278). Emotions initially regulated by others become increasingly self-regulated as a result of neurophysiological development.

Neurobiologically, as well as psychologically, the most vital and influential experience is that which occurs, for better or for worse, in the context of attachment relationships. These transactional models of mother-infant relations highlight the considerable co-regulation that takes place between mother and baby, and point to the need to work with both mother and infant to address

issues of infant development as well as maternal mental health.

2.2. Parent-infant psychotherapy (PIP)

PIP is underpinned by these transactional models. It is mainly rooted in psychoanalytical theories, but has also been enriched by other perspectives. Various models have been developed and researched with overall positive outcomes (Robert-Tissot et al, 1996; Cohen et al, 1999; Fonagy, Sadie & Allison, 2002). Despite some theoretical and clinical differences, key common factors have been identified, such as the physical presence of the parent(s) and the infant and the focus on the relationship (Barlow, 2007).

2.2.1. Historical and theoretical perspectives

In Europe, World War II brought about the disruption of many parent-infant relationships. This had dramatic observable consequences on children and led to the emergence of innovative theoretical thinking and clinical interventions. In the 1940s, René Spitz highlighted the need for early psychoanalytic intervention for babies that had become depressed after a sudden separation from their mothers. Similarly, Dorothy Burlingham and Anna Freud (1942; 1944) studied the impact that separation had on children in their war nursery. They attempted to involve the parents as much as possible in the care of the infants to reduce the dramatic impact of separation.

In America

Selma Fraiberg, a PIP pioneer, was strongly influenced by Freud and Burlingham's work. Like them, she adapted her thinking and practice to the reality of her clinical population. She worked with 'hard to reach' families who tended not to use child clinics due to a mistrust of health institutions. She and her colleagues recognised the need to adapt their psychoanalytical model and started doing home visits for mothers and their babies, which they called 'psychotherapy in the kitchen,' (1980, p.108). Thus, parent-infant psychotherapy was born. Fraiberg developed an important early theoretical and methodological

approach; she coined the term 'ghosts in the nursery' (1975) to illustrate how unresolved aspects of the parents' past came back, uninvited, into the relationship between parents and infant. The 'ghosts' distorted the mother/baby relationship either because the mother was too preoccupied with her past and therefore unavailable, and/or because it altered her perception and therefore her relationship with her infant.

In France

Serge Lebovici, a pioneer in infant psychiatry, really changed the child mental health field in France. He was interested in the phenomena of transmission and affiliation between generations. He developed the concept of transgenerational mandate; it was based on the idea that each child is unconsciously mandated by its parents to accomplish a mission rooted in the parents' unresolved conflicts with their own parents. This transmission of psychic life through generations could become pathological if the parents' rigid projections denied space for the development of the child's own self. Similar to Fraiberg's 'ghosts in the nursery' (1999), the parents' past came uninvited to the child's present and invaded all the space, seriously affecting the parent-child relationship. For Lebovici, the therapeutic challenge was to create the conditions that would enable the identification of these ghosts; but rather than chasing them away, the object was to negotiate with them in order to humanise them. He would offer two to three long sessions to the parents and their child, aimed at unravelling the unconscious transgenerational mandates.

In Switzerland:

Cramer and Palacio-Espasa developed a model of brief, 12-week, psychodynamic mother-infant psychotherapy (1993), aimed at uncovering the unconscious conflict that the mother brings to her perceptions and interactions with her infant. Theoretically and methodologically similar to PIP, their approach is mainly concerned with the maternal fantasies and projections onto the infant. They saw parents engaging in a process of taking possession of the representation of the unknown, provided by their newborn, through the projective identification they passed on their infant. They viewed this process as

a means by which mothers ended to delegate aspects of their own psyches to their child.

For Cramer and Palacio-Espaca, the crux of the brief mother-infant psychotherapy consisted of identifying and elaborating these diverse fantasies and projections. It is different from Lebovici and Fraiberg's model in terms of length and intensity (12 weekly sessions instead of 12 months' treatment), and in its sole focus on mothers.

In the UK

The schism in the psychoanalytical world, brought about by the famous Anna Freud-Melanie Klein controversy (1941-1945), has left its mark on the current psychoanalytic landscape.

At the Tavistock, centre, Daws and the post-Kleinian school (1989; 1999) based their thinking on Bion's theory of containment (1962): namely that the parent-infant-therapist group is a collective psychic apparatus that is susceptible to contain, digest and transform the infant psychic productions. This capacity for reverie, normally assumed by the mother, is here assumed by a group-object. Within a non-directive approach, a conversation takes place that allows the emergence of parents' fantasies and representations of their child's symptoms. The child's communication through its behaviours, play and interactions with its parents and the psychotherapist, combined with the 'free associative conversation' (Watillon, 1993) with the parents, are at the heart of the psychotherapeutic process. Here the child is perceived as an active partner in the psychotherapeutic encounter.

The PIP model developed at the Anna Freud Centre (Baradon et al, 2005) has a fundamentally psychoanalytical underpinning and stresses the centrality of unconscious processes in mental and relational life. Disturbance in parental functioning is seen as resulting from unconscious processes that contribute to intergenerational repetitions, in which the parent-infant relationship is invaded by repressed pain from the parent's past (Fraiberg's 'ghosts in the nursery'). The psychotherapist is used as a new object that helps the parents develop more

benevolent representations and ways of being with the baby. The psychotherapist emphasises parental strengths, building the parents' observing ego and mentalising capacity, which helps the parents see the baby as both separate and dependent, by observing and thinking about the baby together. Within this model, the baby is both a partner in the process and a patient in its own right. The therapist imagines and verbalises what may be happening in the baby's mind. At a deeper level, the psychotherapist also formulates interpretative possibilities relating to the mother's difficulties. The idea is to stimulate the parents to think about how their pasts might be impacting on their experience of parenthood. Parents are helped to understand and change their ways of relating to their infant.

2.2.2. PIP and parental reflective functioning

Reflective functioning is 'the capacity to make sense of one's own and others' behaviours in terms of mental states such as feelings, thoughts, desires' (Fonagy & Target, 1997). This capacity is born and shaped within the parent-infant relationship and depends on the parents' own capacity to identify, name and regulate emotions and to attune and adequately respond to the child's physical and psychological demands (Fonagy, Steele & Steele, 1991).

Fonagy and his colleagues (1991) first identified the importance of reflective functioning (RF) in a study that used the Adult Attachment Interview and reflective functioning scale to look at parents' attachment style in pregnancy (George, Kaplan & Main, 1985). One year after the birth, the child's attachment relationship with its parents was assessed. Results showed a level of agreement between parents' capacity to reflect on their childhood, their attachment organisation and the child's attachment style, which suggested the caregiver's RF capacity might be key to the intergenerational transmission of a secure pattern of attachment (Fonagy et al, 1991b).

Arietta Slade and her colleagues (2003/2005) developed the Parent Development Interview and the Parent Reflective Functioning (PRF) scale to

assess parents' capacity to reflect on themselves in relation to their children (rather than only on their past relationships with their own parents). In a study on attachment style, Slade, Grienenberg et al. (2005a) found a correlation between high PRF and secure attachment which led them to hypothesise that 'the parent's capacity to reflect upon her own child is the variable that more accurately links adult and infant attachment organisations and better explains the transmission of (in)security of attachment from one generation to the next' (Camino Rivera et al, 2011).

These findings are cardinal as they establish a link between the way a mother thinks about her child and the way she behaves towards him/her, which then shapes the child's attachment organisation. Hence the importance of early interventions to foster RF in parents, which in turn will promote secure attachment.

2.2.3. Concluding thoughts

The diversity of practices raises numerous questions: Who is the client? Where should the focus be? How much of the session should focus on the infant? Is the presence of the baby really useful? Does it make sense to talk about the infant's transference? If so, what kind of transference would it be? Some authors even questioned the use of the term 'transference' for infants, as evidenced by the debate between Cramer and Lebovici published in the *Infant Psychiatry Journal* (1994). Despite these variances and questions, there seems to be a common focus on transmission. As Lebovici pointed out, the parental function consists of the transmission of life, but even more so of the transmission of the capacity to transmit. Similarly, the different approaches to PIP all seem to function at the level of the dynamic transmission of transmission.

In other words, parent-infant psychotherapists are external to the parent-infant dynamic, so do not transmit the content of their psychic elaboration; however, they transmit their capacity for containment, mentalisation and psychic transformation. Parents and their infants can then identify themselves with, and

internalise, the psychotherapist's capacity for psychic functioning. Indeed, the ultimate aim of the session is the transmission of a capacity to transmit. It aims to help parents (re)discover their position vis-à-vis their child in a creative and dynamic fashion. The psychotherapist together with the mother-infant dyad co-constructs a history that is not factual, but which gives existential coherence to the child's suffering and puts it within the perspective of the child's biography and the familial, social and cultural biographies of the group (Golse, 2012).

2.2.4. Towards a unified model of parent-infant psychotherapy

Jane Barlow, C. Bennett and N. Midgley (2013, p.3) articulate the logical model underpinning representational forms of PIP as:

'the changes to the mother's representations (internal working models) will improve the mother's sensitivity and behaviours towards her infant (for example, Lieberman 1991) and make it more possible for her to see the infant as someone with a 'mind of their own'. In other words, the representational changes (internal working model) lead to psychological (maternal sensitivity) and behavioural changes themselves strongly associated with more optimal parent-infant interaction, which is in turn associated with infant attachment security (De Wolff et al. 1997).'

Daniel Stern (1995) offers 'a unified view' of PIP that focuses on the commonalities between the different models. He reduces the clinical situation down to his core elements: an infant, its parent(s) (the client being the mother-infant dyad or the mother-father-infant triad) and a psychotherapist. Each participant is understood to be part of a system that can be approached at different levels (behavioural, representational, dynamic and systemic).

According to Stern, changing any one element will result in a change to all the separate elements. A chain reaction will occur no matter where the first change was made. In other words, psychotherapists can choose to enter the clinical situation at a behavioural, representational, dynamic or systemic level according to their theoretical allegiance; it will still impact the whole system. This can be viewed as utilising different ports of entry into a single dynamically interdependent system, leading to general clinical outcomes (Stern, 1995).

2.3. Maternal and infant mental health research

2.3.1. Maternal mental health and the parent-infant relationship

Maternal ill health impacts the quality of the mother-infant relationship: domestic violence (Lyons-Ruth et al, 2003; 2005), substance misuse (Suchman, 2005; Tronick, 2005), PND (Murray, 2003; Toth, 2006; Timmer, 2011), personality disorders (Crandell, 2003; Pawlby, 2005; 2010; Newman, 2008) and psychotic disorders (Chaffin, 1996) have all been identified as significant factors in the disturbance of the parent-infant relationship. Traumatized women are more prone to postpartum mood disorders and attachment difficulties with their children (Seng et al, 2008). Depression and post-traumatic stress disorder (PTSD) are clearly linked to early abuse (Carlson & Sroufe, 1995; Dubowitz et al, 2001; Hall et al, 1993; Lyons-Ruth et al, 1999; Margolin & Gordis, 2000; Tyler, 2002).

2.3.2. Infant mental health as a predictor of adult mental health

Around 18% of children aged 1.5 years suffer from mental health disorders such as emotional, behavioural and relational disorders (Skovgaard, 2008; Skovgaard, 2010). Infant regulatory difficulties, manifested in crying or problems with feeding, sleeping and bonding, are the principal reasons for referrals to infant mental health clinics (Keren, 2001). Such regulatory disorders are significant predictors of long-term difficulties in emotional, behavioural, cognitive and social/relational development (DiGangi, 2000a, 2000b; Granot, 2001; Sroufe, 2005a, 2005b; Berlin, 2008). Disorganized attachment is a strong predictor of significant later pathology (Green, 2002).

2.3.3. Maternal mental health and its impact on parenting and child development

Maternal psychopathology impacts maternal parenting, which in turn impacts the development of the children being parented (Seifer & Dickstein, 2000), thus in the antenatal and postnatal period (O'Connor et al, 2002). More specifically, maternal depression has many negative effects on the mothering process and the

developmental and behavioural outcomes of children (Carlson & Sroufe, 1995; Coyl et al, 2002; Cummings & Davies, 1994; Gotlib & Goodman, 1999; Zahn-Waxler et al, 1984a; Zahn-Waxler et al, 1984b). Depressive mothers reported less maternal gratification and confidence, had more negative feeding interactions with their infants and were less satisfied with the social support available to them (Panzarine et al, 1995). PTSD, which is interwoven with depression, has also been associated with attachment insecurity (Lyons-Ruth et al, 1999), as well as later behavioural problems (Banyard, 1997; Dubowitz et al, 2001; Lutenbacher, 2002).

Mothers suffering from mental disorders struggle to look after themselves and their children, whose health and development suffer as a result. Their parenting difficulties are manifested in a range of perinatal infant difficulties such as a high rate of infant mortality, preterm delivery, low birth weights well as a range of neurodevelopmental impairments (Olds et al, 1999). They are further manifested in regulating and organising difficulties, often characterised by an abusive, coercive, inconsistent or neglectful parenting style, further resulting in poor emotional, regulatory, and behavioural outcomes across the childhood years (Carlson & Sroufe, 1995; Dickstein et al, 2001; Kaufman & Cicchetti, 1989; Olds et al, 1999).

2.3.4. Disrupted attachment – a major risk factor

Research has found a correlation between parental behaviours and the child's attachment style (De Wolff, 1997). The quality of the attachment between a child and its main caregiver (Bowlby, 1969) is key to the establishment of the child's sense of self and security, its regulatory and relational capacity, self-esteem and autonomy, and even its future parenting capacity (Carlson & Sroufe, 1995; Slade & Aber, 1992).

A child learns to adapt to his parents' relational style and develops a secure or insecure attachment accordingly. Madigan (2006) finds a strong association between anomalous, dissociative or disrupted parenting behaviours and

disorganised attachment at 12 to 18 months; these abnormal parenting practices have been understood as manifestations of unresolved conflicts with regard to parental trauma (Jacobvitz, Hazen & Riggs, 1997; Cicchetti, 2006; 2010). Mothers who have experienced high levels of trauma are more likely to have children who are themselves disorganised in relation to attachment (Hesse & Main, 2000).

Rates of infant disorganisation have been especially high in poor and disadvantaged samples of caregivers and infants, especially in maltreated samples, where rates of insecurity have been estimated at 50-100% (Carlson & Sroufe, 1995; Lyons-Ruth et al, 1999) compared to 30-34% in normative samples. They are also high in children of depressed, affectively disordered and anxious mothers (Carlson & Sroufe, 1995); Insecure attachment organisation in both parent and child is strongly associated with maternal psychopathology such as affective disorders, anxiety disorders, eating disorders, substance abuse, borderline personality disorders and antisocial personality disorders (Dozier et al, 1999).

Insecure attachment in infancy is also highly predictive of later regulatory and behavioural problems; among are them aggressive disorders and childhood depression (Carlson & Sroufe, 1995; Greenberg, 1999). Poor parent-child relationships have also been linked to the development of depression, borderline pathology, dissociation and aggressive, antisocial behaviour in children (Carlson & Sroufe, 1995; Cicchetti & Lynch, 1995). Insecure attachment is a major risk factor predicting emotional, behavioural, and regulatory difficulties.

2.3.5. Mothering psychological processes – a mediator

Infant regulatory difficulties and attachment difficulties are best understood in their relational context; that is the parent-infant relationship. The relationship between parental behaviours and infant attachment seems to be mediated by maternal psychological processes such as attunement (Beebe, 2010), regulation (Schore, 2009), mentalisation (Fonagy, 2002) and mind-mindedness (Meins, 2010). The primary caregiver plays a major role in regulating the infant (Beebe,

1988; Tronick, 1989; Scroufe, 1997; Tronick, 1997), which depends on the caregiver's own self-regulation (Beebe, 2010; Beeghly, 2011). A mother that struggles to regulate, mentalise and organise her own emotional and relational life also struggles to sensitively regulate, mentalise and organise the emotional and relational life of her child. High maternal RF is strongly associated with maternal flexibility and responsiveness towards the infant, whereas low maternal RF is associated with maternal emotional unresponsiveness (Slade, 2001; Slade, 2005; Grienberg, 2005). Carlson & Scroufe (1995) speculate that depressed, traumatised and affectively disordered mothers are unavailable to their children – psychic vacancy that is indistinguishable, from the child's perspective, from a long-term separation or loss.

2.3.6. Maternal representation of the child and her self

A mother's relational engagement with her child is also dependent on the representations she forms about him or her, which may or may not relate to the 'real' child (Lebovici, 1988). These representations start forming before birth, are strongly rooted in a mother's own attachment organisation (Slade et al, 1999; Slade & Cohen, 1996;) and powerfully determine parenting behaviour (Slade et al, 1999), the mother's capacity to see herself as providing a secure base for the child and the child's attachment organisation (George & Solomon, 1996; Zeanah et al, 1995). Several studies have suggested that a parent's representation of the child mediates the link between adult attachment and child outcomes (Slade et al, 1999; Slade et al, 2001), hence infant mental health interventions being directed at changing maternal representations of the child (Lieberman & Zeanah, 1999).

2.4. Early interventions research

Early childhood prevention programme evaluation has been widely reviewed in the past decade (Barnett, 1995; Bryant & Maxwell, 1997; Durlak & Wells, 1997; Hertzman & Wiens, 1996; Karoly et al, 1998; Mrazek & Brown, 2002; St.Pierre, Layzer & Barnes, 1995; Webster-Stratton & Taylor, 2001). The reviews conclude

that evaluations of intervention programmes has been inadequate in terms of coverage (breadth) and quality (depth), especially with regard to programmes for under fives (Mrazek & Brown, 2002; Webster-Stratton & Taylor, 2001). The British Department of Health commissioned a systematic review of the evidence for childhood and adolescent interventions (Fonagy et al, 2000). The results were published in a report (Fonagy et al, 2002) from which the findings presented below (section 2.4.1 through 2.4.4) were extracted. They looked at the effectiveness of preventive interventions by differentiating five types of strategies:

2.4.1. Home visiting interventions

Seven studies evaluated home visiting (Campbell & Ramey, 1995; Gutelius et al, 1972; Jester & Guinagh, 1983; Karnes, Teska & Hodgins, 1970; Levenstein & Sunley, 1968; Powell & Grantham-McGregor, 1989; Ramey & Campbell, 1991; Slaughter, 1983). The results suggest that intensive early home visiting involving parent education and infant stimulation has the potential to prevent cognitive delay and is associated with intelligence, language and academic gain. Comparing across studies, it appears that those programmes spanning the infant's first two years of life, and including at least weekly home visits, were most likely to be effective.

Multi-systemic programmes providing extended support services for children and families from infancy into middle childhood were clearly the most effective. Home visiting and preschool programmes are somewhat more effective than preschool programmes alone, indicating the importance of family involvement. Longer programmes are clearly far more effective than short programmes. All the studies agree that broad, intensive, early, long-term, culturally appropriate, family-based programmes that are manualised, but fitted to the individual needs of the child, and implemented by trained and supervised staff are highly likely to prevent cognitive delay in socially disadvantaged children. However, interventions where there is significant psychological disturbance on the part of the parent are effective less frequently.

2.4.2. Relation-based early family interventions

'Relation based family interventions are amongst the most effective early interventions, which underscores the importance of the family for child development (...) and belies behaviour genetics based critiques of the traditional assumption that parents have a profound impact on the personality of their child (Baruch, Fonagy & Robins, 2006, p.43). A good example of this type of intervention is the University of California Los Angeles (UCLA) Family Development Project (Heinicke & Ponce, 1999), whose mission is to enhance the capacity of family members to support each other and effectively recognise and meet the needs of their infant. The comprehensive approach includes pre- and postnatal health care, weekly home visits for the first two years, weekly mother-infant groups, developmental assessment at the one- and two-year points and psychiatric diagnosis and treatment services available as and when they are needed.

'The provision of a trustworthy relationship is assumed to improve the mother's functioning, and her relationship with her family of origin, partner, and her child...There were multiple benefits to a group of high-risk mothers randomized to the programme: increased support from the family of origin, less coercion in disciplining, higher prevalence of attachment security in the child, greater autonomy in problem-solving tasks. In particular, the most pernicious category (disorganised attachment) is reduced by almost two thirds (Heinicke et al., 1999; Heinicke et al., 2000). There were further benefits at two years in terms of the mothers' sensitivity, support of the child's autonomy and task involvement as well as the child's attachment security and task orientation (Heinicke, Fineman, Ponce, & Guthrie, 2001). Evidence suggests that for relation-based preventative intervention to be effective, multiple systems that interface with the family need to be engaged.'

(Baruch, Fonagy & Robins, 2006, p.44).

2.4.3. Attachment-based interventions

Since insecure attachment is a risk and a potential mediating factor (Solomon & George, 1999), and since adverse outcomes are seldom associated with secure attachment, secure attachment has been identified as a possible protective mechanism and therefore a legitimate conceptual framework for organising preventive intervention (Baruch et al. 2006). Depressed parents can be assisted

to become more sensitive and less intrusive with their infant (Malphurset al, 1996). Improved maternal sensitivity appears to lead to secure attachment (Van den Boom, 1994; 1995).

Programmes targeting mothers with depression have been shown to impact early attachment relationships (Cicchetti, Toth & Rogosch, 1999). The Mt. Hope Family Center programme at the University of Rochester (Cicchetti, Rogosch & Toth, 2000; Toth et al, 2002) provides corrective emotional experiences for depressed mothers and addresses maternal distortions of the child. Compared to a control group of mothers, the intervention group of depressed mothers showed a reduction in the number of insecurely attached infants as well as infants having a more positive view of the parent and the self (Toth et al, 2002).

Another trial compared three brief interventions, all of which aim to prevent the adverse consequences of maternal depression: a cognitive behavioural intervention, a psychodynamic psychotherapeutic protocol and non-directive counselling (Cooper et al, 2003). Interestingly, at 4.5 months, all three treatments had a significant impact on maternal mood and on maternal reports of early difficulties in relationships with the infants; counselling gave better infant emotional and behaviour ratings and more sensitive early mother-infant interactions; only psychodynamic therapy significantly reduced depression (Murray et al, 2003). The benefit of treatment was no longer apparent by nine months postpartum, with no significant difference from the control group on maternal management of the infant, infant-mother attachment security. By the age of five, there was no advantage over the control group in any of the children's emotional, cognitive or social outcomes. The conclusion is that early intervention only has short-term benefits to maternal and infant mental health and the mother-infant relationship. McLennan & Offord (2002) suggest that more prolonged intervention may be needed for more lasting effects and/or that postpartum depression may not be an efficient target for improving child mental health. Baruch et al (2006) favour another hypothesis which sees the insufficient involvement of the infant in the therapeutic protocol as the reason for the absence of long-term benefits.

Kranenberg's (2003) review of 70 attachment interventions, including PIP, video-interaction guidance and social support, showed that the most effective interventions used a moderate number of sessions and a clear-cut behavioural focus in families. 'Interventions that were more effective in enhancing parental sensitivity were also more effective in enhancing attachment security, which supports the notion of a causal role of sensitivity in shaping attachment' (Barlow, 2014). It suggests that an integrative approach to PIP would increase its efficiency and that long-term treatment might not be necessary (Robert-Tissot et al, 1996; Cohen et al, 2002).

2.4.4. Relationship psychotherapies

There is a large range of relationship therapies. Some focus on (1) the intrapsychic world of the parent and how it impacts the parent-infant relationship (Cramer & Palacio-Espasa, 1993; Fraiberg, 1980; Fraiberg, Adelson & Shapiro, 1975; Lebovici, 1988), (2) the interactions between the internal and external world with some consideration for real stressors (Fraiberg, 1980; Lieberman & Pawl, 1993); (3) the inter-subjectivity of the parent-infant/infant-parent relationship and its contribution to the child's mental health (Lieberman, 1991; 1998; Lieberman, Silverman & Pawl, 2000) with the parents' strengths as a foundation for the development of positive parenting practices (McDonough, 2000a). Each approach uses different strategies to generate emotional, representational and relational change.

Although there are few evaluations of the effectiveness of these interventions, there is a growing body of evidence on the effectiveness of PIP (Cramer et al, 1990; Robert-Tissot et al, 1996) both in improving parental functioning (Cohen et al, 1999; 2002) and in fostering secure attachment relationships in young children (Toth et al, 2006), with enduring improvement over the three years following treatment (Fonagy, Sadie & Allison, 2002). Some studies suggest that different forms of PIP may be differentially effective for parents with different types of attachment insecurity (Bakermans-Kranenberg, Juffer & van Ijzendoorn, 1998).

2.4.4.1. Review of PIP research

To date, and to the best of my knowledge, there has only been one thematic summary of the evidence for PIP's effectiveness (Sleed & Blank, 2007) and three systematic reviews (Singleton, 2004; Bakermans-Kranenburg, 2003; Poobalan et al, 2007), all of which suggest promising results. However, these reviews included studies with high levels of heterogeneity, both in terms of the intervention/s being tested and the design of the evaluations themselves.

Overall, the treatment outcomes were positive for the children (with some symptom reduction) and the mothers (increased self-esteem and decreased negative affect towards the child), leading to improvements in the mother-child relationship (Lieberman, Weston & Pawl 1991; Fonagy, Sadie & Allison, 2002; Robert-Tissot et al, 1996).

The findings also revealed that greater levels of parental engagement in the therapeutic process resulted in better outcomes (Lieberman, Weston & Pawl, 1991). For instance, in programmes such as Watch, Wait and Wonder, when mothers were actively involved and had support in fostering their positive mothering capacities (Muir, 1992), outcome assessments showed higher levels of satisfaction and competence and lower levels of depression for the mother. In addition, there was a greater increase in emotional regulation and cognitive development for the child, and a greater shift toward more secure attachment strategies than with psychodynamic PIP (Cohen et al, 1999). The results seem to indicate a link between maternal engagement, maternal satisfaction and the child's improvement.

Overall, families were positive about their therapeutic experience and had less concerns about their children by the end of the treatment (Fonagy, Sadie & Allison, 2002).

2.4.4.2. Systematic review of PIP efficiency

Only one systematic review (Barlow et al, 2015) assessed PIP's efficiency in its uniqueness by examining randomised control trials (RCTs) comparing PIP with either a control group or another type of perinatal intervention.

When compared to control groups (Cicchetti, Toth & Rogosch 1999; Cooper et al, 2003; Lieberman et al, 1999; Salomonsson and Sandell, 2011; Sled, Baradon & Fonagy, 2013), PIP showed significant improvement in the proportion of securely attached children, and significantly fewer children with disorganised attachment post-intervention. More infants were secure pre- and remained secure post-intervention compared with the control group. More children were insecure pre- and post-intervention in the control group. However, there was no significant post-intervention difference between PIP and control groups in studies measuring maternal depression, maternal sensitivity, maternal positive engagement or an impact on child behaviour and/or cognitive development.

When compared to alternative treatments (Cohen et al, 1999; Robert-Tissot et al, 1996; Cicchetti et al, 2006; Sled, Baradon & Fonagy, 2013), the meta-analysis showed no significant differences in outcome between PIP and alternative treatment interventions in terms of parent mental health (depression), parent-infant interaction (maternal sensitivity), infant attachment category (secure, avoidant, resistant, disorganised) or attachment change (insecure to secure; stable insecure).

While these comparative studies suggest that PIP is effective for infant attachment security rather than maternal and relational outcomes, clinical outcomes studies have shown that PIPs can be effective in alleviating maternal and infant mental health issues and developmental problems, and in improving the quality of the parent-infant relationship. The results of Barlow et al.'s systematic review (2015) provided no evidence of an effect; however, this may simply be due the limited number of studies reviewed as well as some quality issues (Barlow, 2014), and does not confirm a zero effect. The heterogeneous

results might be due to the heterogeneity of the populations and interventions evaluated and the variety of study designs, including non-RCT.

2.4.4.3. Qualitative approach to PIP research

The literature on PIP studies is mainly outcomes-based, designed within a positivist model where psychotherapy outcomes are objective and measurable. The focus is very much on the mental health of the parent and child, and the quality of their interactions. However, there is an absence of qualitative studies exploring therapists' and clients' experience of parent-infant therapeutic interventions.

To the best of my knowledge, to date there has been only one piece of qualitative research exploring clients' views on PIP (Barlow, 2007). Its objectives were to explore parents' perspectives on the value of PIP for themselves and their babies, and to establish which aspects of the psychotherapy and psychotherapist they found more or less helpful. Results showed that parents perceived the service to be unique and that it fulfilled an important function (prevented client's breakdown or helped restore feelings of sanity, provided a safe place to explore feelings and resolved hitherto unconscious conflicts). Many felt that the service had a significant impact on their own functioning (such as gaining a sense of confidence about the future and in their mothering capacity, helping them be different from their own parents, recognising achievements as well as accepting struggles) as well as on their relationship with their partner (better understanding and mutual support) and baby (fewer distortions and improved attunement, mentalisation and playfulness). Parents felt that the presence of the infant during the session was a good opportunity for the therapist to see and gain insight into their interactions, which ultimately helped build and reinforce the bond between mother and baby. Although some women found the experience challenging, overall they found it less daunting to have their baby present in the session than to come alone. Some parents (10%) reported difficulties regarding their relationship with the psychotherapist (lack of chemistry, clash of personality) and felt ambivalent about the psychotherapeutic

process (being too distant and psychotherapist-led, lack of cooperativeness and mutuality). Yet despite some relational difficulties, they could still acknowledge the therapeutic benefits of the treatment.

Barlow concluded that parental perceptions of PIP seem to support its efficacy yet it may not be suitable for all mother-infant dyads. According to their history and personality, some mothers appear to benefit most from behavioural approaches whereas others feel more comfortable with a representational approach, or a combination of the two (Bakermans et al, 1998).

Together, the results of quantitative and qualitative studies seem to converge towards a need for greater attention to the mother's experience, her representation of herself as a mother and as a PIP client and how it impacts the therapeutic process and outcomes. It would also facilitate the process by which women identify a means of support that is most suited to them and their needs.

2.5. The importance of the client's view in counselling psychology and psychotherapy

Clients have been identified as an important area of focus in developing an understanding of the psychotherapy process and outcomes. However, much research has been developed from a scientific psychological perspective that psychological events are quantifiable and measurable. As a result, the client's perspective tends to be examined as a client variable rather than a client's view, limiting greatly what can emerge from it.

Such domination of the natural model of science in counselling psychology and psychotherapy research can be explained by researchers' desire/need to prove the efficacy of psychotherapy and to lend scientific credibility to the practice (Saunders, 1993), each school trying to establish its supremacy over others. Researchers' internal sense of pressure to claim objectivity echoes strong institutional pressures to follow the assumptions and practices of natural science (McLeod, 1990). This is based on political and financial imperative to provide

evidence for the efficacy and efficiency of psychotherapeutic treatments offered within the public sector.

However, the relevance of the scientific method has been questioned as it deals poorly with the subjective meaning of the psychotherapeutic encounter (Frank & Frank, 1991; Richardson, 1996). The relational turn in psychotherapy has led to the acknowledgement of the importance of the therapeutic relationship defined by mutuality, reciprocity and co-regulation (Beebe & Lachmann, 1998). In other words, the client is a partner within the psychotherapeutic encounter. His or her personal beliefs and perspectives about the therapy will impact his/her way of experiencing and making sense of it (Wampold, 2001).

From a phenomenological perspective, the therapeutic experience cannot be objectified. Its meaning cannot be inferred by an external observer; only the participating subjects can express their subjective truth about it. In other words, if psychological phenomena 'cannot be understood apart from the intersubjective context in which they take form' (Atwood & Stolorow, 1984, p.64), it is necessary to ask clients (and therapists) about their experience in order to understand the process of psychotherapy and its outcome (Elliott, 1989; Rennie, 1994; Greenberg, 1986; Stiles, 1993).

The need to hear clients' voices has been acknowledged at an academic and clinical level, but also at a political level. In the UK, the NHS has developed a patients' charter for mental health services aimed at ensuring that the NHS listens and acts upon people's views and needs.. It is now recognised that if individuals' needs, expectations and wants are not met by a specific treatment or service, they will either fail to comply with the treatment or choose not to make use of that service (Fitzpatrick, 1984). The current economic crisis and tightening of mental health budgets make it even more crucial to justify services on the basis of both clinical effectiveness and user demand.

2.6. The rationale and value of the research project

From a philosophical, theoretical and evidential perspective, it has become clear that clients' contribution to, and therefore their perspective on, their psychotherapy is equal in importance to any other perspective with regard to developing an understanding of psychotherapy processes and outcomes. It is crucial that counselling psychology and psychotherapy services listen to their clients so that the quality of service provision can be improved.

The lone qualitative study of clients' perspectives on PIP supports the intervention in general, but acknowledges the diversity of experience and therefore the possibility that the treatment cannot be universally recommended. In my own experience of practice, it is evident that mothers experience and use the psychotherapeutic framework and encounter differently according to their personalities and difficulties (some bring their babies to individual therapy, some come alone to PIP, some feel relieved by the mother-baby-psychotherapist triad as it gives them a more benign view of the baby, whereas some feel resentful of or persecuted by it).

Barlow (2007) allowed mothers to express their point of view about PIP's importance and usefulness and Kitson (2011) established what was specific about parent-toddler groups compared to other forms of intervention from the mothers' point of view. This research is interested in mothers' subjective experience per se – what they felt, thought and did while undergoing PIP and what impression it left on them even before they assessed its usefulness, value and specificity.

The purpose of this research is therefore to explore mothers' experience of PIP, paying attention to their subjective description and sense-making process. An idiographic perspective will be applied to address 'the wholeness and uniqueness' (Malim et al, 1992) of their experience with the aim of giving a complete and in-depth picture. It is hoped that this study will provide insights into mothers' subjective stories of the therapeutic encounter and how their

expectations, experiences and preferences impact the therapy process and outcomes. By gaining individual insight, insight into the whole can also be achieved (Pringle et al, 2011). Adopting Caldwell's (2008) distinction between 'Theory' with a capital 'T' and theory in a broader sense, the findings of this research can contribute to the theory and practice of PIP by providing an account of it based on clients' experience. Holding together and integrating clients' experience with their own, psychotherapists can expand their understanding of the inter-subjective psychotherapeutic encounter and hopefully adapt their clinical practice accordingly.

2.7. The research question

How do mothers experience PIP?

1. How do mothers experience being referred to PIP?
2. What were mothers' fantasies, wishes, expectations and anticipations about PIP prior to the treatment?
3. How do mothers experience the process of PIP (such as the triadic relationship between mother-infant-psychotherapist and the presence of their infant during the psychotherapy) and what sense do they make of it?
4. How do mothers experience the impact of PIP on them and their relationships and what sense do they make of it?
5. How do mothers reflect on and evaluate their experience of PIP (like/dislike)?
6. What are mothers' preferences in terms of psychotherapeutic treatments, based on their subjective experience?

Chapter 3. Methodology

This methodology chapter aims to transparently demonstrate how my personal and philosophical beliefs have informed my research question and my attempt to answer it: how my theory of knowledge defines the production of knowledge, and how my philosophical beliefs determine the overall methodological research strategy and choice of specific procedures to produce such knowledge. Crotty's research design elements are used to structure this methodology argument (1998).

3.1. What kind of knowledge I aim to create

I aim to create phenomenological knowledge using an interpretative phenomenological approach. I intend to generate knowledge about the mothers' subjective experience of PIP (i.e. their feeling, thoughts and descriptions) as well as the meaning they attach to it within their social and cultural context.

I am interested in the experiential world of the person, which means that I assume the existence of different subjective worlds. I attempt to understand what the world is like for my participants, acknowledging the subjectivity of meaning-making processes for them as well as for myself. I believe that knowledge is inter-subjective and co-constructed.

Phenomenological knowledge is 'knowledge of the quality and texture of the experience itself' (Willig, 2013, p.16). I am interested in the quality and texture of mothers' experience of PIP, but more so in the meaning it has for them.

Phenomenological research lies on a spectrum ranging from descriptive to interpretative. I do not believe that pure description is possible, nor do I take the experience at face value; instead, I seek to 'understand the meaning of an account of experience by stepping outside of the account and reflecting upon its status as an account and its wider (social, cultural, psychological) meanings' (Willig, 2013, p.17). I locate myself towards the interpretative end of the spectrum.

The question of accuracy, understood as a faithful representation of objective truth, is irrelevant in this case as I target the subjective experience of the subject and the co-construction of the meaning-making process between that participants and the researcher. However, the experience related by the participants during the interview is accurate to the subjective truth of the subject. The account is co-constructed during the interview by both participant and researcher. It is a jointly and simultaneously co-constructed, accurate account that later evolves separately for the participant and the researcher. Its existence remains in the mind of the participant outside the research process; but in the mind of the researcher engaging in the latter stage of the research process, it becomes open to further analysis, questioning and interpretation. This interpretative approach has some implications for the evaluation process, which will be explored in a later section.

3.2. My epistemological and ontological assumptions

I am aware that my assumptions about reality and knowledge have influenced this research project, from the choice of question to construction of the findings. These assumptions are encapsulated in Heron & Reason's participatory worldview, which comprises a subjective-objective ontology and necessitates an extended epistemology (1997).

The dialectic subjective-objective ontology is a compromise between empiricism and its postmodern critics; an attempt to hold the complexity and ambiguity of reality. While the objectivist sees a world of things independent of human thought and the relativist asserts that there is nothing but the constructions of the human mind:

'a participative worldview accepts that there is a given cosmos, a primordial reality, and that human presence actively participates with it. Mind and the given cosmos are engaged in a co-creative dance, so that what emerges as reality is the fruit of an interaction of the given cosmos and the way mind engages with it. Mind actively participates in the cosmos, and it is through this active participation that we meet what is Other.'

(Reason, 1988, p.4).

This quote exhorts us to acknowledge that our mind participates in the construction of reality (Berman, 1981). Skolimowski (1994) termed this the 'participatory mind', which both moulds and encounters reality. People interact with the world around them and create their own meaning. Thus a researcher 'attempts to understand phenomena through accessing the meanings the participants assign to them' (Orlikowski & Baroudi, 1991, p.5).

I believe that truth emerges from and in a community of inquirers (Pierce, 1933). 'Since none of us can entirely escape the confines of our personal perspective, our view of truth is necessarily partial, but conversation can increase our access to the whole' (p.61). Orange (1985) calls such inter-subjective perspectivism 'perspectival realism'. Applying this epistemological position to the research process means that research can only provide access to the subjective organisation of experience, understood in an inter-subjective context (Stolorow et al, 1987, Orange, Atwood and Stolorow 1997, Stolorow, Atwood and Orange, 2002). The researcher can use three different, yet inter-related, ways of knowing to make sense of participants' subjective organisation of experience:

'(a) existential or experiential knowing which focuses on the subjective experience of the participant and includes notions such as empathy, phenomenological understanding and so forth; (b) contextual or interpersonal knowing which refers to the knowing of self and other within an inter-subjectively constructed, dyadic relationship; and (c) textual or narrative knowing which encompasses knowing the other in such a way as to confer a sense of meaningful coherent order.'

(Downing, 2000, p182).

3.3. My role as a researcher

Weber claims that any social research can only be biased; objectivity and neutrality are unachievable since the values of the participants and the researcher are always present (Holloway, 1997). The research-participant co-construction of knowledge happens within the particular conceptual framework of the researcher, whose role is therefore pivotal.

As a researcher, I believe I contribute to the construction of meaning throughout the research process. I want to acknowledge the impossibility of remaining outside of my subject, and I want to make my contribution as transparent as possible by openly exploring, throughout the research process, how my being and my beliefs have influenced my engagement with this project and how my particular involvement with this subject 'influences, acts upon and informs' (Nightingale & Cromby, 1999, p.228) this research.

3.4. My reflexive stance

Like Holloway (1997) and Charmaz (2006), I believe that interpretative research needs to be reflexive. The researcher influences the research both as a thinker/theorist (epistemological reflexivity) and as a person (personal reflexivity) (Willig, 2013, p.25).

Epistemological and personal reflexivity acknowledge my conceptual and personal biases and how my own reactions to the research context and data actually enabled certain insights and understanding. The purpose of this reflexivity is 'not in order to suspend subjectivity, but to use the research personal interpretative framework consciously as the basis for developing new understandings' (Levy, 2003, p. 94).

'Researchers need to bring a critical self-awareness of their subjectivity, vested interests, predilections and assumptions and to be conscious of how these might impact on the research process and findings' (Finlay, 2008, p.17). I placed my subjectivity at the centre of the research process, as knowledge in the human sciences always involves some self-knowledge (Gadamer, 1996). In this context, reflexivity became a 'process of continually reflecting upon both our interpretations of our experience and the phenomena being studied so as to move beyond the partiality of our previous understanding' (Finlay, 2003, p.108).

For instance, working as a psychotherapist – attempting to make sense of my patients' stories, reflecting upon their meaning-making process, digesting it and

returning something to them that makes sense and is digestible – has been very useful in this research process. I felt I approached the data like a psychotherapy session: the participant, like a client, is telling me a story, which I try to make sense of using my own personal and theoretical tools. Reflexivity has much in common with counter-transference (Willig, 2009), whereby I reflect upon and use my subjective reaction to the research process and content in order to inform my understanding of it.

Reflexivity has been central at every stage of the research process as well as at all levels: at the micro level of the narrative and empirical materials and at the macro level of the underlying interpretations (Alvesson & Skoldberg, 2009).

3.5. My philosophical stance

‘Without theory there is nothing to research’ (Silverman, 1993, p.1). The theories I hold as a researcher have determined the way I construct my research questions and a response to them.

3.5.1. Phenomenology

Being the patient of a Kleinian psychoanalyst for several years left me frustrated with her authoritarian interpretist approach. I felt my voice had no weight, and the meaning I attached to my experience was systematically overruled by her interpretation. It shaped my determination to listen and make sense of my patients’/participants’ experience in a way that acknowledges their subjectivity.

‘Phenomenology is a philosophical approach to the study of experience’ (Smith et al, 2009, p.11), which focuses on how human beings live and experience their subjective world. It is concerned with existential issues inherent to our human condition, which continental philosophers such as Heidegger (1927-1962), Merleau-Ponty (1942-1965) and Sartre (1943-1969) have described and referred to as ‘lifeworld’. It aims to capture lived experience and produce rich descriptions.

Applying the phenomenological approach to my work as a psychotherapist and a researcher gave me the opportunity to give a voice to my clients and participants and to explore and make sense of their lifeworld from their subjective perspective.

Although Husserl's *transcendental phenomenology* describes the essence of the observed phenomenon, free from the observer's biases (1931), Heidegger's *interpretative phenomenology*, in the hermeneutic tradition, acknowledges the perceiver's impact on the description and argues that all description constitutes a form of interpretation (Willig, 2009).

Applying this interpretative phenomenological approach to study mothers' experience of PIP allowed me to focus on their lived experience and the meaning they attached to it, using their subjectivity and my subjectivity as sources of richness.

3.5.2. Hermeneutics

Hermeneutics, or the science of interpretation, was first directed at religious writing but most recently has been perceived as 'a general human endeavour whereby interpretation happens whenever we try to understand spoken or written language or indeed any human acts' (Willig, 2009, p.40).

As a psychotherapist and as a researcher, I am interested in creating new meaning through interpretation by bringing to light that aspects of my own and others' experience that are not immediately accessible, but which render our understanding deeper.

Ricoeur (1970; 1996) made the distinction between interpretation driven by empathy, which aims to better understand the inside perspective of the subject, and interpretation driven by suspicion, which aims to uncover some hidden truth. I tried to balance the tension between empathetic and suspicious

interpretation throughout the research process, as I believe both have something to offer.

I used empathetic interpretation to develop an understanding from within participants' perspectives; exploring, expanding and collecting meaning from the participants' account of their experience. Suspicious interpretation questions manifest contents from the perspective of some theoretical framework; I made my conceptual framework transparent at each stage of the research process in order to render explicit the underlying processes and structures used to access presupposed latent meaning.

Since I have experience of what it feels like to be with someone who believes he/she owns the truth, I aspire to hold my beliefs/truth lightly, acknowledging my lens as one amongst many possible lenses, and by collaboratively co-constructed meaning emerging out of a dialogical encounter.

3.5.3. Idiography

My interest in psychology originally arose from a nomothetic concern. I needed to understand the human race so I could be part of it. However, the past ten years of my clinical experience have returned me to an idiographic perspective. Having learnt general theories about human beings and their psychological processes, I was forced to realise that one's subjectivity can never be reduced to those general principles. I have been astonished by individuals' uniqueness, which I am curious about and pay attention to.

'Idiography is concerned with the particular' (Smith et al, 2009, p.29) which is different from being concerned with the individual per se. It focuses on individuals' unique way of experiencing a specific phenomenon and making sense of it according to his or her subjective perspective and context. This is precisely what interests me in exploring mothers' experience of PIP: to understand how mothers' unique perspective and engagement with PIP impacts its process and outcomes.

3.6. Methodology: Interpretative Phenomenological Analysis

'Methodology is a general approach to studying research topics' (Silverman, 1993, p.1). It is the 'strategy, plan of action, process or design' underlying the choice and use of particular research methods (Crotty, 1983, p.3). My personal interests and philosophical beliefs underpin my methodological choice.

I chose a qualitative (as opposed to quantitative) approach for two reasons. Firstly, because the approach is more conducive to descriptions than explanations, aiming to develop insights and understandings rather than seeking causes and effects (Willig, 2008). This corresponds with my interest in mothers' subjective experiences and lack of testable hypothesis or predictions for the results. Secondly, research in this area to date has been predominantly quantitative, disregarding mothers' subjective experience of the psychotherapeutic intervention ((Lieberman, Weston & Pawl, 1991; Fonagy, Sadie & Allison, 2002; Robert-Tissot et al, 1996; Cohen et al, 2002). It felt particularly important to give mothers an opportunity to be heard, given the importance of mothers' engagement for psychotherapy outcomes.

Several qualitative research methods were considered and rejected before settling on interpretative phenomenological analysis (IPA). For example, grounded theory methodology aims to produce theories grounded in data and assumes the existence of an objective reality (Glaser & Strauss, 1967). Although Charmaz (2006) brought a social constructivist perspective to it by acknowledging the role of the researcher who constructs the theory, still, subjectivity was to be set aside in doing so. Although I am interested in understanding the interplay of the participants' subjectivity and their experience of the psychotherapy process and outcomes, I do not aim, nor believe that it is possible, to construct an objective and explanatory theory about it. The understanding I aim for is a descriptive understanding of the participants' subjective perspective and how that impacts their meaning-making process, thus acknowledging and using our inter-subjectivity to inform this understanding.

One-dimensional phenomenological approaches were also considered in order to envisage the constructive process of descriptive knowledge. However, they were rejected because they call for the bracketing of the researcher's subjectivity in the knowledge construction process, which I believe is neither possible nor desirable (Nightingale & Cromby, 1999).

IPA (Smith et al, 2009) seemed most appropriate because it is concerned with understanding the participant's psychological (phenomenological) world via in-depth case-by-case analysis of transcripts, with the aim of gaining an 'insider's perspectives' (Conrad, 1987).

'Understanding' in IPA refers both to empathising with the participants' accounts and to making sense of them. To do this, the researcher needs to interpret the participant's account (interpretative) via analysis of the transcripts in an attempt to access not only what is said, but also underlying thoughts and feelings which may not be reflected in their words, and which may be more difficult to articulate (Smith & Osbon, 2003). In turn, interpretation of a participant's underlying thoughts and emotions is dependent upon the researcher's own experiences and preconceptions. Thus, a two-stage interpretation process or 'double hermeneutic' is involved (Smith & Osbon, 2003, p.53) in which meaning is always co-constructed by the participant and the researcher (Larkin et al, 2006). This, the findings of this research would necessarily be different if undertaken by a different researcher.

Other key aspects of IPA are that it is inductive and idiographic (Smith et al, 2009). IPA is inductive in the way it seeks to build up knowledge, which fits well with this project's aims. Being idiographic refers to IPA's commitment to the particular, firstly in terms of the details and depth of the analysis and secondly in the way it accounts for how context affects people's experience. It also refers to the process of analysing one case in detail before moving on to another, and eventually performing a cross-case analysis (Smith et al, 2009). Finally, IPA contributes to psychological literature by linking findings to existing research and literature. Indeed, Larkin et al (2006) proposed that a principle aim of IPA is

to 'develop a more overtly interpretative analysis which positions the initial description in relation to a wider social, cultural and perhaps even theoretical context' (p.104).

IPA, like any other phenomenological methodology, relies on 'the representational validity of language' (Willig, 2009, p.94). This is of course questionable, especially in the current sample in which five out of the seven participants do not speak English as their first language. It has been argued that language constructs reality, as it precedes and therefore shapes experience (Potter & Wetherell, 1987). This research is limited indeed by its non-consideration of the constitutive role of language in how and what participants share in a research interview. Although a discursive methodology was originally considered, it was rejected for its disregard for the participants' and researcher's subjectivity (Langdridge, 2004; Burr, 2002; Butt & Langdridge, 2003). With the centrality of subjectivity to this study, I felt the limitations of IPA were more acceptable.

3.7. Methods

Having established the principles that guide this research, I will now present the techniques or processes used to conduct this project.

3.7.1. Recruitment of participants

Following the favourable ethical opinion of the NHS National Research Ethics Service (NRES) committee, the participants were recruited at an NHS family clinic offering group PIP to women and their babies. The clinic worked in partnership with a perinatal psychiatry service, based on the relevant NHS trust's integrated model for liaison perinatal psychiatry services. The perinatal psychiatry service received referrals from general practitioners (GPs), midwives, obstetricians, neonatologists and other psychiatry services. Once accepted, the patients received a package of care, including a full assessment distributed during pregnancy, delivery and puerperium, coupled with liaison with the

relevant psychiatric services and agencies. The women assessed as suitable for psychological interventions were offered CBT and/or were referred to the NHS clinic offering PIP. The perinatal psychiatry service and family clinic worked in close partnership to offer a comprehensive package of care to meet the needs of mothers, their infants and their families. This model acknowledges the inter-relatedness and inter-subjectivity of the dyad.

The PIP group was run by a multidisciplinary team comprising a family psychotherapist, a child- and adolescent psychotherapist and a clinical psychologist. Their approach was integrative and systemic. Since it was set up in 2000, the group ran four times per year until the clinic shut down in 2013.

Mothers with a history of, or currently suffering from, depression and/or struggling with relational issues with their babies were referred. Most of the referrals came from the perinatal psychiatry service, but not exclusively. The treatment offered was a course of eight sessions of group PIP, with the possibility of a second course of treatment if necessary. The group, made up of three psychotherapists and up to five or six mothers and their babies, met at the clinic weekly. PIP was a component of the mothers' broader care package, which included psychiatric assessment, possible medical treatment and possible individual treatment pre- and post-PIP. At the end of the PIP treatment, mothers were discharged from the service back to the care of the GP and/or referred to other appropriate services if necessary.

The study's participants were recruited on a voluntary basis. Every mother who had been offered PIP and had started the treatment was invited to participate in my research. That was the only inclusion criterion. Completion of the full eight sessions was not a necessary criterion, as it would create a bias towards those mothers that engaged well with the treatment. Being a native English speaker was not a necessary criterion either as it would have created a biased sample. Interviews were conducted once the mothers had been discharged from the service and had no further involvement with the clinic.

Initially, potential participants were contacted by a designated clinician who acted as a research coordinator at the clinic. He explained the purpose of the study and circulated the information and patient consent forms. Nine women expressed an interest, of whom seven agreed to be interviewed. Of the other two, one could not be contacted and the other felt her schedule would not allow for her participation. Out of seven participants, only two used English as a mother tongue, which is representative of the local population surrounding the clinic. One woman needed an interpreter, but since she had also used an interpreter during her PIP, I decided to include her despite the language barrier. Even though it is unusual to include different language groups within a single research sample, it is very representative of the population accessing psychological therapy services, especially in London. In accordance with the Department of Health's Research Governance Framework for Health and Social Care (2001, paragraph 2.2.7), I intended my research to fully account for the diversity and multicultural nature of society (Allmark, 2004). This imperative arose from a concern that the ethnic and cultural mix of research participants was not representative of the general population (Mason, 2003).

In my daily NHS practice, the majority of my clients are non-native English speakers, with varied levels of language fluency. Being a non-native speaker myself, I have to believe that language barriers can be overcome – that it is possible to understand each other despite our diversity. I used the same rationale to define the inclusion/exclusion criteria of this research sample. Without denying the importance of language on thought formation and communication (Bloom & Keil, 2001; Boroditsky, 2011, Vygotskii, Hanfmann, & Vakar, 2012) I believe that managing the challenges of language diversity, interpretation and communication is part of the day-to-day reality of clinicians working in London. I undertook the same challenge in this research believing that it would enrich the findings. It felt essential to use this research to give a voice to women who are usually underrepresented in research, relative to their presence in NHS services. English was used as the common language with which to think together and build knowledge together (Mercer, 2000). English is neither my mother tongue nor that of most participants, but it is the language of

the country that welcomed us and made this research possible; I believed we could rise to the challenge together.

Likewise, the presence of the child was not an exclusion criterion. Participants could choose whether to bring their child to the interview, and money was offered to cover the cost of childcare if they chose not to. In my clinical work, some women bring their child to individual psychotherapy whereas others choose not to bring the child, even when they are offered PIP. I always adopt the position of welcoming the presence or absence of the child as an intentional (conscious or unconscious) act of communication, which can be thought about and used to facilitate an understanding of the mother-child relationship. I adopted the same position during the interviews, and indeed noticed that those who brought their children were very proud of their progress during PIP and wanted me to see it.

Table 1. provides anonymised information regarding the participants. It shows that all the mothers had been referred by the perinatal psychiatrist service; they had received individual treatment there before being referred to the group PIP. Once the referral was accepted, every mother was visited at home by a psychotherapist who built a therapeutic alliance prior to the group.

Table 1. Participant Characteristics

Name (changed to preserve anonymity)	Age	Nationality	Number of groups attended	Referred by perinatal psychiatry service?	Home visit prior to PIP?
Asa	32	Iranian	2	Yes	Yes
Maya	41	Nepalese	2	Yes	Yes
Maria	42	Spanish	2	Yes	Yes
Rose	27	English	1	Yes	Yes
Lilly	40	English	1	Yes	Yes
Bindhy	33	Bengali	2	Yes	Yes
Bav	37	Indian	2	Yes	Yes

3.7.1.1. A multicultural research sample

Working with clients from different ethnic and cultural backgrounds opened my eyes to the importance of acknowledging people's experiences as socially constructed and culturally situated. Factors such as race, ethnicity, gender and economic status are significant markers for cultural difference that impact how women experience both motherhood (Johnson & Ferguson, 1990) and psychotherapy (McNamee & Gergen, 1992). Racial and ethnic minorities tend to receive a lower quality of medical care (Egede, 2006) associated with worse health outcomes (Stith, 2002). Such disparities in access, use and quality of care are highly problematic in the mental health care field as well (McGuire & Miranda, 2008), although the patterns of disparity differ between physical and mental health.

In general, minorities have poorer physical health and health outcomes than do white people (Williams, 2005), although the effect of race/ethnicity on health outcomes diminishes significantly when controlling for socioeconomic position (Williams, 1996). On the other hand, minorities have either equivalent or lower rates of mental disorders when compared with white people (Breslau et al, 2004; 2005) and therefore equivalent needs; the disparities appear more in terms of access to and quality of care, and in mental health outcomes.

Although minorities don't seem to suffer from higher disorder rates, psychological symptoms do tend to be worse among minorities and the poor (US Department of Health and Human Services, 2001). For instance, black Americans were found to have lower rates of lifetime major depression but were more likely to rate their depression as very severe and disabling (Williams et al, 2007). Poor women in ethnic minorities tend to suffer higher rates of maternal depressive symptoms, poorer functioning and worse mental health (Miranda et al, 1999), but are less likely to perceive a need for depression care than are their similarly poor white counterparts (Nadeem et al, 2004). How individuals experience their symptoms is of great importance as it impacts their functioning and, in the case of mothers, the functioning of their offspring.

Hearing the voices of mothers from different cultural backgrounds is crucial to developing a better understanding of PIP as a relational, dynamic and context-dependent intervention. Feminists have fought to develop a 'women's psychology' to counter the dominance of male attitudes underpinning mainstream psychological theory – an alternative framework in which the understanding of women's key phenomena, such as motherhood, is derived from women's subjective experiences. However, there is a concern that this emerging field is based on white, western, middle-class women, imposing a different hegemony while failing to address the full breadth of women's experience (Gawelek & Rodriguez-Nogues, 1981; Brown & Ballou, 1993). The sample used in this research gives a voice to women in a patriarchal society and, moreover, to women of colour in a context of white hegemony.

3.7.2. Ethical considerations

This study was granted ethical approval by Metanoia Institute and Middlesex University as well as by the research ethics committee/NHS Health Research Authority. It was conducted in accordance with the principles for research provided by the British Psychological Society (2010), which led to a number of ethical considerations.

Participant specificity: PIP is a treatment for mothers and babies under two years old, which meant that the participants were mothers with young children. Childcare issues and interview site appropriateness therefore had to be considered. The information sheet described the interview procedures including the option to be interviewed in the participant's own home or in my practice (which was in the same borough). As I offer PIP in my private practice, I had appropriate toys, mat and facilities for mothers and babies. The information sheet also mentioned the offer of a ten pound voucher to compensate mothers for their time and possible childcare and/or transports costs. These options and offers were reiterated once mothers had given their verbal consent.

Participant vulnerability: The exploration of participants' experience of PIP evoked painful memories about their struggles prior, during and for some even after the treatment. Mothers shared their complex emotions, painful insights and consuming concerns. Although I was very clear about the distinction between a research interview and a psychotherapy session, I was aware of using my clinical skills to contain mothers' anxiety, guilt and remorse which was brought to the fore by the interview process. I did this in order to guide their exploration to access the richness of their experience, while respecting mothers' defences and psychic organisation, and to offer some interpretations when I felt it would benefit the participants and deepen our co-constructed understanding of their experience.

Although I felt that all participants benefited from the research interview and left contained and able to re-engage with their life, two mothers raised doubts in my mind regarding their vulnerability. The first one had disclosed very painful emotions and thoughts regarding her initial disconnection with her child, her ongoing attachment difficulties and her terrible sense of guilt towards her child (who had turned into a difficult toddler). She feared that her murderous fantasies, her powerful rejection and her wishes to escape had damaged her child, and were the cause of his current emotional dis-regulation. A few hours after the interview, I received a phone call from an unknown number, which went to answerphone. When I listened to the message, all I could hear was a child screaming hysterically and few minutes later, the barely audible voice of a woman who, out of breath, timidly piercing through the screams, asked for help without leaving her name. My heart sunk when I heard the message. I felt overwhelmed by the sense of someone needing help, asking me for help. I quickly realised who it was because of her distinctive accent. I took some time to think and called the number back. The mother knew she had called me and apologised. She explained that she had wanted to call her husband but had dialled the wrong number. Her voice was calm and she seemed controlled. We had a quick conversation where I acknowledged her distress coming through in the message. She agreed and explained that indeed when her child was rageful, she felt lost and helpless. I explored this enactment in supervision, which I

understood as the mother demonstrating her current relational struggle with her child which she had verbally shared in the interview. Although it was very distressing to hear, I felt it was not appropriate to break the research framework and intervene clinically.

The second incident that shook this boundary occurred during an interview with a mother who had disclosed to me how psychotic she had felt following the birth of her child. Although she had tried to disguise the seriousness of her disorder so as not to have her child removed by social services, she realised how dangerous she had been for her child, and how dangerous she had again become having collapsed after the end of the treatment. She felt PIP had saved her life and the life of her child, but only temporarily, as she had failed to internalise the therapeutic work. When the psychotherapy ended, she gradually returned to her previous state of mind where she felt helpless and hopeless, completely isolated and on the edge of breaking down. Throughout the interview, she had disclosed her ambivalence about being helped; the neglected and abused inner child crying out for help and desperately wanting to grab the offer, the defensive adult telling her that she could never rely on anyone, that no one will ever be there for her and therefore it was too unsafe to come out of her defensive, reclusive state. Her ambivalence towards PIP had also coloured our relationship. It took several weeks and numerous emails before we met. During the interview, she told me how desperate she felt to return to PIP, knowing that she and her child were at risk again, yet knowing she would not take any steps towards seeking psychotherapeutic help. She felt the defensive adult had won again, suffocating and silencing the needy inner child.

I felt that she wanted me to worry about her child, yet she threatened to deny everything if I were to contact social services. She wanted me to speak to her past clinical team, even though they had referred her to a different service due to the age of her child. When exploring her experience of ending PIP, she spoke about her anger and inability to forgive the clinic for abandoning her. At that point, I made a conscious decision to intervene therapeutically; I linked her anger with her inability to engage with the current help offered by the NHS, and

her ambivalence regarding any treatment despite her real need for it. I felt I had to respond to her unconscious communication, even though it was outside the purview of the interview per se. I also explored her child protection concerns in supervision. I came to the conclusion that she had mental health professionals currently involved in her care and although her projections had strongly affected me, it was unnecessary to contact social services, nor was it appropriate to speak to the clinical team which would make me a co-conspirator in her wishful fantasy that they could save her again.

These two examples illustrate the ethical delicacy of the research interview process, and the powerful transference and counter-transference movements that further complicate this already complex process. Even though I thought very carefully and made what I believe to be the best decision under the circumstances, I am left with an ethical dilemma regarding the wellbeing of those two women and their children. I do not believe the research process hindered them, but it unravelled their distress and I witnessed it. It now lives in me, in that I am concerned for them and hope that their and their children's mental health is not deteriorating.

Participant consent: Oral consent was obtained before I contacted the participants, and written consent was obtained before the interview. At the beginning of each interview, I explained that consent could be withdrawn at any time and ensured they felt comfortable using that right if need be.

All the participants framed their willingness to participate as an expression of gratitude for the service they had received and their desire to give something back, hoping that it would support the service and enable other women to benefit from it.

The conversation mentioned above involving social services illustrates that consent is not immovable, and might need to be renegotiated. In this case, the mother repeatedly alluded to me possessing powerful information about her and my possible use of it; I had to openly discuss where the limits of her consent

touched the limits of my responsibility to her confidentiality and my ethical responsibility should I feel she or someone else was at risk.

Anonymity and confidentiality: In the participant information sheet, it was clearly stated that the research was part of a doctoral study, which meant that the data collected would be accessible to my supervisors. I could therefore guarantee anonymity by removing any identifiable details, but I could not guarantee total confidentiality. The principles of the limited confidentiality guarantee, and the conditions under which it might have to be breached, were also discussed and agreed upon with each participant.

3.7.3. Gathering data

3.7.3.1. Interview approach

As knowledge is situated and contextual, the purpose of the interview 'is to ensure that the relevant contexts are brought into focus so that situated knowledge can be produced' (Mason, 2002, p.62).

My approach to the qualitative research interview was underpinned by the concept of research as conversation, whereby the interview is an attempt 'to understand the world from the subjects' points of view, to unfold the meaning of their experiences, to uncover their lived world prior to scientific explanations...It is an inter-view, where knowledge is constructed in the interaction between the interviewer and the interviewee' (Kvale & Brinkmann, 2009, p.1).

In accordance with my epistemological and ontological position, I am interested in the participants' lived experience and the meaning they attached to it. Therefore, a researcher-participant co-constructed dialogue seems to be the only meaningful method of generating data. I co-constructed knowledge with semi-structured open interview questions, aimed at obtaining descriptions of mothers' experience of PIP and seeking interpretations of meaning of its central themes. The directedness provided a focus on the mothers' experience of PIP,

while the openness ensured that my opinions did not limit the exploration. I aimed to produce two sorts of knowledge according to classic Greek philosophy: doxa (subjects' experience and opinions) and episteme (knowledge validated through conversational and dialectical questioning) whereby 'interviewing and analysis are intertwined phases of knowledge construction' (Kale & Brinkmann, 2009, p.49). This approach is in line with my epistemological position that conceptualises knowledge emerging from a conversation between persons, being 'neither inside a person nor outside in the world, but existing in the relationship between persons and the world' (p.53).

3.7.3.2. Pilot interview

I conducted a pilot interview with a fellow psychotherapist who had experienced PIP in a different clinic. My aim was to have a sense of myself as a researcher guiding the interview process, find out how my interview questions would be received and if they would generate the data required to answer my research questions.

It was an important learning experience, bringing to the fore certain aspects of the interview process that I had not anticipated, such as how to gently bring someone into this internal space where one can connect and reflect upon one's past experience.

A post-interview discussion also informed my refinement of the interview questions. I rephrased some questions that had been too directive, I eliminated questions that were repetitive, and I added a question aimed at exploring the participant's experience through the lens of someone close to them. I streamlined my interview questions so that each addressed a possible territory within the overall landscape, directive enough to initiate the exploration but open enough to enable each participant to draw it according to her subjective experience.

It enabled me to reflect upon my insecurity as a researcher and how I could free myself by giving myself permission to use my transferable skills and expertise as a clinician, able to explore my patients' stories in a phenomenological and interpretative way.

3.7.3.3. Subsequent interviews

I subsequently conducted seven interviews – one with each study participant. Out of the seven mothers who had agreed to be interviewed, two had been identified by the clinic as needing interpreters. When I contacted them, one declined the offer and said she now felt able to communicate in English. During her interview, it transpired that one of PIP's positive outcomes was that she had learnt English and developed a sense of her own ability to engage with herself, her baby and the world. She felt very proud of coming alone to the interview, not needing anyone to help her express herself.

The other woman's English was sufficient to speak to me over the phone, but she felt she needed an interpreter in the interview and requested I contact her husband to act in that capacity. However, he was reluctant as he feared he would make assumptions about his wife's intentions and would therefore distort her meaning by using his own words rather than hers. I therefore used an interpreter from the company that supplied my NHS practice. It was a frustrating experience as the interpreter was rather incompetent – summarising the participant's responses, losing track of the questions and responses or simply not understanding what the participant was trying to express – to the point of the participant's husband stepping in to explain. Surprisingly, I still found some richness in the data and felt that some of the complexity of the participant's experience had survived the translation process.

Although the interview was planned as an individual interview, five mothers of the seven brought their child(ren). Interestingly, I found a parallel between the content of the interviews and what I was able to observe. It seemed to me that the mothers who brought their children to the interview were the mothers who

felt PIP had enabled them to bond with their child, which they demonstrated during the interview by being attentive, attuned, responsive and warm towards their child. I wondered if they had wanted me to see this and therefore unconsciously decided to bring their child. The two who did not bring their children were the two mothers who reported ongoing attachment difficulties. One showed me pictures of her child, and the other unconsciously had me listen to her child's voice by accidentally calling.

PIP is an intervention where mother and child come to psychotherapy together as a dyad and where conscious and unconscious interactions between mother and baby are identified as important and considered as material for therapeutic work. I felt that the research process mirrored the psychotherapy process with mother and child coming together (or not) to the research interview, with their interactions (in the room, over the phone or in the pictures shown to me) being valuable research material worthy of analysis. My analysis and findings are included in the findings section.

All interviews were recorded and transcribed verbatim replacing names with 'P' for participant and 'R' for researcher.

3.8. Managing data using HyperResearch – a choice

Throughout the analysis, I felt ambivalent about using software to manage my data. At first I used pen and paper, which was frustrating as I felt I never had enough space to write in the margins of the interview transcript as recommended by Smith et al (2009). I then moved to using a qualitative data analysis software called HyperResearch, which facilitated the storing, organising and retrieval of the products of my analysis. Once again, I felt it restricted my analysis, as though I didn't have enough space to express myself and elaborate my thinking. In hindsight, I realise this frustration was a manifestation of my fear of losing the complexity and singularity of participants' stories by condensing them into ever shorter themes. Working with my supervisor, we decided that I would send him the complete analysis of one participant's interview (see

Appendix 4). As this was impossible with HyperResearch, I redid the analysis using a simple word document. I enjoyed the process as I finally felt free to think and write as much as I wanted in the first phase of analysis. But interestingly, when identifying emergent themes and bringing them together into subordinate themes, I arrived at the same results as when I had used HyperResearch. Being the same researcher doing the analysis, this was not unexpected. However, coming to that point of sameness enabled me to simply see the software as a tool, upon which the creativity of the analysis process did not depend. This process highlighted my internal insecurity about the process, which had been projected onto the tools. As I worked through the analysis with my supervisor, I came to feel more confident about my thinking and revisited the analysis I had done using HyperResearch. I subsequently used it as an efficient tool for experimenting with the deconstruction and reconstruction of new shapes, and to create reports that bring together all the quotes related to superordinate and master themes.

3.9. Process of analysis

I have used the guidelines offered by Smith et al (2009) to orientate myself through the process of analysis, going from the rawness of the participants' experiences to the emergence and consolidation of a new shape. The journey involved four phases of analysis for each interview and a final phase that brought them all together into a shared analysis.

3.9.1. Reading and re-reading

For each interview, I immersed myself in the data by reading and re-reading the interview transcript and revisiting my initial thinking. Before my first interview, I was aware of bringing a set of assumptions, anticipations and expectations to the interview encounter. After each interview, I recorded my impression and thoughts about the process. I paid close attention to, and reflected upon, the movements of subtle influences between my initial expectations, my experience of the first interview, my post interview reflective comments and the individual

analysis. This reflexive process informed how I entered the second interview, and therefore the second interview analysis, and so on until the end of the last individual analysis.

3.9.2. Recording initial notes

My aim was to start making sense of the singularity of the participants' ways of talking and making sense of their experience, as well as starting to develop my own interpretative stance on how and why my participants had these concerns. My initial reflections were descriptive (highlighting interesting, rich, detailed, unusual, or subjective descriptions of participants' experience), linguistic (the participants' specific use of language and its possible meaning) and conceptual (starting to link relevant theoretical concepts to data and their possible latent meaning). I enjoyed the movements backwards and forwards from description to interpretation, which facilitated the emergence of meanings and paved the road for the next stage of analysis.

3.9.3. Developing emergent themes

This task broke the whole interview into parts before bringing them back in a new shape later in the analysis. It reduced the detailed analysis down to its emergent themes, without losing the complexity of the participant's experiences. Using my reflection and notes, I endeavoured to convey my ideas in crisp and concise conceptual statements that reflect my understanding of the psychological processes at stake, grounded in the participants' accounts which intertwined their experience of PIP, motherhood, identity and change. Generally, between 60 and 80 emergent themes were identified per interview.

Emergent themes were coded using HyperResearch. The length of quotes varied from a few words to a few sentences, with some corresponding to various codes as they condensed multiple layers of meaning.

Table 2. Coding an Excerpt of a Transcript

Transcript Excerpt	Notes/Reflections	Emergent Themes/ Codes
<i>I didn't think I could ask anybody or that it was good to share...But attended the group, I became so confident.</i>	Something about what she experienced as her inability pre-PIP 'she couldn't ask for help/disclose her struggle	Change
<i>You know, other people said, I also got that problem. Other people have problem, other women. That is what I felt after I attended the group.</i>	Normalization – other people have the same problem. Again before and after. 'I became' – idea of a gradual process of change. Becoming a different person	Sameness/Belonging to humanity
<i>...And after six week, I felt like a different person like I don't cry anymore...</i>	Idea of difference – became a different person because of her experience in the PIP	Difference

Smith et al (2009) recommend analysing each interview independently to honour the uniqueness of each singular's story, bringing together each participant's superordinate themes only in the final phase of the analysis. However, I decided to take a different approach, keeping in mind the previous emergent themes when analysing subsequent interviews, using them when appropriate. My rationale for this divergence is as follows:

- I felt it was disingenuous to pretend that I was able to enter each single analysis free of any impressions, feelings or thoughts from the previous ones. Although I understand the rationale for the phenomenological rule of horizontalisation –to prevent the researcher placing comparative value on participants' narratives and process (Martin, 2001) – I believe it is essential to acknowledge my limitation in doing so and the inevitable resonance within and between the interviews.
- I trusted my ability to reflect upon the impact that the previous analyses had had upon the following one, and to not let it mask or distort the singularity of each one.
- I felt it was useful to hold the previous themes in mind and to be aware of similarities and differences emerging through the analysis. It facilitated

the iterative process by making the unique themes even more salient, emerging from the strong theme convergence amongst the interviews.

- I bear in mind the complexity of the analysis, paying attention to the uniqueness of each account yet searching for a new whole that captures the specific and the universal simultaneously.
- HyperResearch supported this approach by providing individual code books for each interview analysis, listing each one's emergent themes, and a general code book which provided an overall list of emergent themes for the whole study, which facilitated the use of previously identified themes (codes).

3.9.4. Consolidating to form superordinate themes

The emergent themes were identified following the organic sequence of emergence in the verbatim. I then reorganised them into a new shape based upon my psychological understanding of the participant. This mapping exercise sought meaningful ideational links that bring the emergent themes together into a coherent and cohesive superordinate theme. This stage involved a greater degree of creativity and interpretation. I identified thematic and conceptual connections, which then defined the superordinate themes (in general between eight and ten per interview). This process brought to the fore the salient features of each participant's story and meaning-making processes.

3.9.5. Cross-case master theme formulation

This final stage of analysis brought the cases together for a more ideational level of analysis. It brought to light their shared higher order qualities, which yet find a unique embodiment in each case, while being aware of the tensions and considering the plausible contradictions between the individual (specific) and the general. It comprised the cross-case development of master themes based on the identification of connections and inter-relationships amongst individual cases' themes.

This phase was like solving a jigsaw puzzle. The superordinate themes were the puzzle pieces which I aimed to bring together into a whole new form, with the four master themes being the figural features of my new landscape. My thinking around the list of superordinate themes evolved throughout the analysis, with master themes forming, dissolving and reforming differently. I finally arrived at a new puzzle solution, with three salient features rather than four. But when I started writing about it, I felt uneasy about what I felt was the dominance of idea-driven themes over experience-driven themes. I decided to shift again the assemblage of superordinate themes into different master themes, which I felt were able to expose complex aspects of participants' experience, grounded in the data and ideationally significant.

I applied a bottom-up strategy that moved the analysis from the emergent themes to the master themes (see Appendix 2 for an example of a verbatim analysis from the initial notes to the subordinate themes). The initial phase of analysis yielded 549 emergent themes across seven interviews. The number of themes identified for each interview averaged 78. The commonality of themes across interviews was important; a considerable number of similar themes emerged in each interview. The emergent themes were then organised into superordinate themes – 61 in total, around eight per interview – again with a noticeable degree of theme convergence across interviews. Finally, a cross-interview analysis was done grouping the superordinate themes into four master themes.

During this process, I used HyperResearch to generate a list of quotes for each superordinate theme within the master themes, selecting the quotes that were most pertinent and illustrative of that idea/theme.

3.10. Evaluation

The phenomenological knowledge produced through an interpretative approach is inter-subjectively constructed, provisional and context-specific, therefore the positivist research evaluation criteria of internal validity, reliability, generalisability and objectivity are not relevant (Angeen, 2000).

I did not want to use a parallel set of interpretative evaluative criteria, such as Lincoln and Cuba's set of trustworthiness criteria consisting of credibility, transferability, dependability and confirmability (1985). Its focus on outcomes mimics the positivist evaluation criteria (such as member checking, or returning analysis to participants for confirmation of accuracy) denotes a subtle realism paradigm (Hammersley, 1995), and is criticisable for assuming an idea of fixed truth (Sandelowski, 1993). I am more interested in a form of evaluation that focuses on the research process itself (Schwandt, 1997). As recommended by Smith et al (2009), I followed Yardley's guidelines (2000) for assessing the quality of this research project based upon four broad categories:

Sensitivity to context: I have shown my sensitivity to the social-cultural milieu of the study by reviewing the relevant literature on the topic. I also exhibited sensitivity with regard to the material obtained from the participants during the data collection and analysis. Throughout the research process, I held my perspective lightly, honouring the complexity of our inter-subjectivity.

Commitment and rigour: My commitment to the project is evident in my endeavour to achieve the highest familiarity with my topic, described by Lincoln and Cuba as 'prolonged engagement' (1985). I work as a parent-infant psychotherapist, I am the perinatal psychotherapy representative for Central and North West London Mental Health Trust (CNWL) in perinatal services and a member of the London Perinatal Mental Health Network. I am also a member of the perinatal faculty of the British Psychological Society and attend perinatal conferences. I am training in interpersonal psychotherapy, which is the NICE-recommended therapy for PND. Considering my special interest in the perinatal period, perinatal cases are referred to me within our NHS service. I have perinatal supervision with a perinatal psychiatrist, a health visitor and other perinatal psychotherapists. I immerse myself in the field both clinically and theoretically. My commitment has also been shown in my attentiveness to the participants during the data collection, and my careful analysis of the data.

Rigour refers to the thoroughness of the study in terms of the appropriateness of the sample, the quality of the interview and the completeness of the analysis, which I hope is evident in this report.

Transparency and coherence: Throughout this research, I have attempted to demonstrate transparency by clearly describing the research process, from the participants' recruitment to the writing up of the findings. It is my hope that the coherence of my research project is apparent as this project design explicitly links my philosophical assumptions with my theoretical beliefs, which in turn trigger a specific research question and methodology.

Impact and Importance: The real validity test is whether the reader finds something interesting, important or useful in the research. This is what I aspire to. I hope this research will enable mothers to be heard, allow clinicians to better understand clients' experience of PIP and therefore adapt their practice accordingly, and enable commissioners to grasp the importance of maternal mental health and the need to provide therapeutic interventions for mothers, their babies and their families.

Braud (1998) describes validity as research findings that are true to what one is studying. When interested in individuals' experience, findings take the form of subjective versions of what is true to them (McLeod, 2003). I aimed at developing a coherent account that did justice to the participants' subjective narrative truths. By its nature, such an account is the fruit of my interpretation. I believe that readers' auditing capacity will 'ensure that the account produced is a credible one, not the only credible one' (Smith et al, 2009).

3.11. Initial assumptions of the research

My early assumptions can be summarised as a collection of expectations based on my experience as a child, a daughter, a sister and a mother, and more specifically as the mother of a child who was in psychotherapy, as a clinician working with mothers and as a researcher interested in hearing clients' voice.

My life as a whole, from my early years in a loving and joyful family of four, where children's wellbeing was at the centre of my parents' preoccupation, to the complex sibling relationships amongst us with one sister going through dramatic crises, her tragic death and the subsequent traumatic implosion of our family life, the psychoanalytic milieu in which we evolved and the emotional support I received from friends and their parents when my mother could no longer manage. All these experiences have shaped my sense of self, my understanding of the world and my curiosity about human beings. My drive to understand parent-infant relationships, to support struggling mothers and their babies and facilitate the healthy development of children began growing in me long before I could articulate it clearly. This research project contains a strong ongoing unconscious motivation, which I present in key moments below, knowing full well that these are artificial encapsulations. However, they enabled me to provide a condensed account of my assumptions and expectations.

For instance, I first completed a Master's degree in clinical psychology and psychopathology in France, aged 24. I had gained a vast theoretical knowledge but lacked some life experience. I started my second training in psychology and psychotherapy in the UK just after the birth of my first child, which meant that I engaged with my studies from a completely different perspective, especially when it was about baby observation, child development, attachment and object relations. I knew from my own experience how overwhelming it can be to become a mother, how one's personal history can re-emerge in the early relationship with the baby and how difficult it can be to engage with one's child for who he is, free from the projection of the 'ghost in the nursery' (Fraiberg, 1980). In my research, I expected to hear stories about motherhood and its difficulties with a possible intergenerational perspective.

I took my first child to psychotherapy when he was two years old. He was aggressive and struggling to engage with other children and I was struggling to understand why, and to know how to handle him. Although his treatment was very efficient, and within a few months he was able to have more pacified

relationships with other children, I still struggled to understand what had happened intra-psychically for him, and interpersonally for us. I vividly remember one of our trimestral meetings with his psychotherapist when I asked if she could help us, parents, to understand what was happening. Her response was that it was our son's psychotherapy, it belonged to him, and therefore she could not disclose anything. I remember my frustration and discomfit. I felt it was very unhelpful to pretend he was an isolated mind and wished for a more relational approach. I was able to make sense of it in my own therapy, but nonetheless regretted not working jointly with my son, especially when I came to discover the existence of PIP through my studies. I was very interested and relieved to know that such a relational and inclusive approach existed and quickly attributed a very positive psychotherapeutic value to it. I realise that my overly positive view of PIP has influenced my research journey. Since the beginning of the research and throughout, I held the assumption that mothers' experience of PIP would be positive and I expected mothers to talk about it. I have been mindful and reflective upon that process, not to eliminate it but to include in my analysis its impact on the findings and reflexion.

At that time, I was working in a parental mental health service, offering psychotherapy to mothers who had parenting difficulties to the point of involving social services. I noticed how many of them took their children to their sessions, despite being individual sessions, and how fruitful it was to have the baby in the room rather than just the represented baby in mother's mind. It reinforced my belief that PIP was needed when working with mothers of young children, so I joined a perinatal service where I was able to offer such interventions. Here, again, it was very interesting to see how mothers used the presence or absence of the child very differently, and how useful it was to make sense of this material in the session. I entered this research with the assumption that the presence of the child in psychotherapy was meaningful to the mother and the child and expected the child and the parent-child relationship to occupy a figural part of mothers' experience of PIP.

Having been in psychotherapy for many years, with several psychotherapists, I

still remember with great pain the instances when I felt my subjective experience rejected as untrue, defensive or argumentative. Bringing together my personal experience and my theoretical learning, I have a strong belief that what clients have to say needs to be carefully listened to and respected as their truth. I expected mothers to value the opportunity to share their subjective experience of PIP and I assumed I would hear singular stories illustrating how each individual differently experiences a common process.

Chapter 4. Findings

4.1. Overview of findings

In this section I present an overview of the master themes and a summary of my understanding of participants' experience of PIP. The summary is based on the master themes that emerged through my analysis of participants' description of their experience. The master themes with their constituent superordinate themes and corresponding quotes are given in the appendices.

I organised my findings into four master themes, each of which illustrates an aspect of mothers' experience of PIP and the impact it had on them: (1) from a negative to a positive experience, (2) nurturing experience, (3) humanising experience, and (4) transformative experience. I have presented the findings under each of these headings. The master themes and superordinate themes are presented in Table 3 below.

I provide a brief integrating statement of my findings, followed by a reflection on my experience as a researcher engaged in the research process. I then move on to providing a detailed presentation of the central themes from the research.

Table 3: Themes from the Analysis

Master Theme 1: From a negative to a positive experience

Superordinate themes:

From the negative experience of motherhood

- Inability/incompetency
- Detachment
- Isolation
- Depression

To a positive experience of motherhood

- Difference
- Competency
- Maternal
- Relational

Master Theme 2: PIP as a nurturing experience

Superordinate themes:

- PIP as a positive experience
- PIP therapists as good objects
- Maternal functions/mothering mothers
- Learning experience

Master Theme 3: PIP as a humanising experience

Subordinate themes:

- Talking/opening up
- Sharing
- Normalising
- Sameness/togetherness

Master Theme 4: PIP as a transformative experience

Superordinate themes:

- Willingness to change
- Transformative experience
- New perspectives
- Reflectiveness

4.2. Overview of participants' experience of PIP

Participants' accounts of their experience of PIP revealed that it had been a transformative experience that profoundly changed their experience of motherhood.

PIP was experienced as a pivotal moment that created a temporal shift between their experience of motherhood before PIP, and their experience of motherhood since PIP up to the present day. The temporal structure of their experience underpinned their experience of change.

Prior to PIP, participants' experience of motherhood had been negative. They described their state of being a mother in terms of their inability to mother, the painful feelings of failure and shame that came with it, and the negative representations of themselves as different, bad and mentally ill within the context of their disconnection with their child and their social isolation. Motherhood had been a negative and painful emotional system that steered participants into a place of withdrawal.

During the referral phase and later throughout the treatment, PIP therapists were experienced as agents of hope coming into participants' place of despair and loneliness, linking them up to the world through their loving and caring relationship.

Participants' determination to change emerged from their painful awareness of their struggle with motherhood. Although they had no knowledge or understanding of PIP prior to beginning the treatment, their established primary connection with PIP therapists opened the door to the participants' engagement with PIP and other human beings, including the other in themselves.

Their relationship with the therapists was the vehicle for change. Therapists were identified as maternal figures providing the mothering that they had lacked. Being listened to, heard, held, responded to, understood, supported,

taught and challenged made them feel loved and worthy of love. Being mothered with love unleashed their capacity for loving mothering.

Their relationship with other mothers in the group was also a powerful vehicle for change. They came to the group alone, isolated and disconnected, and came out together in connection. The opportunity to take a risk and share their complex stories about motherhood enabled them to reintegrate humanity by experiencing sameness, normalisation, togetherness and belonging.

PIP was experienced as a positive relational experience that enabled participants to identify and position themselves as ordinary benevolent mothers. Being a mother became a source of pleasure, and motherhood became a positive emotional system providing women with connections. Their relationship with themselves, their child(ren), their family and others inside and outside the PIP group was both the process and the outcome of the therapeutic work.

The vantage point from which mothers experienced and thought about motherhood had shifted. PIP gave them new perspectives and enabled them to develop a different regard.

4.3. Reflections on the research process

In line with Heidegger's tradition of the hermeneutic process, I aim here to go through the cycle of self-reference. It will place my understanding within my *a priori* prejudices (fore-structure). I will also discuss my experience of going through Gadamer's hermeneutic circle (1996). It is an iterative process from which a new understanding of a whole reality emerged. I will explore what it meant for me, with the idea that understanding 'oscillates between finding consistency with pre-conceptions and new but alien ideas' (Iser, 1972).

4.3.1 Reflection on the recruitment and interview process

From my experience of psychotherapies that segregated parents and children, I always felt extremely enthusiastic about parent-infant joint psychotherapy. I was interested in the mirror effect that I experienced while interviewing participants. I felt that my own enthusiasm about PIP and my belief in its psychotherapeutic value was echoed by the participants' positive experiences and noticeable gains. In fact, their enthusiasm refuelled my own, which had faded over the time it had taken for this research project to emerge. It was very moving to hear participants' emphasise how much they wanted to take part in this research to ensure that other women could also benefit from PIP:

'I would like to say that if you guys can continue those things, please continue! For people like me, like, there are so many mums like me who really need you guys. I would say 'what you guys are doing, please keep doing it'. It is a really good job. Probably you guys can't feel it but I am feeling what it's done so, it is different. Probably J. (therapist) can forget what she's done because she did her job. But for me, it is my new life...so please keep doing it. And...keep doing it (tears in her voice) because of the next generation (...) It is quite difficult so I would thank everybody.'

(Bav)

This speaks directly to why participants agreed to take part. I felt that many wanted to give something back out of gratitude and to support the institution and psychotherapists delivering the treatments:

'I do owe them a lot. That's why I agreed because I always said to the team, if you ever need anything, just let me know...They have given me so much, I must return the favour.'

(Bindhy)

Both researcher and participants come to the research interview with personal motivations and interests. The subjective relevance for me of the research subject met the subjective relevance of the mothers' desire to participate in it. Undoubtedly, this shared positive drive underpinning the inter-subjective encounter shaped the interviews' content. Only one participant was initially

more reserved about the psychotherapeutic value of PIP, which she later explained by her inability to participate when she had the opportunity:

R: Would you recommend it to other parents?

P: I would, yes, I would. But one thing I'd say is, try to be open. Don't do what I did because eventually, you want to say something so...but it might be too late then.

R: do you think that is what happened to you, that when you were ready to talk...

P: it was too late, yes. Yeah (laughing with some sadness).

(Rose)

This participant positioned herself in the group not as a client but as a co-psychotherapist. She enjoyed the positive feedback she got and the feeling of being a model for other struggling mothers. But she could not bring out her own distress and therefore join the group as an equal member. She felt ambivalent about being one amongst others (like she was in her family) and sadly, when she overcame her ambivalence and felt ready to engage, the treatment was over. It is interesting to notice that despite her ambivalence and reluctance to participate, she beautifully summarised the therapeutic feature of the group process: the experience of walking in as an individual and walking out as a group; a group to which she sadly did not allow herself to fully belong.

It is undeniable that mothers' willingness to be interviewed creates a bias, in the same way that my willingness to hear their stories creates another one. However, the weight of their positive experiences remains the same for the development of an experience-near understanding of PIP. Women who engage with the PIP process from beginning to end do seem to gain something very positive, so perhaps the focus should shift from whether PIP is valuable towards creating the pre-treatment conditions that will facilitate mothers' engagement with it.

4.3.2. Reflection about the analysis process

Throughout this study, I aimed to be transparent about my personal, philosophical and theoretical positions and how these impacted the research in

its entirety, from its design to its writing. As proposed by Gadamer (1996), temporality might be a great ally to reflexivity; therefore I looked back at my interpretative journey once the findings were complete and reflected on the tension I experienced between process and outcome throughout the analysis phase. I entered the research with a clear determination to focus on participants' experience of PIP, distancing myself from the quantitative research tradition and its interest in outcomes. However, participants chose to discuss the impact PIP had had on them, during the process as well as afterwards. Participants talked about the process of change during PIP, what facilitated it and the contrast pre- and post-PIP in terms of their way of thinking, behaving and feeling.

I considered limiting my findings to three master themes (nurturing, humanising and transformative experience), which captured the ongoing process experienced during the psychotherapy, eschewing the experiences before and after PIP, since those statements were not about their experience of PIP per se. However, I ultimately felt those statements were very telling about the participants' experience of themselves in relation to their experience of PIP.

However, one could argue that the outcomes of the PIP process are implicitly present in the nurturing, humanising and transformative themes. Indeed, I battled with that question myself. What ultimately influenced my decision to present my findings under four themes – rather than three – was the understanding that the distinction between processes and outcomes is not immutable. The statements regrouped under the 'from a negative to a positive experience of motherhood' theme illustrate the movements experienced by women as a result of the nurturing, humanising and transformational processes of PIP, as well as an ongoing process of movement occurring through their PIP experience. The gradual and ongoing experience of change came to impact the process of PIP, and can therefore be considered a process in and of itself as well. In the end, I felt that in spite of the overlap with the other three themes, presenting the statements under a separate theme would be more beneficial as it showed how participants experienced and expressed personal change from a behavioural, affective, representative and relational perspective.

How my eyes shaped what I saw in the data

My subjective experience of motherhood and the narrative I developed about the story of my mother and my sister shaped my capacity to see but not in the way I was expecting it. I was expecting to find what I knew from my personal experience. To my surprise, I saw alterity within sameness.

4.4. Master theme 1: From a negative to a positive experience of motherhood

This theme speaks to participants' experience of motherhood and its evolution from negative to positive. The idea of a temporal evolution from pre- to post-PIP is expressed linguistically, with the repeated use of temporal adverbs such as 'before' and 'now'. The negative experience encompassed themes of inability, disconnection and isolation, whereas the positive experience was expressed as newly acquired competency, maternal engagement and attachment.

Table 4. Superordinate Themes of Master Theme 1

Superordinate themes	Interviews containing this theme						
From a negative experience of motherhood							
Inability/incompetency	1	2	3		5	6	7
Detachment		2	3	4		6	7
Isolation		2	3	4	5	6	7
Depression	1	2	3	4	5	6	
To a positive experience of motherhood							
Difference	1	2	3	4	5		
Competency	1	2			5	6	7
Being maternal/ the mother	1	2	3			6	7
Bonding	1	2	3		5	6	7

4.4.1. From a negative experience of motherhood

Participants' state of being a mother prior to PIP was described as a negative experience that brought intense psychological pain.

4.4.1.1. *The experience of inability/incompetency*

A salient feature of participants' motherhood experience prior to PIP was their feeling of inability and incompetency. The theme was expressed through participants' thoughts, feeling and behaviours. The emotional tenor was negative, with feelings of doubt, worry, fear, anger, lack of confidence, and anxiety about their lack of knowledge. Pleasure and enjoyment seemed completely absent.

'Before I wasn't confident to do things and I was like so worried...Before I couldn't do any task, any simple task I was not able to do, housework, children, nothing really...I didn't know what to do so I couldn't enjoy him...I didn't know what to do with my son so I walked away...'

(Asa)

The emotional negativity seemed to go hand in hand with negative behaviours, with inaction as the foreground feature. Participants' state of being a mother was defined by the mothering behaviours they could not do; looking after, protecting, soothing and enjoying. And those mothering activities they did perform were judged to be inadequate, wrong and damaging.

Participants' cognitive assessment of their motherhood experience was equally negative, judging themselves to be unable, incompetent, bad, failing and monstrous to the point of wanting to and/or abnegating their maternal function to others whom they judged more adequate, and removing themselves from the mother-child encounter – some wished for this exit to be.

'I think I was doing none of the good things (really crying) sorry...like you are a monster...'
(Maria)

These powerful avoidant and punishing movements described by participants can be brought together in a coherent model using emotion theories of Panksepp, (2011, 2012) and Frederikson, 1988).

From their theoretical perspective, an emotion is understood as a dynamic system, starting with a change in circumstances and its appraisal, followed by consequential physical and mental changes and ending with an emotional behavioural response, which then feeds in/loops back to the first stage of appraisal and change.

Here, becoming a mother (whether for the first time or not), and all that goes with it, is the change of circumstances. The women made a negative appraisal of their state of being a mother which led to negative feelings and action urges. These psycho-physiological changes culminated in a behavioural response of withdrawal.

'I just left him to go to sleep, because I did not know what to do. If I tried to carry him, he's gonna still cry, it's gonna pissed me off more. So I just left him.'
(Bindhy)

Emotions being action-driven, the withdrawal response can be understood as an attempt to flee psychological pain, thereby reducing it. Mothers fled their feelings of inability and impotency by being physically removed from the mother-child interaction, or else psychically absent by providing empty/automatic mothering.

'Before I couldn't, I didn't really want to play with them...euh I just sit down. I was just watching them but don't get involved. I just cook them, put food on the table, watch them...I was really bad, so bad.'
(Maya)

Such relational withdrawal might have created a negative loop depriving mother and baby from the opportunity to co-construct their relationship in a different way.

4.4.1.2. Detachment

One of the primary processes of motherhood is the attachment that develops between mother and baby. However, participants described an experience of non-bonding, or struggling to bond with their child, which clashed with what they had expected or felt was expected of them:

'You know, that thing that people say that when you have your child you just see it and love it, it did not happen with me. I was looking at her and thinking, my god, oh my god who is this...It is not that you don't love your child, I don't know...you don't feel what is so clear for others... You know that thing they say you have a baby and you look at it and you feel in love? They said to me "Waah it is wonderful!" But it is not wonderful to be honest. It is terrible.'

(Maria)

This detachment seemed at odds with their individual and cultural/societal expectations of a spontaneous attachment. The positive interpersonal relationship that defined emotional bonding was experienced as difficult or even impossible. The expected positive emotions (love and joy) seemed to have been replaced by painful ones (anger and fear), the connection and intimacy replaced by disconnection and drudgery. The gap between expectations and reality was experienced as a source of psychological pain, with mothers' powerful ambivalence embodied in the disjunction between love, attachment and mothering.

The phenomenon of childbirth creates a biological mother and a biological child. But as the participants expressed, this does not necessarily give rise to the psychological identification of oneself as a mother, nor of the child as one's own. Their experience of motherhood prior to PIP seemed to have been characterised by this disjunction between the biological and the psychological, which seemed to correlate with their attachment difficulties.

'When my son was born, I just felt like what is it? It was a boy. Ok, thank you and that was it. I didn't cry, I didn't, I didn't care... I didn't connect with him, I didn't. He was just a baby to me. Yeah I fed him and did everything but he was, it was just a baby.'

(Rose)

What makes a psychological (as opposed to biological) mother is the relationship that attaches her to her child; a relationship based upon love (affection, pleasure, liking), care (looking after and providing for one's needs) and nurture (fostering growth). This loving, caring and nurturing engagement was precisely what these mothers failed to experience with their children; instead of feeling love, they felt indifference or fear. The child was not identified as a source of pleasure or enjoyment but as a source of pain and possible danger. Being with the baby was a source of psychological pain and dread, hence the secondary detachment.

4.4.1.3. Depression

Depression was widely reported by participants, from a temporal perspective.

'I had a history of depression.'

(Maria)

'I was depressed during my pregnancy.'

(Asa)

'I knew I had postnatal depression because I checked on Internet and I had all the symptoms. I think there is a questionnaire and I did it and I knew I was not normal.'

(Maria)

Participants described themselves as depressed ante- and postnatally, which they identified as a pathological mental state leading to a distortion of thoughts, feelings and behaviours. For some, the distortion was so powerful that the benevolence of the child was perceived as a persecutory malevolence, representing a risk. Depression was also identified as presenting a risk for the mother.

'Because my thoughts weren't correct. Because obviously with postnatal depression, you understand that mothers' thoughts of harming the child are very very great.'

(Bav)

'It is an illness. You can kill yourself. You can die.'

(Maria)

The Oxford English dictionary defines depression as 'the feelings of severe despondency (low feelings from loss of hope or courage) and dejection (sadness)'. The Diagnostic and Statistical Manual of Mental Disorders (DSMV, 2013) uses an a-theoretical descriptive approach combining cognitive (i.e. I am bad, I am a failure, I let my family down), affective (i.e. feeling down, depressed, hopeless, suicidal) and behavioural (i.e. inactivity, withdrawing) symptoms.

Here I propose to understand participants' depression (as defined above) and depressive experience of motherhood as a negative emotional system, triggered and maintained by the accumulation of psychological pain generated by motherhood (Panksepp, 1980).

4.4.1.4. Isolation

The realm of experience related to isolation is complex and encompasses different types of isolation: physical isolation (*'did not leave the house' Maya*), social isolation (*'did not feel worthy of being with others in the outside world' Bav*), relational isolation (*'did not feel close to husband/family members' Bindhy*) and emotional isolation (*'had friends but did not feel emotionally connected to talk' Lilly*). These can be attributed to various things such as geographical distance (family being far away), emotional distance (endured or self-imposed), conflicts or difficulty sharing and opening up. Mothers felt alone in the world; some even saw themselves as being outside of the world/humanity due to their experience of feeling different and undeserving. The experience of interpersonal and/or intrapsychic isolation seemed to have contributed to participants' struggle with motherhood, being both a trigger and a maintaining factor of their depressive experience.

Mothers' relational difficulties with their children seemed to have occurred within a context of isolation and poor interpersonal relationships. Out of seven participants, five were immigrants, far from their families and origins. The disconnection with the mother country/culture, as well as the real mother, was described as a source of pain. In addition to the physical distance, participants described difficult emotional relationships with their families, especially their mothers. There seemed to be a correlation between mother-child, mother-mother and mother-world relational difficulties, bringing together attachment/detachment, depression and isolation.

'I did not have anybody because mum...mum is back home (crying)...sorry...(crying).'
(Bindhy)

'I felt really isolated. I was really isolated and I was really really scared generally and really really depressed...I did not leave the house... I desperately needed someone to talk to. I was very very isolated from my husband. I didn't really get on at that time with my parents... If I had a supportive family, maybe also things would have been different but I did not get on with my parents at that point because I had residual issues for years and years. So...'
(Bav)

'I felt different, very different. And I felt not good enough to be anywhere. So obviously to branch out, a) you physically can't, b) you don't want to be there, and c) all the other mothers or children would all be happy happy. I mean this is all I could hear, laughter and groups of mothers. I felt different.'
(Bav)

Becoming and being a mother was experienced by participants as a source of intense psychological pain, disturbing ambivalence and frightening thoughts and feelings. Motherhood, isolation and depression came together to form a negative emotional system, within which mothers judged themselves as incompetent, bad and damaging. Such negative appraisals made them feel ashamed, guilty and irremediably different, hence their emotional behavioural response of withdrawal from the world and humanity in general. Their internal and external world was already coloured by relational struggle and disconnection.

4.5. Master theme 1: To a positive experience of motherhood

The participants reported having markedly negative feelings, thoughts and behaviours prior to PIP. They could only see what was lacking and failing. PIP was identified as a turning point that enabled them to shift from negative to positive.

4.5.1. Difference

The difference was expressed temporally, with a 'before' and an 'after', with regard to their experience of themselves as mothers and their relationships with their child(ren) as well as others.

'I am not depressed anymore...I am happy now.'

(Maya)

'...all these fear (with tears in her voice)...I don't hate myself anymore...I feel different.'

(Maria)

Participants described a movement from depression to happiness, from inability to competency, from fear to confidence, from harshness to tolerance, from the one who was distressed to being the supportive one. They referred to their relationship with others as well as their relationship with themselves, highlighting an interpersonal and intrapsychic change.

4.5.2. Competency/Ability

In the same way that the experience of incompetency emerged out of participants' description of their thoughts, feelings and behaviours prior to PIP, their experience of competency post-PIP came out of an interlinked cognitive, affective and behavioural perspective. The transition towards a positive experience of motherhood materialised through an experience of participants' own maternal sense of competency gained through PIP:

'Compare to the person in the past, I feel less angry like I used to be...Previously I used to, I was unable to do any task for myself, my child or my husband, now I am much for enthusiastic. I gained some confidence going to the sessions, somebody can cry on my shoulder now.'

(Asa)

Participants' sense of inability seemed to have been replaced by a sense of ability, a capacity to do and to achieve, which, in a positive self-feeding loop gave them the courage to do and achieve even more. Also, being able to do seemed to have led to a different appraisal of themselves, which then fuelled mothers with enthusiasm and a belief that they can mother their children. This growing confidence appeared to be a result of both PIP and the actual difference in experiential encounters with their child(ren), which itself had perhaps started in PIP.

'After a while, I found that I had achieved something there, which encouraged me to continue...Now I can reach the objectives I had, finding the courage, finding a nursery for my son and a college for myself so it was...I gained confidence going to those sessions...By the end I felt I could stand on my own two feet.'

(Asa)

Mothering is about holding and handling the baby (Winnicott, 1960) from a physical and psychological perspective. Participants' referred to both perspectives: they described a physical engagement with their children through playing, swimming, feeding, touching and changing nappies – the physicality of the exchange being perhaps the place where their competency was expressed as well as fostered, as well as a psychological engagement through the capacity to soothe, intervene and contain the child's emotional life.

Before PIP, the mother-child encounter had been experienced as a source of unbearable psychological pain that necessitated an escape, with the mother abnegating her maternal function. The change here was the movement towards the child as opposed to away from it, leaving only when it was beneficial for the child, and with the mother embracing her maternal function.

'I wasn't able to touch her when she used to cry. Now I can stop what I do and pay her attention rather than just letting her cry and leave it alone.'

(Maya)

'Now if he cries, I know how to handle him. If I know he is hungry, I feed him, or nappy changing time, I do it, and if he still cries, I leave him. He wants to cry, give him time. I learnt that in the group.'

(Bav)

The emotional quality of the mother-child relationships appeared very different with reference being made to feelings of hope, courage, satisfaction, confidence and knowing. The practical and psychological knowing seemed to allow mothers to operate from a place of authority within themselves (as opposed to that of the culture of origin, the mother-in-law or the husband).

4.5.3. The maternal self

The growing confidence in their maternal ability, gained through PIP, seemed to have allowed participants to embrace their maternal function and to identify themselves as mothers and their children as their own:

'I am a mother now, now I know what to do, what is good for them...by attending the group I became so confident.'

(Bindhy)

'I am not feeling like a monster anymore, I feel like a mother.'

(Maria)

'From the days of having proper fears of she was not my child, she was a baby, so for something that wasn't mine to become mine, to actually love her, bond with her, play with her now. I was given the tools to be able to, you know (crying) to be a mother, that for the rest of my life.'

(Bav)

Those statements powerfully and movingly communicate participants' different mental states with regard to motherhood.

The relational dynamic between mother and child changes with active doing (feeding, playing, talking, cooking, baking) replacing passivity, involvement replacing withdrawal, dedication replacing rejection, hard work replacing capitulation and togetherness replacing avoidance and disconnection.

The emotional tenor of the mother-child interactions also changed drastically, with interest replacing boredom, pleasure/enjoyment replacing anger and dislike, confidence replacing fear and love replacing hatred and indifference.

'I enjoy being a mother now, whereas before, if my other older one cried, I was so angry and...sometimes I used to say "I don't want you, you just cry.'"

(Bindhy)

'Now he (her child) take more love from me...it is yeah, it is better for us, better for the family, my other children got something out of it as well, which is more love from me, more love and more attention.'

(Maya)

For the participants, the disjunction between biological, relational and psychological mother gave way to a more integrated experience of themselves as mothers. Motherhood replaced not being a mother (being a monster), with a sense of providing goodness and nourishment rather than badness and potential danger.

4.5.4. The bonding experience

Participants experienced PIP as a moment of bonding that impacted them deeply and far beyond the purview of the mother-child relationship.

'It was bonding for us. Yes I think that was quite bonding for us, just those little songs that we sang, just us, it was nice. It was bonding for us.'

(Lilly)

Participants described PIP as an experience that allowed them to bond, to establish a relationship with their child, where previous mother-child

encounters had been avoided as too generative of psychic pain. As a result, participants experienced a sense of closeness and enjoyment that went beyond the mother-child dyad to include husbands and other family members.

'We are very close to each other now. Even my relationship with my husband has improved; I used to pick on him. Now we are very close.'

(Asa)

In a spirit of mutuality and co-creation, it seemed that the capacity to attach oneself to another (child, husband and psychotherapist) also unleashed the capacity to see that others are there, willing to engage, and to see that feeling alone was not the same as being alone.

'It changed me from within, it allowed me bonding between...bonding of relationships, not only me and my daughter, not only me and my husband, but bonding between me and my therapist, me and almost society and...I suppose the word I am looking for is trust. It allowed me to trust the world in general.'

(Bav)

'I do have a life now, I do have people who care for me. Before I felt completely alone even so I wasn't.'

(Bindhy)

The profoundness of the experience moved participants to their core and transformed them from within. The mother-child relational difficulties came to represent the mothers' essential difficulties with the relational world in general. But through PIP, the relational world was transformed by the establishment of trust at the heart of human encounters.

4.6. Master theme 2: PIP as a nurturing experience

This master theme brings together experiences of a nurturing nature. The Oxford dictionary defines nurturing as caring for or protecting (someone or something) while they are growing, or to encourage someone's development. Participants described their positive experience of feeling cared for by a good object

(psychotherapist) who mothered them and taught them how to mother. They felt supported to grow into their maternal being.

Table 5. Superordinate Themes of Master Theme 2

Superordinate themes	Interviews containing this theme						
Psychotherapy as a positive experience	1	2	3	4	5	6	7
Psychotherapist as a good object	1	2	3		5	6	7
Maternal functions/ mothers		2	3	4	5	6	7
Psycho-educational process		2	3	4	5	6	7

4.6.1. PIP as a good experience

When describing their experience of PIP, participants distinguished between the service providing the treatment, the psychotherapists delivering the treatment, the treatment per se and its impact on them and their children. Each of these elements represented a feature of their PIP experience. The quality of the service, the psychotherapist and the treatment were experienced as good, which led to a sense of goodness being absorbed and therefore making them (mother and baby) feel good as well. The vocabulary used by participants to describe their experience was emphatic:

'It (PIP) was wonderful.'

(Asa)

'I mean the service that I got was exceptional.'

(Bav)

'They were really good, I cannot fault them...amazing service. It was really amazing.'

(Bav)

Before PIP, something had been lacking with regard to the participants' state of being a mother, which created intense and disturbing psychological pain. Here they described PIP as an extraordinary process that gave them what was

missing, healing their wounds and enabling them to return to a positive state, characterised by the presence rather than the absence of distinguishing features. The use of the Good Friday analogy in the following quote illustrates the death of the negative in order for the positive to emerge; the bad, failing, distressed and angry mother gives way to a positive, engaged and happy mother.

'Because on Tuesdays, I was full of anger, anger, anger, and then on Thursdays, I was fresh. He (her husband) could tell the difference. He could tell that Thursday was the refreshing day (laughing)...You know Good Friday? Well every Thursday is Good Friday for him (laughing). It is Good Thursday.'

(Bindhy)

A need is something that is required because it is essential rather than just desirable. Prior to PIP, participants felt that their needs were not being met, which generated psychological pain and seemed to disable them from meeting the needs of their children. Having their needs met, being given what they had been lacking, was described by participants as one of the key features of PIP. The movement from negative to positive, from absence to presence, created a different psychological experience of happiness rather than pain.

'I think I needed some empathy or sympathy, or something, I needed something and they gave it to me...I was healed and it was healing.'

(Bav)

'So in conclusion, my mother's experience is while I had the support and the trust, I was healed. There is no other word to describe it.'

(Bav)

Participants described PIP as an extraordinary and exceptional healing process. Healing means returning to health. It was as though mothers experienced PIP as freeing them from illness and psychological pain. They identified this process as benefitting themselves as well as their children. Participants also felt that other mothers should have the same opportunity to heal.

This sense of gratitude and reciprocity appeared to be a powerful motivator for mothers to participate in this research.

'I feel so grateful They helped me so much. I wanted people to know. I wanted to help as well.'

(Asa)

4.6.2. PIP psychotherapist as a good object

This superordinate theme describes the participants' experience of their psychotherapists as physically and psychologically containing good objects that acted as links between the participants and the world, therefore decreasing their isolation.

Therapists were experienced by participants as family members (most of the time a mother or a sister) fulfilling a maternal function, and as benevolent and genuinely caring. They occupied what the participants felt was an empty space due to the interpersonal or intrapsychic absence of a good mother. The group became their family and they felt devastated when PIP ended. Even though the 'as if' quality of the maternal relationship was acknowledged, the depth of the bond was authentic and therefore painful to let go of.

Whenever she (psychotherapist) used to come to my house, she was acting like a mother, or a sister. She would hold me and say any problem you can call me.'

(Asa)

'I suppose it is like she fulfilled the role of the mother that I never had, even so I had one...I suppose, now that I think back, that's why I was so upset. I never ever let them know how upset I was, and obviously you can't tell them this but I was devastated...because I had a family....J. (psychotherapist) was my family.'

(Bav)

The participants reported an active engagement with the therapists that seemed to go beyond the ordinary framework of psychotherapy (i.e. home visiting, physical holding, hugging and calling). They felt this was central to their

therapeutic experience and their identification of the therapists as genuinely caring. Mothers felt physically and psychologically held and contained, which created a sense of safety and trust.

'She really cared for me. She used to call me every day after she saw me. I felt like she was my sister. I don't have a sister. She used to hold me and hug me, you know, she wasn't really related to me but still I felt she was related to me.'

(Bindhy)

Therapists were experienced as kind, considerate, gentle, safe and trustworthy. Those personal attributes, also used to describe the quality of the therapists' relational engagement with the participants, seemed to have acted as catalysts to the participants' engagement with PIP.

'She was so kind and considerate. She was very gently with the way she speaks to you and I already trusted her so I already felt that she was looking out for me.'

(Lilly)

Participants felt that their therapist(s) kept them in mind by making themselves actively and passively available during, but also outside of, the therapeutic encounters: they visited everyday and/or phoned every day when necessary and let participants know that they were reachable at any time. Participants felt that the therapists were able to adapt in order to and meet their needs. This made them feel that their needs were acknowledged, attuned to and met, in contrast with their experience outside PIP. That experience was conducive to feelings of safety and trust.

Participants reported feelings of confusion and loss with regard to their own mental states prior to PIP. Not understanding what was happening also meant that they had no idea what they needed. But they were ultimately enabled to engage with and trust the value of PIP because of the therapists' engagement, encouragement, explanation and persuasion in the context of the growing safety of the participant-therapist relationship.

'When J. (psychotherapist) came to my house, it was some sort of amazing achievement...She (psychotherapist) was my link. Yeah she was definitely my link, I mean, I would have never gone really without her because...I did not really understand.'

(Bav)

The therapists were experienced as genuinely caring and the PIP encounters as real connections. The therapists connected the mothers with the centre – and the world – by forming a connection based on attunement, trust and safety. It seems the therapists' care enabled the participants to engage differently with the world (inside and outside), seeing love and care that they had not been able to see before.

4.6.3. Maternal function/mothering mothers

Participants felt mothered by their therapists, who occupied a maternal function. Maternal function was highly relevant and valued, especially considering the participants' universal experience of an absence (concrete or psychic) of a good mother.

To mother is to bring up a child with care and affection. In the PIP encounters, participants felt they were like children being raised by the therapist-parents. PIP was described as an experience of growth and an upward movement towards becoming a mother able to mother her child. Participants felt helped, supported and encouraged by therapists who engaged with them with care and affection. They felt the therapists facilitated and fostered their development in a warm and loving manner.

'There is like mothering love coming to me and I just felt happy afterwards.'

(Maya)

'They were loving people. They helped me to love more.'

(Maya)

Participants felt the therapists provided a primary human environment in which their development could take place. They did this by being present, available, willing to listen without judging, willing to engage and struggle together, willing to talk and think together, willing to help and encourage and by holding on to hope even when participants felt desperate.

'Someone that makes you feel comfortable and not judged and being understood.'

(Maria)

'Not feeling like a monster, not feeling judged...more than the talking, not feeling judged was key.'

(Maria)

Participants felt that the therapists acted as a psychic container (Bion, 1962) for their emotional lives. They listened to their complex, painful, negative stories of motherhood. They made sense of them without judgment, sharing their digested understanding which made the participants feel understood. The unthinkable and unbearable stories of their lives became shareable, thinkable and somehow acceptable. Their experiences could be learnt from, rather than rejected.

'It was obviously the biggest relief...finally someone is listening, finally I can tell my story to anyone but to someone who actually I could trust.'

(Bav)

'They did. You know what it was with J. (the psychotherapist), because I had a relationship, because you grow with the person you are talking to, you're telling your life story to somebody, you're sharing your deepest, darkest secrets, you know. I don't know how deep and dark I went, how honest, how far I could actually go? But I probably was quite honest, and they listen. I think it is a very big thing their listening.'

(Bav)

The participants related to these mothering mothers as being loved, which unleashed their capacity to love their children and themselves. This illustrates the idea that one's capacity to love emerges from having been loved. Fredrickson understands love as micro moments of connection that are co-experienced and co-constructed (2013). This resonates with the inter-subjective experience of

PIP as a powerful emotional experience of love that brought all other positive emotions together in shared moments of connection.

'They gave me that...love...I know they were health professionals, they get paid to do it but it wasn't, I didn't feel that. I felt loved (tears)...'

(Bav)

4.6.4. Learning process

Participants felt that the learning process that took place during PIP was cardinal and transformative. Therapists taught them the path to becoming a better mother, which seemed to mean a mother that could mother (her child and herself) and a mother that could connect and enjoy the connection with her child.

'They gave me ideas how I can be...a better person, a better mum.'

(Asa)

'That it is easy to be a bad mother and that, like I said, I know how to do that extremely well but actually to take the difficult, they taught me the difficult path of how to be a good mother. That's what they taught me, which is then going to save her and her future and her children.'

(Bav)

Participants prior PIP struggled to occupy the position of care provider, which they linked to their lack of positive experience and therefore procedural knowledge (*'I did not know', 'I never experienced being loved'* Bav). Both self-care and child-care were problematic and interlinked. They felt they could not meet their own needs nor the needs of their children as they did not know how to.

The experience of being cared for by therapists, as well as being actively taught how to care for others –indeed succeeding in providing care – created a fertile learning ground from which emerged a different and better sense of personal and maternal self.

'They taught us how to play, how to enjoy them, you to give them time. Within few weeks, they taught us how to play with them, you know, how to attach, to get attach to them. How to understand their feelings. Before I couldn't watch him playing, I thought it was boring, when they are playing, or crying. I found it so boring. Now, how they teach us, it makes a big difference. It shows that this is their life, enjoy this time. That's your life.'

(Bindhy)

The learning/teaching process addressed the three interlinked aspects of mother through doing and feeling. For instance, mothers learnt to play, which made them feel more adequate and able, and therefore allowed them to experience joy and satisfaction whilst engaging with their child. Mothers learnt to attune, contain and mentalise their child's emotional experience, which gave them the strength to regulate their child's distress as opposed to removing themselves from it as they had previously done.

As a result of this learning process, mother-child encounters became a source of positive emotions as opposed to negative ones, and therefore were no longer avoided. Instead, mothers sought to repeat these interpersonal experiences marked by an increase in shared positive emotions (joy, happiness, satisfaction), which allowed for the development of a bond between mother and child. Mothers learnt how to attach and how to love, which were mutually supportive skills: the love they experience (shared positive emotions) builds their bond and commitment to the child. The more they experienced love, the more they felt connected.

'I tell you what else they really helped with and this is what the group was about, which was really important the second time I went and my individual therapy, they taught me how to play with her. I can't tell you how important that was. Now when I think, I couldn't even hold or touch my baby (tears in her voice)...to read to her, to do one-to-one, to try to do fun things with her, because I never experienced fun, so if you don't know what it is, how you're gonna do it (crying).'

(Bav)

The assimilated learning during PIP was experienced as the agent of change that facilitated the transformation from bad to good, from the repetition of the same to the creation of the new, which then freed the children from to the destructive cycle of abuse.

4.7. Master theme 3: PIP as a humanising experience

This master theme brings together experiences of sharing, normalising, belonging and togetherness, which contrast sharply with the sense of isolation and alienation reported prior to PIP. The feeling of a humanising power that brought participants back from feeling outside of humanity is the common thread unifying these experiences.

Table 6. Superordinate Themes of Master Theme 3

Superordinate themes	Interviews containing this theme						
Talking/Opening up	1	2	3	4	5	6	
Sharing	1	2	3	4	5	6	
Normalising	1	2	3	4	5	6	7
Sameness/Togetherness	1	2	3	4	5	6	7

4.7.1. Talking

Breaking the previous isolation by talking, opening up, letting the other know what is on your mind and learning what is on other people’s minds was described by participants as an important feature of their PIP experience.

The act of talking implies the expression of mental states through spoken words. Talking therapies rely on the process of talking to facilitate a return to health and indeed, participants experienced PIP as a place where they observed the therapeutic results of talking. They learnt how to talk, and when they did, they felt listened to, understood and responded to.

'I could see the other ladies when they were experiencing, discussing their problems, they were crying and healing at the same time.'

(Asa)

'My intention was to express myself so that I could feel better when I go home, so that I could look after him (her son) and pay attention to him.'

(Asa)

'I am not in the same condition that I used to be to go there. I have learnt to express myself. Now I know how to express myself.'

(Asa)

'Talking is healing.'

(Bindhy)

The mutuality, reciprocity and collaborativeness of the talking process amongst group members and therapists were experienced as helpful, protective and facilitative. It made the act of talking doable and manageable despite its great difficulty.

'I had my little slot and everyone listened and then we moved on to the next person. It wasn't a very long slot but it was long enough to get something back, to get some kind of feedback and that was nice because I suppose you don't get feedback like that. Not only it was listening but it was also giving you back something. You didn't just talk for ten minutes about the stuff that were happening. It was a discussion, it was a two ways thing. Whereas with friends you just talk and they just listen but don't give you any feedback.'

(Lilly)

'It was very collaborative and that helped because otherwise you would feel slightly exposed at the end of it without knowing where to turn to...that reciprocity was, from the therapists and the mothers, was key.'

(Lilly)

Talking was described as healing. Prior to PIP, mothers had felt sad, bad, mad and isolated, with the isolation being endured as well as sought. They felt

ashamed of their mental states regarding motherhood, and therefore kept them secret. The healing effect they felt through talking took them from that self-critical and negative place outside humanity to a more tolerant and normative place inside/within it. Mothers returned to health and humanity by embarking on a talking journey, in which they opened the door that had completely separated their internal and external worlds. They took the risk of expressing what was inside their minds, what was experienced as different, unacceptable, shameful and even dangerous. Talking was about dissolving the barrier, moving the internal into an interpersonal space, a shared space that rendered the unbearable bearable. It was experienced as a powerful transformative process to realise through talking that others thought and felt the same way.

4.7.2. Sharing

Talking can have different purposes. One of these, described by participants, was sharing emotions, thoughts and experiences with other mothers.

Talking and sharing were experienced as gradual processes. Mothers started by being observers in the group before moving to a participant position. Some managed to make the move during the course of one series of sessions others had to return to another series before achieving that transition.

'Initially I went there...just going there and sitting with the others then gradually found out by sharing, that we shared the same problems and we could exchanged our problems...and that expressing each other helped. By the end, I could share my problems. I was happy I could do that, I felt better.'

(Asa)

Mothers moved to a position where they felt they could share their intimate life (internal and external) because they had a deep sense of others (therapists and mothers) being interested and genuinely caring about them.

'The sharing of the women was powerful. We built a really, really nice atmosphere in the room where we all really cared about each other's problems you know, we really wanted to get deeper into what was upsetting each of us. That was quite amazing.'

(Lilly)

Talking, sharing and caring happened within the safety of what one of the participants described as a 'sharing friends group'. Mothers felt they had a special bond with each other and with the therapists. The bond that connected them created a safe space within the PIP group where psychological pain could be inserted, contained, processed and digested. The pain that had once built up inside them, to the point of making them ill, could then be shared interpersonally, which was experienced as a freeing/liberating process.

'When I used to come to that group, you know, every week, the whole Monday like every day, things build up in my mind and Thursday I come here, and everything is given away (laughing). Like when I went home, I didn't have anything left, anything to say. That was my sharing, you can say my sharing friends group.'

(Bindhy)

The sharing process generated a horizontal move from an intrapsychic to an interpersonal place, which enabled mothers to come out of their isolation and form connections. Within that horizontal movement, there was also a vertical movement into the depth of one's pain, supported by the safety net of mothers in connections with each other. Sharing was experienced as a powerful force, reversing the process of moving away from others and oneself, to moving towards oneself and others.

4.7.3. Normalising

Whereas participants had experienced feelings of isolation and societal alienation, PIP was a powerful process wherein they could come to feel normal.

'My problems became normal, like actually many women struggle with their babies, their husband...there is a world out there with other people who have the same problems. So if you see other people, it makes a big difference...And that's why I think now, it is normal, it is not just me.'

(Bindhy)

Prior to PIP, mothers had felt alone. They believed nobody else thought and felt the way they did, which induced a shame-based withdrawal and negative feelings about themselves.

'For someone to say "actually it is ok, it is really common. There is nothing to be ashamed of". So if you are feeling of those things and someone says all of those things that you are feeling and they say there is nothing to be ashamed of, it changes everything.'

(Bav)

PIP's normalisation process relied on two different transformative experiences. The first is sharing negative mental states about motherhood (mainly their ambivalence towards their child, feelings of anger, hatred, murderous fantasies) without feeling judged or rejected, but rather being told that it was normal. Here the normalisation process relied on therapists providing some context and reassurance ('it is normal', 'it is common', 'it is ok', 'it is nothing to be ashamed of') as well as some explanation regarding the impact of PND on women's mental states. Learning about the ordinariness of their motherhood experiences, and being given permission to not feel ashamed, freed them from their devastating sense of guilt. It removed their belief that they were doing something wrong, and the feeling of humiliation that came with it.

'I remember something, oh something that was very good. I learned in the group that, I remember having this thought; I thought it had been only myself. I was holding my baby and I was through my, I was living in another apartment but for you to understand, going next to the knock, and my thought was like, pff...if I walk this this bit, I'm gonna kick her, her head. I never did it but it was my thoughts. It was terrible obviously, how can I think that kind of things? And I have learnt that all the mums (crying) once think that. But the difference between mums with postnatal depression and the normal mums, the normal mums forget about it, and we think about it. I remember that helped me a lot...I remember the psychologist said to us: the difference is that the mums that are not going through this forget about it. She thinks and forgets. But if you are thinking about you thinking about doing that to my baby (crying)... all the mums, actually all the mums think that, otherwise I would have had keeping it for me and thought I was a monster because I was having those thoughts. Now I know they are normal.'

(Maria)

The second experience underpinning PIP's the normalisation process was the realisation that many other women shared their difficulties. Hearing about the other women's stories made the participants realise that they were not alone, and that there was a world full of women who were also struggling with motherhood. This coming together in a group (rather than in individual therapy) broke their sense of isolation and difference. It changed how they made sense of themselves and how they felt in relation to others and the world: they did not feel alone anymore, did not feel different and therefore felt they had their place in humanity.

'Before I got to the clinic, before I met the Iranian lady and the psychiatrist, I was not too happy because they used to take me into a small room and it was me alone. When I got to the clinic, because there were too many women like me, like in my situation, I was feeling better. It is not only me in the world, there are many women like me. I compare myself to others, maybe I am better than others. But previously, when I went to the Iranian lady and the doctor, I feel I was the only one with these problems. And they used to take me to this small room, an old room. It used to scare me like I was crazy or something. But at the clinic, I felt different, very very different to the other places.'

(Asa)

These realisations allowed them to understand something about solidarity: together, they were stronger and they could support each other.

4.7.4. Sameness and togetherness

The experience of sameness described by participants had different objects:

'You are with people that are going through the same things. Maybe not feeling the same but going through the same things.'

(Maria)

'What bonds you is that you both probably got similar hormones rushing through, you've got young children and it is hard work.'

(Lilly)

'We were in the same pain. I had different issues but I felt I was on the same boat with them...I could relate to their emotions...the other were on the same boat I think.'

(Asa)

This sameness expresses participants' awareness of existential similarities without a loss of subjectivity: they shared the same experiences but had different feelings, or the same feelings but different experiences, or indeed the same feelings and the same experiences. Mothers felt they shared the same stories about the complexity of becoming and being a mother. They felt that they were in the same boat – the boat of life.

This shared experience of existential sameness was at the heart of the bonding process. The common thoughts, feelings and behaviours within their experience of motherhood, but also the shared experience of the PIP group, brought mothers together.

'If you see someone that is going through the same thing that you are going through, and that basically her life is very similar to your life, you feel much better, much more, I don't know like, bond with her.'

(Maria)

Experiencing sameness and togetherness was described as a profound transformative experience, beautifully captured by Rose, even though she could not experience it for herself but could only notice it for others:

'What was amazing was how everyone came in as a single person with a kid or, you know, mother with a child, and at the end they came out as a group of mothers with children. It wasn't just, you were on your own sort of thing. There was a group you know, you walk in as an individual but you walk out as a group.'

Indeed, mothers and babies walked in physically together but emotionally disconnected. Mothers felt disconnected from their child(ren), husbands, family members, others and the world. They walked in feeling painfully alone and different. The PIP process made them come out as a group; in other words, it made them into connected relational individuals:

'Knowing that your mind can think things and it is not just me, like other people feel the same. It is not just me that is feeling like that, some people can even feel worse. If you compare ten women, you can think five are like you so you feel, I am quite ok. It is not like no, I don't have anything, I have to die. I don't have any life, that's it. I left my mum because of this guy and this guy doesn't even listen to me. What should I do? I can't leave him because I love him. I have to die (laughing). Then you come to the group sharing your story and hearing other stories as well. And you think those people also love them, their parents...I don't need to die anymore. I have a life.'
(Bindhy)

4.8. Master theme 4: PIP as a transformative experience

This superordinate theme relates to the participants' desire to change and their experience of a change in being, feeling and thinking which opened new perspectives. They linked past and present experiences in a reflective manner, which opened a possibility of rupture with the past and a creative engagement with the future.

Table 7. Superordinate Themes of Master Theme 4

Superordinate themes	Interviews containing this theme						
Willingness to change	1	2	3		6	7	
Transformative experience	1	2	3		6	6	
New perspectives		2	3	4	5	6	7
Reflectiveness		2			5	6	7

4.8.1. Willingness to change

Participants entered PIP with a strong desire to change. They wanted to get better, to feel better, to leave depression behind and embrace life more positively, both for themselves and for their children. For some, the fantasy of a magic cure was also present.

'I wanted to get better myself...my intentions was to express myself so that I could feel better when I go home.'

(Asa)

'I told my doctor I want to go to this thing (PIP) because I did not want to wake up in the morning feeling like depressed and so unhappy...I want to feel more happy, more positive.'

(Maya)

Mothers' awareness of the seriousness of their difficulties and its impact on and potential risk to their child(ren) led to a painful awareness of their need for change, a self-imposed obligation to safeguard their children. There was a sense of unfairness for the children having to endure the consequences of these difficulties, which brought with it a feeling of guilt.

'I needed to be ok to...for me and for my daughter. I wanted to be ok, I was not happy with how things were. I was not happy with how I was feeling and I was on my own with my daughter so. I couldn't, I knew I, I couldn't keep going like that. Obviously you want to be, you want to be ok. You need to be ok...I knew I had to do whatever it takes, whatever had to be done because she was there (crying), and it was not her fault. Oh sorry...I knew I was going to cry (sobbing).'

(Maria)

The desire and the need for change was expressed in terms of what they wanted and needed to be different, as well as what they did not want and could not remain the same. There was a desperation about their mental states and their relationships with their children, which came across as very painful. They felt that something ought to change. In order for that change to take place, they felt ready and willing to do anything, including going to PIP, even though they had no clear understanding of whether or how it would help them.

'So I would have done anything because I knew I wasn't right. Deep down I knew I was slightly dangerous to my child and I couldn't say that to anyone at the time. I mean I can say that because it is anonymous and because obviously my child is alive and well, you know, three and a half now nearly...I needed the help and also part of me fought it, I also desperately wanted to change.'

(Bav)

/The desire/need for change was coupled with a feeling of expectation, a belief that things would get better. That sense of hope underpinned their willingness to engage with PIP

4.8.2. Transformative experience

Participants experienced PIP as a psychological transformation that led to a deep change in how they felt, thought and related to themselves and their significant others.

A transformation is a marked change in form, nature or appearance. Participants described themselves as having markedly changed. They felt transformed. They described the state of being a markedly changed individual by listing what they had gained (such as feeling better, feeling happier, feeling more connected) and what they had ceased to feel (such as anger, hatred, fear, depression). Those marked changes culminated in their identification with the maternal function. 'I am a mother', and not just a biological mother struggling to embrace motherhood, but a mother that can mother her child(ren) and provide love, care and affection to her child.

'She got...a mother that she nearly didn't have...because if you look at for example that photo, she was six months old. That's how S. (her daughter) used to look. No smiling, no giggling, no nothing. I think J. (therapist) described it. It was just like a completely dead expression on her face...apparently a mother and a child, especially in the early days, they reflect each other. I don't know what that reflects (laughing with embarrassment) but that was me and that was her (showing me a picture). She was seven months then. Now she smiles, she laughs, she's got personality, obviously it's within her age as well but they saved me...they saved me and they saved her because they gave her a chance to have a mother. Otherwise she would have never had a mother, which is, you know...I definitely gave her love, warmth and attention. It unlocked her. It did unlock her. Now she has a future.'

(Bindhy)

Mothers felt transformed and also felt others could see that positive transformation. Most importantly, they felt their children experienced them and

represented them (internally and externally) as transformed. They felt their children had benefited from their positive transformation, in the same way that they had previously been negatively impacted by their negative mother-child relationship.

This awareness of these personal (for the mother and the child) and relational benefits of their transformed maternal selves fed their desire not to return to their previous states prior to PIP. It gave them the determination to keep the work, long after the end of the actual PIP experience.

'I used to be so angry and sad all the time. I am not depressed anymore. I am happy now. I changed deeply. I can see how much I changed, my children can see it as well and they are much happier. I was waiting...they're like, they're like drawing mum and dad and the family. They always draw me with a smile on my face now. I like it...and I thought one day that might draw me with an angry face (laughing anxiously). I was scared of that. So when they draw me with a happy face, I was so happy...so I felt, I need to keep on like that to keep them drawing happy face about me.'

(Maya)

The process of transformation was experienced as gradual and facilitated by PIP and the PIP therapists. The process of transformation via the connected PIP mothers' relationships was a gradual movement away from negative, painful emotions towards the positive. This process of change materialised in different thoughts, feelings and behaviours towards motherhood and within the context of motherhood, and was described by the participants as evidence of their deep transformation.

The transformation experienced through PIP was conceptualised by mothers as an act of salvation. Prior to PIP, mothers had felt that they were falling, taking their children with them into the darkness of life. For some, suicide felt like the only exit. They felt that PIP saved their lives by giving them a life, by enabling them to see themselves and others differently, to feel, to think and to act differently, and therefore to make sense of and experience life differently. It gave them a life of being loved and loving others.

4.8.3. New perspectives

Through PIP, participants felt they gained a different way of regarding and a different vantage point from which to regard.

They described their sense of having been given something valuable that changed them from within. The experience of being part of the PIP group, and being with the PIP therapists, gave them an openness and mental flexibility that culminated in the establishment of a new perspective. It gave them an understanding of reality as subjective, that there is a distinction between internal and external reality and that others have their own subjective reality. It broadened their minds and capacity to make sense of the world.

'It changed me from within because...every story has three sides. That's the point, that's what they taught me. You can't just have such a narrow-minded perspective. They opened my eyes.'

(Bav)

'Basically, this is exactly what they did. So it was almost like, you know in the cartoon, one is fighting with the other but it is the same person switching his head around, that's what I was like. And a third person came and said "let's look at the story"...because there were obviously different perspectives that I did not understand because throughout my life I have only seen things through the child's perspective. They've wronged me, my parents wronged me, but I am a parent now.'

(Bav)

Their newly gained mental openness crystallised into a capacity to see. There was a difference in terms of whom they saw (themselves, their child, their husband, other mothers, the world), how they saw (with more tolerance and positivity) and what they thought (abilities, acceptable difficulties).

'I see now. I experienced seeing other mums and now I can see my mistake, an open mind they gave me. I can see now.'

(Maya)

'I can see reality. If I had left my baby behind and just got there and sit, it's nothing. I can see her now, and I can feel her, touching her, what it is like to be with her.'
(Maya)

The acquisition of this new capacity to see, and the correlated development of a new perspective, seemed to have been facilitated by the therapists who taught them how to have a different regard. Mothers had barriers that blocked and/or distorted their vision. Therapists were experienced with pushing/opening those barriers and bringing a new perspective into mothers' minds. They planted seeds of new visions, which grew into a capacity to regard differently.

'Now I know I have got a life. I have children...now I feel confident I do have a life. I do have people that care for me. If you don't know that sort of things, it makes it very difficult, life...And somebody comes to you and says 'no, it is not like this. It can be so good'. It makes you happy. You can be happy in your life...You don't have to believe that...you can say to someone there is hope.'
(Bav)

Likewise, hearing the other mothers' stories took them out of their own world and transported them into other people's worlds. It brought to their awareness the existence of other perspectives. This gaze outward and into others' minds seemed to have removed them from the confines of their own internal world, to which they then with a different vision.

This new perspective gained through PIP gave them hope.

4.8.4. Reflectiveness

PIP impacted different features of the participants' being during their process of change. It transformed their sense of agency and their self-representations. This final subordinate theme brings together statements that unravel participants' reflective self and their thinking capacity.

Prior to PIP, mothers felt locked within their own subjectivity, unable to see/think outside their painful vision. The willingness of the PIP

psychotherapists to engage them in a mentalising activity was experienced as a powerful psychotherapeutic process, extricating them from their psychic equivalence mode and bringing an awareness of inter-subjective truths. Psychotherapists' encouragement to distinguish the internal from the external, the past from the present, and to understand how one impacts the other, opened the possibility of a new future for them and their children.

'I used to blame my mum because my mum gave me away to my auntie. Dad passed away when I was six month so. My mum and dad used to live in B (town of origin), there was no education there for girls, only for boys. That is why if I go in the town, so my mum sent me to my uncle and auntie. That's why I was upset with my mum. Then I had my baby so I know how my mum felt (crying) having to give her child away. It is never good, even though it is good for them, how big did my mum done it but still I blamed my mum.'

(Bindhy)

Some mothers could not think at all. It was as if their thinking process was frozen. They could not hold their child(ren) in mind nor could they engage mentally with their future. They were trapped in a thoughtlessness which clearly contrasted with the post-PIP experience of feeling able to think and to hold their children's needs in mind. It is as if mothers' thinking capacity came alive through PIP.

'Before, when I was depressed, I did not really think about them (her children). I didn't really think about their future, I didn't really think what it is going to be like if I carry on like this. I didn't really think about that. But now I really think about, if I carry on being like...I ruin my children...emotionally.'

(Maya)

'I don't have to be angry with my children. They are just children. I don't have to be at home. I understood...I could not be angry and loving to my children. I should, I thought, I could be a good mum as well not just like my mum. I thought I could be a good mum, loving mum to my children.'

(Maya)

The thinking/reflective process allowed them to separate past from present, their identity from that of their mothers and their own children from themselves as children. They realised they had a choice. They could decide to be different, to not repeat the trauma of the past and therefore to free their children from that painful heritage. Out of mothers' reflectiveness came out a clear determination to be a better mother, giving their children the necessary nurturing for them to go through life with resilience.

'The other fighting thing in me was not wanting to repeat history, which I still have a battle with. Mine was more physical and relational abuse, mine was not any other type of abuse but the emotional abuse was so great that to this day, it still continues...'

(Bav)

'Therapy gave me the tools to be able to give her a really good life so then she won't repeat history so...it is generational. What they did, they broke the link of what could have been. Because it was very close, don't get me wrong. It was so, so close, and even now because I am fighting it, although I have to battle it, my thoughts, my feelings and everything you know, with a toddler it is very difficult as well.'

(Bav)

The process of change enhanced their capacity to see, to do and to think, which transformed their maternal beings and opened up some maternal preoccupations. They expressed concerns about the impact they had had on their children prior to PIP, their understanding of what was at stake for future generations and the dramatic impact PIP had on them, and therefore their children. This appeared to underpin their motivation to take part in the research, perceiving testimonies as potential arguments for continuation of the service.

'So please keep doing it. And...keep doing it (tears in her voice) because of the next generation...those things can happen.'

(Bindhy)

Chapter 5. Discussion

The aim of this study was to illuminate how mothers experience PIP. The central themes across the interviews were mothers' experience of PIP as a nurturing, humanising and transformative experience that led them from a negative to a positive experience of motherhood. In this section, I reflect upon my own journey of understanding and interpretation. Applying this reflection to the findings, I then return to the literature review and the field of PIP to examine its implications on how I have answered the research questions. I consider the possible significance of this work for future perinatal clients and mental health professionals. Finally, I examine the limitations of this study with a view to potential future directions.

5.1 Reflections on the journey of understanding and interpreting

5.1.1. How assimilated theoretical concepts and personal experience created anticipation with regards to the findings

My interest and understanding of PIP is constructed around its aim of freeing parents from Fraiberg's 'ghost in the nursery' (1975) and its concomitant distortions of the parent-child relationship. It gave me a conceptual model to make sense of my clinical work as well as my personal experience with my child. I unconsciously thought my baby boy was my sister – a troubled human being destined to die – which prevented me from engaging with him in an ordinary way.

With this conceptual framework in mind, I expected to hear stories about the difficulties of motherhood and intergenerational transmission. Indeed, Bav's story fitted in with my expectations of ghosts, projection, separation and mentalisation.

'I was completely confused. I was confused because I would see her but she would be me, I would be her. I can't let her have the experience that I had, then I would be reliving things from a child point of view. Someone else is gonna hurt my child (tears

rolling down her face)...I couldn't detached from D. (child). And I could not understand she was different from me.'

(Bav)

However other mothers presented different stories. For example, Maria did not have an issue with the baby, but motherhood:

'Yes, I think that was the problem because I did not want to be next to my baby...it changed you know. It is nothing like you wake up one morning and then you say oh I want to be next to her...no...with the therapy and the pills and her growing up...it is gradual evolution. It is a gradual process. It is not like...I mean I loved her, I was kissing her all the time and hugged her, and also I did not want to be next to her. I did not want to look after her.'

(Maria)

Although she loved the baby, she struggled to accept the changes motherhood had brought to her life, including the responsibility for nurturing. This was echoed by Rose, who also loved her baby, felt attached to her and wanted to look after her. And although she did, she struggled to cope with the weight of being a the sole caregiver:

'When she was born, I cried. I knew from then that I was not going through postnatal depression but I knew that I needed that support as her father was not giving it to me. And I just needed to, you know, to prove to myself that I was not going through postnatal depression because I did have a big bond with her, as soon as she was born. Literally it was, it is a girl, I cried, I held her, and when they took her away from me to clean her I was like "no I want her back" (laughing) so, but yeah...when we got home, it was literally I did everything. I had to take her out and she was only few days old. Her dad did not help but it was just, I needed that extra bit of help. I was tired.'

(Rose)

The interview and analysis processes enlarged my perspective on what had brought mothers to PIP, and therefore what might be needed in psychotherapy. Motherhood is a complex experience that women navigate with singularity. Some mothers indeed needed to work on the ghosts in their nurseries, whereas others brought the focus elsewhere. As a researcher, it was fascinating to follow

their subjective stories, which outgrew my expectations and expanded my unconscious restrictions on what I had thought PIP clinical material would comprise.

5.1.2. Why so much convergence

In my clinical practice, I have been struck by mothers' different use of PIP. I felt strongly that I was offering a frame, which was used very subjectively according to the woman's needs and difficulties. I do believe that clients find in psychotherapy what they need, which may vary greatly from one person to the next. I entered this research expecting a great diversity of stories, but what emerged was rather the opposite.

One component of this might be the fact that all the participants went to the same clinic to participate in PIP, which was delivered by the same clinical team, therefore with common referral processes, inclusion criteria, theoretical models and clinical culture. It is likely that the convergence of themes/experiences reflected something of the homogeneity of the clinic population, staff culture and therapeutic encounters.

But I also wondered if this convergence might be explained by some similarities amongst the participants themselves.

Cultural and social factors

Five out of seven participants were immigrants, with a common experience of being dislocated from their culture and cut off from their extended family. Interpersonal isolation was reported by all seven as a great issue, in combination with intrapsychic aloneness. While immigration was not necessarily the cause of their mental distress, the experience of moving away from one's country is meaningful, especially during the perinatal period, and therefore should be included in psychotherapists' clinical thinking.

Mental health factor

Another commonality between all seven participants was a diagnosis and lived experience of PND. Knowing about the relationship between depression, loss and isolation (Sheeber et al, 2007; Brunstein-Klomek et al, 2007), I wondered if participants shared common difficulties and needs, and therefore found in PIP similar responses. The 'humanising experience' master theme with its talking, sharing, normalising, and sameness/togetherness subordinate themes seemed particularly relevant within their context of dislocation, loss and isolation (which once again might be interpersonal and/or intra-psychic).

Personal history

Interestingly, only one participant, Rose, did not value the group and would rather have had individual psychotherapy. She felt that the group echoed her experience of being in a large family, having to vie for parents' far-too-divided attention. She wanted the psychotherapist for herself and experienced the togetherness of the group as division and competition:

'If I had been given the choice, I would have had individual therapy. It would have been nice to just concentrate on me. All my life, it has always been...not that many people have concentrated on me, if that makes sense. I always had to share. I always had that thing were I would like it just to be about me like, on my birthday, I don't want to hear anything. It is me, my day, you lot should all spoil me, it is my day. But euh, yeah, you know...'

(Rose)

Clients are not passive recipients (Gordon, 2000) of psychotherapeutic interventions delivered by mental health professionals. Their individuality and subjectivity impact how they receive interventions and what they make of it. This story is a reminder that the convergence is not absolute and that experiences are still unique

5.1.3. An overly positive view of PIP and its inevitable limitations

I am aware that my representation of the participants' stories appears overly positive – like in a fairytale, mothers seemed magically transformed and permanently changed by their experience of PIP. This idealisation had not escaped me, but mothers wanted to convey a positive story – they did feel transformed as a result of their unique experience – and I wanted to be true to their narratives. That is not to say that their experience can be generalised and that PIP guarantees such powerful transformation under all circumstances. However, it seemed important to share the fact that PIP has the potential to be powerfully therapeutic.

It is also interesting to note that the two participants with whom I had a number of important and painful ethical dilemmas enacted a stories that contrasted with the idealised narrations/tellings. The participant that called me by mistake, asking for help while her child was screaming in the background, seemed utterly distressed. The discrepancy between the consciously told story of PIP as life changing and the unconsciously acted story of a mother and child emotionally uncontained and in need created some ethical anxiety in me (which I explored earlier). It reinforced my awareness that what was shared during the interview was an intentional story, influenced by the context in which it was constructed. I wanted to honour both polarities and hold them as subjective realities that co-exist, perhaps with different levels of awareness.

The other participant consciously moderated her experience during the interview by explaining that the transformation only lasted as long as she was in treatment. The loss of what she had experienced as 'her PIP family' gradually brought her back to her original place of despair. She remained grateful because she felt that it did give her daughter a mother that she would never otherwise have had, but it left her wondering about their future. She powerfully communicated beyond words how PIP was a life changing and –saving experience, and yet how in danger she currently felt and therefore how her daughter was potentially at risk. When I invited her to explore the current distress, she threatened to deny it if I were to let anyone know about it. She

seemed to struggle with her neediness and felt highly ambivalent about engaging with further help – and yet she wanted me to know about her internal conflict, perhaps hoping I would resolve it for her by informing her 'PIP family' who could rescue her. Here again we feel the complexity of women's experiences and how different mental states can conflict with each other, co-exist, be superposed, advanced to the fore or be denied.

As a researcher, my challenge was to hold together empathy and suspicion, to be with and to reflect upon. I wanted to tell the idealised story without naivety or collusion, respecting the manner in which it was shared, as I believe this idealised story had a therapeutic value for the participants. Holding a good experience alive inside one's self opens the possibility of such an experience happening again in the future, even if and even when one does not feel so positive anymore.

Acknowledging a possible gap between how PIP was experienced and narrated, and the existence of a different reality at the time of the interviews, opens up questions of internalisation and length of treatment: interpersonal changes do not translate into immediate intrapsychic changes. The great majority of women undertook two consecutive treatments. More research is needed to better understand what the optimal length of treatment is in order to produce lasting changes.

5.1.4. Holding the maternal self in mind

Similarly, I came into the research with a psychodynamic conceptualisation of psychotherapy and PIP. I expected participants to talk about the value of insight, especially with regard to their understanding of the child's mind – this is what I imagine I would have found valuable, considering my own perplexity regarding my child's mental functioning. Although the presence of the baby seemed valued by participants, very little was said about the impact of PIP on their understanding of their child's internal world. The development of participants'

mentalising capacity seemed to be more about their own mental states and understanding the impact they have on their children:

'It was nice to have the baby there but...the problem was not her. I loved her. I did not like motherhood. So it (PIP) makes you change about motherhood, about yourself in motherhood.'

(Maria)

Holding the baby in mind (Slade, 2005) has been defined as an important feature of PIP. The therapist holds the actual baby in the room and the mother's baby self in mind, thus modelling a key feature of psychological mothering which can then be internalised by the mother. Mothers reported that 'being held in mind' by the psychotherapists was cardinal in their PIP experience, with their maternal selves being the object of the holding and mentalising.

There is a debate in the field about who the PIP patient is: the mother, the baby or the mother-baby relationship? I sometime feel that when the child and/or the mother-baby relationship is identified as the client, the mother and her relationship to the child become instrumentalised as a means to a psychotherapeutic end (i.e. the child's healthy development). Yet, at the opposite end of the spectrum, when only the mother is the client, the exclusion of the baby is artificial since, to invert Winnicott's idea, there is no mother without a baby. Women walk in to PIP as mothers. What they struggle with, what they want to work on, what they need help with, is their selves within motherhood. Participants reported that being held in mind by the therapists – not just as the mother of their baby but as women experiencing motherhood – is what enabled them to better understand their complex experience of motherhood, with the presence of the child bringing their maternal self to the fore:

'Having the babies there was important because it made it visible that it was about us being mothers. It was there in the room.'

(Lilly)

This study brings to light the importance of the mother's mental health for the sake of her child, but for herself as well. Holding the baby in mind is essential for the child to feel felt and met. Similarly, holding the mother in mind is essential for the mother to feel felt and met.

5.2. Going beyond the findings

It took me a long time to write this section. The findings rested inside me while I immersed myself back into my professional life. I learnt about and started using other relationship-focused interventions such as interpersonal psychotherapy and couples psychotherapy. I got very interested in addiction and the work of Gabor Mate. I reflected deeply upon human psychological pain, and what we, human beings, therapists and clients, do with it. I travelled far away from my original interest in PIP which made me feel like a fraud. Who was I to write about PIP as a supposed specialist, knowing that in my everyday professional and personal life I had moved to different territories? I wrote what I thought was expected of me – a discussion of my findings within the wider PIP perspective. I felt I had nothing interesting to say, nothing that was not known already.

I felt completely discouraged and wondered what had been the point of so many years of hard work? It is only when I allowed myself to think and write from where I was, which was indeed beyond the defined delimitation of the perinatal psychotherapy field, that I was able to grasp what had been learnt and its importance for me, subjectively, and for the field of psychotherapy. Through this research process, I gained the freedom to be led beyond modalities according to clients' needs, and perhaps this reflects a need for freedom in the PIP field to go beyond the current practice.

5.2.1 Psychological pain as a key feature of clients' experience of motherhood

Participants told me stories about motherhood. Their experience of unbearable psychological pain as mothers stood out as being of great importance for them, but also for us clinicians and for the work we do with our clients. Motherhood is

a complex process which evokes powerful emotions. Supporting women through this experience is cardinal for the women and their babies, but also for the whole family and more generally for the well-being of society.

5.2.1.1. The maternal self as a painful self

Because PIP is a relationship-focused intervention designed to support mothers who experience relational issues with their child(ren), I expected to hear about women's struggle to mother their children, to meet their needs, to relate to them, to engage and to understand them. And indeed I heard stories about women who struggled to be mothers. However it is the emotional tenor of those expected narratives that challenged my precepts and directed my thinking.

Participants expressed the deep psychological pain they felt prior to PIP. They experienced their maternal selves as mad, bad and sad (Appignanesi, 2009) with their thoughts, affects and behaviours all linked in a negative cycle. Mothers experienced themselves as not knowing how to mother, not feeling able to mother, doubting their ability to give something good and fearing giving something bad and damaging. Their beliefs about inability and badness came with overwhelming feelings of sadness, guilt and shame that seemed to lead to an intrapsychic and interpersonal withdrawal. The absence of positive emotions and the presence of overwhelming negative emotions were striking. The reported cognitions, affects and behaviours underpinning women's negative experience of motherhood corroborate what is already known about motherhood and its pitfalls. However what was new to me was how to make sense of it through the negative/positive emotions model (Frederickson, 2009). An emotion is more than an affect/feeling. It loops together a subjective assessment of a (new) situation which triggers a physiological, emotional and behavioural response. Motherhood was experienced as a collection of negative emotions that brought together a negative self and relational assessment, painful affects and a withdrawal behavioural response.

5.2.1.2. On escaping the pain and its impact on attachment

Infant regulatory disturbances and bonding/attachment difficulties represent the main reasons for referral to PIP (Keren, 2001) and can be understood in the context of the disturbances of the parent-infant relationship (Skovgaard, 2008; Skovgaard, 2010). My (perhaps naïve) understanding prior to this research was that relational difficulties reported by mothers were the trigger of psychological pain. I myself experienced real psychological turmoil when I was struggling with my child. But what I heard from the mothers I interviewed was different. Being in relation with their child, and what it evoked in them, caused so much pain that they attempted to decrease it by removing themselves from the relationship. The distance with the child was an attempt to manage the pain, as opposed to its cause, even though the resultant distance triggered and/or maintained attachment issues for the child (who, left unregulated by the mother, also learns to withdraw).

These findings do not reveal a previously unknown phenomenon, but it reminds us of the importance of adopting a phenomenological perspective in order to access the client's subjective truth. It brings us back to Freud's cardinal distinction between a symptom and its subjective meaning and function. What does the client's psychological pain mean to him/her? How does he or she regulate it? How does such regulation impact one's relationship to oneself, others and the experience of being in the world? These questions can be used as a compass in PIP, like in any other form of psychotherapeutic intervention, to guide psychotherapists through the exploration of clients' subjective experience. Understanding the psychic function for the mother of the parent-infant relationship is a prerequisite for working towards improving the relationship.

5.2.1.3. Maternal psychological pain in context

The research findings brought to the fore women's painful experience of maternal isolation, alienation and depression. These feelings of loneliness, disconnection and depression have been widely reported (Graham et al, 2002;

Nicolson, 1998; Paris & Dubus, 2006), especially in western cultures where mothers feel isolated from other adults (Cowan & Cowan, 2000; Graham, Lobel & Stein Deluca, 2002; Nicolson, 1998), and with immigrant mothers who feel even more isolated and disconnected from their mother country/community (Bandyopadhyay et al, 2010). This isolation increases the risk of depression (Cacioppo et al, 2006) and difficulties with mothering and attachment (Beck, 1995; Carlson & Sroufe, 1995; Coyl et al, 2002; Cummings & Davies, 1994; Goodman & Gotlib, 1999; Gotlib & Goodman, 1999; Zahn-Waxler, 1984a; Zahn-Waxler et al, 1984b; Lyons-Ruth et al, 1990). The findings confirm the already-established correlation between isolation and depression and the understanding of depression as a response to difficulties in relationships (Lemma et al, 2014).

I remember doing an art therapy exercise during my studies in France. We had to cut and glue images on a board and then present the board to other students. I had cut hundreds of heads – just people’s heads. This collage made me realise how preoccupied I was with understanding my sister’s mind and her relationship with my mother (she committed suicide on my mother’s birthday). The intrapsychic arena was my port of entry to the therapeutic world (personal and professional), and indeed the intrapsychic focus in PIP was one of the features that attracted me to it. I understood and practiced PIP as a relational-focused intervention that identifies unconscious patterns of relating based on the mother’s representational/internal world (Fraiberg, 1980). This research journey took me out of the intrapsychic and into the interpersonal and contextual. The mother-baby dyad evolves in a social/cultural/environmental context that impacts the mother’s experience of motherhood and therefore impacts her relationship with her child(ren). Intrapsychic as well as interpersonal and contextual factors matter. Relations-focused interventions offered to depressed mothers, such as PIP, need to address specific parent-infant difficulties as well as other interpersonal difficulties outside the mother-baby dyad, both being interconnected and impactful.

Postnatal depression, like depression, is not a personal issue, but an interpersonal issue, reflecting the relationship with the environment. Struggling

mothers trying their best under impossible circumstances disconnect, and in that movement of disconnection with themselves/their pain, they disconnect from their child. It is not the relationship with the child that is disordered but the mother's relationship with her pain. What is lacking in her life is soothing, nurturing human relationships that enable her to bear the pain.

Robert Emde (2014) identified several principles in prevention that need to be considered, such as the importance of the contextual factor. 'All preventive interventions deal with context, taking place within particular cultures, circumstances, and relationships. For meaning and effectiveness, such contexts with their associated values must be understood and taken into account (Sameroff, 2010; Spoth, Kavanagh & Dishion, 2002; Emde & Spicer, 2000)' (p.8). He also considers the complexity of disorder, which develops in a non-linear and interactive way, which means that 'many interventions, applied early, may work and that in addition to specific intervention (for example...treatment of parental depression) there is likely to be a role for non-specific interventions (e.g. minimisation of stress, social support, adequate diet, and exercise)' (Emde, 2014, p.9).

These research findings support Emde's understanding of prevention and call for an acknowledgement of the interpersonal and intrapsychic, the cultural and social, the economic and political factors interacting in the development, prevention and early treatment of perinatal psychological disorders, necessitating the adoption of an holistic view of mothers, babies and their difficulties.

5.2.2. On humanising the pain through relationships

Participants experienced PIP as a powerful relational experience which moved them from aloneness to togetherness, from alienation to belonging, through deep emotional connection. The relationships established between mothers and their therapists enabled mothers to tell their stories and share their pain. Mothers engaged relationally and maintained the connection with others and themselves

with the relational space as a source of empathic understanding and non-judgemental reflectiveness. Mothers' psychological pain had found a place where it could land and did not need to be escaped from anymore. As Rose articulated, they came in as isolated individuals full of pain and came out as a group able to contain the pain and let go of it. The relationship and connection between clients and therapists made a difference to women's 'self-in-relation' to their child(ren) and to their capacity/willingness to relate to them.

5.2.2.1. Relationship, connection and growth

These findings confirm the relational-cultural theory of women's psychology, originally called self-in-relation theory (Jordan et al, 1991; Miller & Stiver, 1998). This theory challenges the assumption that maturity equates to separation, and places relationship and connection at the centre of women's growth (Miller, 1976; Gilligan, 1982). According to Kaplan (1984), the three major concepts in their relational theory are (1) the powerful impact of the cultural context on women's lives, (2) the importance of relationships as the central, organising feature of women's development and (3) the importance of women's connection with others placed at the heart of their developmental model of growth. 'The relational model affirms the power of connection and the pain of disconnection for women' (Covington, 2007, p.5) with a connection being 'an interaction that engenders a sense of being in tune with self and others, of being understood and valued' (Bylington, 1997, p.35). Connected relationships lead to increased vitality, empowerment to act, knowledge of self and others, self-worth and a desire for more connection (Miller, 1986). Conversely, disconnection acts as a 'depressive spiral' which diminishes vitality and self-worth, increases disempowerment and confusion and makes women turn away from relationships (Miller, 1990).

Being together in the PIP group seemed to offer a valuable opportunity for connection at a delicate time when mothers are prone to disconnection. Knowing the impact of maternal mental health on children's mental health (Beck, 1995; Carlson & Sroufe, 1995; Coyl et al, 2002; Cummings & Davies, 1994; Gotlib & Goodman, 1999; Zahn-Waxler et al, 1984a; 1984b), this opportunity for

connection, and therefore growth within the motherhood role, is of great importance.

5.2.2.2. A community of mothers to fight isolation and alienation

Mothers came to PIP feeling physically isolated and psychically alienated. Being part of the PIP group, together with other mothers and the psychotherapists, was reported as a key interpersonal process (being-with physically) that facilitated an intrapsychic process (being-with emotionally). Together they created a 'we' that they could more easily work with and think about their pain and difficulties, compared to being alone with the therapist.

The findings confirm Zaphiriou Woods' suggestion (2000) that a group environment might be less threatening and more normalising than individual psychotherapy, with a greater opportunity to break the social isolation often experienced by vulnerable families and their children. Indeed, the vast majority of mothers interviewed had actually been dislocated from their country, culture and family. Juliet Hopkins (2008) captured immigrants' and refugees' experience of loss, and subsequent sense of isolation, as the loss of the mother country. These findings have important implications for practice: (1) a relational-cultural lens (Jordan et al, 1991) should be used to understand mothers' isolation and loneliness in the transition to motherhood (Paris & Dubus, 2005); their need for social contact and support should be thoroughly examined at the assessment phase and used as a good indication for group PIP; (2) group, rather than individual, therapy should be offered to immigrant mothers who have been dislocated from the cultural and social holding provided by the mother country.

It also echoes Zaphiriou Woods' (2011) findings about parent-toddler groups, where fostering the parents' sense of attachment and belonging to the group, of "being in it together" (James, 2005), enables them 'to talk more openly about their toddlers' difficult behaviours, their own ambivalence and the associated shame and guilt' (p.41). Indeed talking, sharing and normalising were experienced by mothers as the building blocks of their new sense of

togetherness and growth. Participants talked about the importance of verbalising difficult emotions and thoughts for themselves and for others and the importance of building a shared narrative. The relief came from the process of making sense of one's own mental states and from the sharing process. The mutuality of the shared experiences and the experience of feeling felt (Siegel, 2013) by others, and of feeling others, normalised their experience in a way that moved them back into humanity.

Applying these findings to the clinical arena, psychotherapeutic interventions in the perinatal period should aim to address intrapsychic alienation and interpersonal isolation through validation and togetherness by supporting mothers' development of a new/better social network. These recommendations are particularly relevant to mental health professionals offering interventions in London where, according to the 2011 census, 37% of the population was born outside the UK, with some boroughs' figures as high as 55% (the borough offering PIP had the highest non-UK born population).

5.2.2.3. Mothering mothers

Psychotherapists were experienced as caring family members, sometimes referred to as the mother or sister the participants had never had – trustworthy and protective, nurturing and loving. Participants reported feeling met, respected, listened to, heard and understood by their psychotherapists. They experienced the therapists as giving them love, care, encouragement, support and help – experiences that I grouped under the 'maternal function' umbrella. Like a mother who attends to the needs of her baby in order to allow him or her to grow, mothers felt that the nurturing stance of the therapists enabled their own growth. Mothers felt met, which then allowed them to meet the needs of their children. The parallel between the psychotherapist-client and mother-baby dyad has already been well established, but these findings highlight the specific mothering dimension of the PIP psychotherapist-mother and the maternal function of the psychotherapist, which facilitates the growth of the maternal self and its mothering capacity. These findings confirm Stern's (2005) understanding

of a mother needing to be held by a maternal figure, which then liberates, unravels and facilitates her own maternal function. 'When someone hears a mother's own cries, she becomes able to comfort her baby' (Hopkins, 2008, p.58).

Winnicott (1965) distinguished three key aspects of mothering: emotional holding, physical handling and object presenting, all necessary to the growth of the baby. Transporting those concepts to the context of mothering mothers, it was very interesting to hear mothers talking about the physical engagement of the therapists through the home visits, phone calls, and physical hugging. They identified it as being the root of their feeling of trust in the therapist and in the treatment. During the initial referral discussion, PIP was identified as a possible source of support as it is provided by a 'caring and loving' psychotherapist who authentically and proactively works towards meeting women through their actions as well as their words.

Here we have the good-object PIP therapist (Fairbain 1981) holding and handling the client. There are two interesting features of the mothers' relationship with the PIP good-object-therapist that requires some attention.

First, this finding highlights the importance of the non-verbal relational dynamic between the psychotherapist and the mother prior to and during PIP, which predisposes the mother to having a different emotional experience with a good-object-therapist. Without attempting to develop a causal explanation, we can wonder whether the mother's trusting relationship with a good-object-psychotherapist in the here-and-now also allows for a reflective exploration of the relational dynamics of the there-and-then. These findings echo the contemporary notion that 'patient's experience with a new object who responds qualitatively differently towards the patient may indeed be contributing to change at the procedural level bypassing language' (Lemma, 2003, p.5) with the interpretative work being less important than once assumed. This 'how to be with others' (Stern et al, 1998) that occurs, and is encoded, at a pre-symbolic level in infancy might also be addressed at the same pre-symbolic level during the developmental opportunity that is psychotherapy.

Second, these findings suggest that the clients' experience with a new object who responds qualitatively differently towards them starts prior the actual beginning of the treatment. Therefore the psychotherapist's home visit with the clients at the referral stage can be used psychotherapeutically to establish the psychotherapeutic alliance prior to the start of the actual intervention. Research has confirmed the efficacy of home visits on children's development (Campbell & Ramey, 1995; Gutelius et al, 1972; Jester & Guinagh, 1983; Karnes, Teska & Hodgins, 1970; Levenstein & Sunley, 1968; Powell & Grantham-McGregor, 1989; Ramey & Campbell, 1991; Slaughter, 1983). However, the home visits suggested here have a different primary use: to establish a therapeutic relationship with the mother and facilitating her engagement with the treatment, while also being part of the overall psychotherapeutic experience. This seems particularly important with hard-to-reach populations who tend not to engage with mental health services. Within this context, the therapeutic relationship starts at the moment of referral, with the recommendation to meet mothers where they are, which is often at home. It echoes Fraiberg's idea of PIP as a 'therapy at the kitchen sink' of the patient's home (1975).

These findings confirm the importance of an integrative approach to PIP, where both intrapsychic and interpersonal interventions are offered, as it gives mothers the opportunity to understand how their relational past impacts their relational present, as well as experiencing a different/reparative relational experience at a symbolic and procedural level. It agrees with Fonagy's understanding of the general psychotherapeutic process as 'more than the creation of a new narrative...[but] the construction of a new way of experiencing self with other' (1999, p.218).

5.2.2.4. Learning and development

Participants reported two highly valued sources of procedural learning in the construction of a new way of experiencing their selves with others (child, family members, society): learning through being with, and learning through being taught. Some mothers felt they did not know how to mother. For various reasons,

they had a general feeling of unconfidence in their mothering capacity. They felt immensely grateful for the therapist teaching them how to love, play, care and be with their child. This educational process was reported as being cardinal to mothers' psychotherapeutic journey. Participants reported gaining a sense of their own maternal competency, which transformed their relationship with motherhood. Knowing how to 'do' made them feel legitimate in their maternal function, which then did not need to be avoided nor abnegated. As a consequence, mothers reported a greater sense of engagement, pleasure and satisfaction in mothering. This confirms previous findings on the active fostering of mothering capacities leading to higher levels of maternal competence, ability and satisfaction (Muir, 1992; Cohen et al, 1999).

Deming (1986) highlights the importance of learning in the process of transformation: new knowledge is obtained through learning from outside (psychotherapists, other mothers), but it is nothing without action (applying new knowledge, leading to relational change). Research on behavioural approaches to PIP, such as *Watch, Wait and Wonder*, has already acknowledged the positive outcomes of actively/physically involving mothers and fostering positive mothering capacities (Muir, 1992). This finding confirms the importance of the active teaching-learning process. From a clinical application perspective, it means that psycho-educational and behavioural interventions should be part of the PIP offering, delivered according to the needs of the mother-baby dyad, with the presence of the baby actualising such opportunities for procedural learning. As teaching is reinforced by observation opportunities, group PIP might be recommended to expand the educational dimension of PIP. An integrative approach should be adopted that allows for a cognitive, behavioural, emotional or relational point of entry, as well as therapeutic goals and interventions, within the PIP umbrella.

5.2.3. PIP as a Relational-Transformational space

5.2.3.1. *The meaning mothers ascribed to changes – a transformation*

Participants reported affective, behavioural, cognitive and interpersonal changes. These findings corroborate the existing body of evidence on psychotherapy outcomes in general (Smith & Glass, 1977; Wampold et al, 1997; Wampold, 2001) and in PIP in particular (Barlow, 2007; Kennedy & Midgley, 2007; Lieberman, Weston & Pawl, 1991; Fonagy, Sadie & Allison, 2002; Robert-Tissot et al, 1996). These findings confirm the conceptual understanding of PIP as an intervention leading to representational, behavioural and relational change (Fraiberg, 1975, Stern, 1995; Baradon et al, 2005; Barlow, 2014) and add to the growing body of evidence that PIP as an impactful intervention with regard to maternal mental health, mothering capacity, relational engagement and self-representations as a mother (Barlow, 2007; Cohen et al, 1999; Cohen et al, 2002; Cramer et al, 1990; Fonagy, Sadie & Allison, 2002; Lieberman, Weston & Pawl, 1991; Murray et al, 2003; Robert-Tissot et al, 1996). Interestingly, these findings add another dimension to our understanding of change in PIP by foregrounding the meaning ascribed by mothers to these changes. Mothers experienced changes not as simple substitution but as deep internal transformation leading to a paradigm shift.

The profound and life-changing experience of psychological transformation described by mothers illustrate beautifully Daszka's theory of transformation as 'a change in mindset based on learning a system of profound knowledge and taking actions based on leading with knowledge and courage' (2005, p.1). When applied to psychological processes, transformation implies the creation of a new internal structure that transforms the individual's rapport with him- or herself (his/her internal world), others and the world. It would be legitimate to ascribe the term 'metanoia' to the participants' profound transformation of their mental processes, which they experienced as a real paradigm shift.

According to Daszka (2005), three conditions are required for a transformation to occur: an intention to change, the courage to change and someone to lead the

change in trust and safety – the intention being rooted in an ‘awakening to the crisis’ (Deming, 1986). These three conditions were present in participants’ experience. Mothers felt desperately unhappy, in crisis. They felt well aware of their limitations and were ready to engage with whatever it took to change. Their motivation facilitated, and then supported, their positive engagement with PIP, echoed in findings on therapy effectiveness (Overholser, 2005; Ryan & Deci, 2008). They found in the psychotherapists/group the trust required to take the risk to change. The psychotherapists were clearly identified as the ones leading, facilitating and containing the process of transformation. ‘Without intention (mother wanting to change), transformation is reduced to change (i.e. mother learnt a new behaviour by identifying with other mothers/psychotherapists)’ (Daszka, 2005, p.4). This change is very different from acquiring profound knowledge (reflexivity), which can then be applied to the world.

As clinicians we need to think about what we offer and how it might facilitate this transformative process. A conscious effort to reunite the necessary conditions for change is recommended: on one side, being the one that knows and leads in safety, yet being humble and open to the client’s knowledge and expertise about themselves and their difficulties; on the other side, being able to assess and work with clients’ desire and courage to change, or lack thereof. It draws our attention to the referral and assessment phase: both referrers and assessors ought to spend time evaluating mothers’ volition to change, as it appears to be an influential factor in their experience of the PIP process and outcome. Ambivalence towards treatment should be explored and worked through sooner rather than later, to facilitate the emergence of a positive working alliance.

5.2.3.3. On becoming a mother

Being a biological mother is not the same as feeling like a mother, identifying as the mother of one’s child or feeling able and/or competent at mothering. Women reported a very important change with regard to their sense of their maternal selves, with movements from bad to good, toxic to nourishing, non-mother to

mother and from mother to the mother of their child – these were life-changing existential experiences. Each movement was singular and subjective in its emotional, behavioural, representational and relational expression. Considering the complexity of women’s experience of motherhood, and the disjunction that might exist between maternal love, mothering and identity, these findings throw some light onto these processes, which would otherwise be impossible to quantify. From a clinical perspective, it means that PIP’s maternal outcomes should be jointly explored by the client and the therapist in a way that honours its subjectivity and complexity.

While comparative studies failed to demonstrate a statistically significant improvement in maternal mental health and the mother-baby relationship (Barlow, 2014), qualitative findings offer a different perspective. Mothers felt different from within, which was not an externally observable change, but which nevertheless impacted their being-in-the-world. Perhaps what is important is not to identify which intervention is more efficient than another, but rather which interventions work for women and their children and why, so that we can develop a better understanding of the matching process between a client’s needs and intervention type.

5.2.3.2. Emotional Reflectiveness as a new position from which to engage

Participants experienced PIP as a process of transformation of their maternal self, which meant that they engaged with themselves, others and the world from a different vantage point (new perspectives). They reflected upon the links between the past, the present and the future, on themselves and others (their children, husbands, mothers) owning their preoccupations and taking responsibility for the interpersonal and intrapsychic links between generations. Within the safety and containment of the PIP relational space, they connected with and reflected upon their emotional world, a process also called mentalising (Fonagy et al., 1997), emotional understanding (Orange, 1995), mind sighting (Siegel, 2013) and more generally some form of meta-reflection. Mothers’ capacity to reflect seemed to have been at the heart of the transformation, which

is in line with PIP's aim of developing parental mental functioning. It is also aligned with the growing body of evidence pointing to the effectiveness of PIP in terms of improving both parental and children's functioning (Cohen, 1999; Cohen, 2002).

The reflective function lies at the heart of our construction of the self (Baradon et al, 2008; Camino Rivera et al, 2011; Fonagy et al, 2002). The self can be understood as the 'I' being the self-reflective agent with a 'capacity to experience, observe and reflect upon oneself as both subject and object' (Aron, 2000, p.3) and the 'me' being the representation that one holds about oneself. Mothers reported that both the 'I' and the 'me' within the maternal selves had changed through PIP. These findings confirm the transformative and developmental value of PIP as a psychotherapeutic intervention, enabling the expansion and growth of the self and its reflective capacity. Giving mothers an opportunity to develop their reflective function through PIP also gives them an opportunity to develop their capacity to connect with their internal (pain) and interpersonal world, without reverting to escapism, to manage psychological pain. This management is essential for the mother and for her relationship with her child and his or her development.

5.2.3.4. The question of hope

Research on resilience and the role of early prevention proposes that 'resilient children had at least one good experience of a relationship. These positive relationships were experienced by the children as a source of hope, that protected them inwardly from psychic resignation and capitulation' (Hauser, Allen & Golden, 2006 cited in Emde & Leuzinger-Bohleber, 2014). Just as Emde (2014) connects prevention with hope, implying that it might be possible 'to open a window of hope in the dark child's world' (p.39) through the experience of being in relation to an empathetic, reliable adult, the same window of hope seemed to open for mothers through the experience of being in a relationship with loving, caring, compassionate and supportive others (the psychotherapist and the group). These connections seemed to allow for the transformation and

instilling of hope. Through PIP, mothers came to experience – and therefore to believe in and expect – positive change. This is a strong argument in favour of making PIP more readily available to struggling mothers, as the instilling of hope will cascade down from the therapist-client relationship to the mother-child relationship.

Providing ‘one good experience of a relationship’ could be understood as the aim of PIP and any other form of psychotherapy. The participants shared stories about inclusive relationships where psychotherapists were able to meet them where they were. The whole of them was welcome in the therapeutic space and as mothers, that meant them and their child(ren). I work in an IAPT service that offers short-term dynamic psychotherapy. Some of our clients are mothers with babies, frequently in very difficult social and economic positions. I had endless conversations with colleagues who systematically refuse to see mothers if they bring their babies. Their rationale is that the presence of the baby disrupts the therapeutic space, the mother cannot focus on the exchange with the therapist while holding and handling her child and that the baby will be distressed by the mother’s distress.

This presupposes that a mother’s distress is only expressed during the psychotherapy hour, that a mother can revert to being a woman only during that hour and that the presence of the child and the mother-child relationship in the psychotherapy room cannot be used therapeutically. Most of the mothers that are told they can only be seen alone do not come back. In the name of theoretical principles, I believe that too many opportunities for ‘one good relationship’ are lost. I understand, of course, the importance of a therapeutic framework, but I believe that the frame needs to be flexible and inclusive, based upon our understanding of what constitutes a ‘good relationship’, whether in PIP and any other type of psychotherapy.

5.3. Contribution of this study

This study contributes to a deeper understanding of PIP processes and outcomes by making sense of it from the clients' perspective. It offers narratives of experience that illustrate conceptual frames and therefore confirm their validity. By adding an experiential and qualitative lens to it, this research builds on the validity of current PIP models and expands them further by integrating new elements.

This study brings to light women's experience of PIP as a nurturing, humanising and transformative experience, which enabled them to experience their maternal selves and navigate motherhood differently. It highlights the qualitative changes in mothers' lives, which they attribute to their experience of PIP and which they value as affirming and transformative. These reflect existential changes that could not have been assessed or quantified by an external observer.

This study engages us with universal themes such as psychological pain, despair and escape as well as growth, connection and hope within the context of motherhood. It identifies PIP as a relational-transformational space that has valuable therapeutic potential for mothers and their children.

This study calls for an integrative approach to parent-infant psychotherapy that transcends the restrictions imposed by singular modalities, with PIP being offered as a relational-transformational space where mothers can experience their selves-in-relation to themselves, their pain, their peers, their children and the intra- and interpersonal world in general.

5.3.1. Practical implications

The study's contribution will be fully realised by integrating and applying its findings to various elements within the perinatal field.

Just as this study's participants hoped that other women would benefit from this life-changing experience, it is my hope that commissioners will use participants' gratitude, generosity, awareness and determination as pillars of their decision to fund perinatal mental health services and widen women's access to PIP, using this study to elaborate their service provision. Key factors would include working collaboratively with professionals in the field to identify potential PIP clients, adopting in-depth assessment procedures that integrate an upstream approach to understanding clients' needs, using the referral and assessment phase as integral parts of the psychotherapeutic process and ensuring that there is a match between the clients' needs and the services offered.

Professional PIP training is very limited in the UK, with only two training institutions offering qualifying courses, both of which are psycho-dynamically informed. However, this research confirms the importance of an integrative approach to PIP that also includes behavioural, psycho-educational and interpersonal interventions. PIP trainers could therefore draw on this research to design and deliver integrative PIP training that conveys to their students the effectiveness of an inclusive approach, honouring mothers' subjectivity.

From the perspective of psychotherapists working in the perinatal mental health field, drawing on this research offers the potential for enhancing the psychotherapeutic relationship (and therefore enhancing the possible psychotherapeutic outcomes) by gaining a deeper understanding of the PIP psychotherapist-client relationship. This research confirms the importance of the psychotherapeutic relationship as the container and vehicle for change, and it expands its purview to the pre-intervention phase. It highlights the importance of the 'realness' of the psychotherapist, the trust of the pre-intervention relationship that cements the psychotherapeutic alliance and the essential maternal function of the psychotherapist. These key features play a determining role in PIP outcomes and need to be integrated into clinical thinking.

In conjunction with the above, PIP psychotherapists and supervisors will gain from this research an appreciation of the delicate balance required in PIP

between holding in mind the baby, the mother-baby-self and the mother, with the mother being acknowledged and engaged with not only as the agent of the child's healthy development but in her entire being. PIP supervisors play an essential role in supporting PIP psychotherapists in their complex clinical activity. This study offers them an additional lens from which to jointly consider PIP clinical material, both inside and outside the sessions.

From a more personal perspective, I have integrated the findings of this study into my clinical thinking and practice, both in my perinatal work and, to a certain extent, in my general work. To me, this study has highlighted the complexity of clinical encounters between psychotherapists and clients, and the need to pay attention to the intrapsychic, the interpersonal and the contextual (cultural, social, economic and political) interplay within the inter-subjective frame. I was so moved by participants' accounts of their transformative journey through PIP that it filled me with the energy and drive to bring this study to completion. Mothers had something so important to say that I was determined for others to hear it and benefit from it.

Considering the gap between the recognition of maternal mental health as a priority and actual service provision in the UK, it is my hope that this research will give commissioners an appreciation of the real distress experienced by mothers who struggle in the perinatal period, the importance of offering an intervention that meets their specific needs and the relevance of PIP as an effective valued and transformative psychotherapeutic intervention for mothers, their babies and their families.

5.4. Limitations of this study and considerations for future research

5.4.1. Linguistic perspective

I am a French psychotherapist-researcher living and working in a multicultural city where more than a third of the population was born abroad, including most of my clients. I live and work in the London Borough of Brent, a complex and

impressive melting pot of ethnicities, religions, cultures and languages. More often than not, I find myself in a clinical room using a language that is neither mine nor my clients'. More often than not, families come to our service with the father speaking one language, the mother speaking another and the children answering in a third, and we all communicate in English, sometimes through an interpreter, with different levels of ease and dexterity.

In this research, like in my clinical work, I worked with the assumption that the English language was our precious tool of communication and that despite our multiple differences and varied linguistic competencies, we would indeed manage to understand each other.

It is undeniable that with the researcher as well as five participants out of seven being non-native English speakers, the impact of the language on the research object, methodology, process and outcomes would be fundamental.

Even though I was well aware of the importance of language, I decided not to use a methodology that placed it at the centre of the analysis; I was more interested in the subjectivity of the participants, with the language being part of that process. As with my clinical practice, I went through the research being aware of the language component, working with it as but one of the factors in the encounter. However, that prism has its limits.

It would be interesting to research mothers' experience of PIP using a linguistic approach that brings to the fore how language structures clients' experience of PIP. Alternatively, it would also be very interesting to research mothers' experience of PIP in circumstances where psychotherapists and clients share a mother tongue.

5.4.2. Anthropological perspective

Similarly, the ethnic heterogeneity of the participant sample was rather representative of the general client population seen in London by PIP clinicians.

While I want to acknowledge the bias that this sample had on the research process and outcomes, leaning as it did towards non-native speakers, I also feel it foreshadows a more common experience in a world where families are more and more transient. Becoming and being a mother in a foreign country impacts women's experience of motherhood; mothers attempting to find their feet in a non-mother-country might present specific wounds, difficulties and needs that differ from the needs of native mothers.

The specific context of dislocation, isolation and loneliness described by the majority of participants undoubtedly impacted their experience of PIP. Future research could benefit from using a social constructive approach that unpacks the structuring role of social and cultural factors upon participants' experience. Comparative research on native and non-native mothers' experience of PIP would also bring a different light to our understanding of the interplay between PIP and clients' subjectivity.

Finally, the research was limited by the fact that only mothers who completed the treatment once, and sometimes twice, agreed to participate. All but one of the mothers were extremely enthusiastic about PIP, but this leaves me wondering about the mothers who never started the treatment, those who struggled to engage and those who stopped prematurely. Further research is needed to discover what facilitates or hinders mothers' engagement with PIP. It would be very interesting to interview mothers who refused to engage and/or drop out. There is as much to learn from failures/ruptures as from successful encounters.

5.5. Impact the study had on me

What really moved me, listening to the mothers' accounts of their experience of transformation, was the sense of movement from darkness to light, from depression to vitality, from escapism to engagement. Whereas they had felt the pain so keenly that the only bearable solution was to exit from the relational world psychically and physically (with the ultimate exit being death), they came to feel hopeful and potent. Unlike my sister, I never felt hopeless to the point of

suicide but I did feel stuck with an unthinkable, unbearable pain that I could only vomit through an eating disorder or concretely express through migraines. Mothers found in PIP a place where their pain could be felt, thought about, understood and accepted, which allowed them to anchor their feet to the ground and embrace life dynamically. They found in each other and in the therapists a relational web that transformed their relationship to their pain. I wish my mother and my sister had found such a relational place. I did find such a place, which I sometimes experienced as a blessing and a curse. Could I really give myself permission to live and to grow when both my sister and mother were physically and/or emotionally dead? Through PIP, mothers became able to accept their pain (as opposed to escaping it), which paradoxically allowed them to let go of it and change.

Reflecting upon mothers' experience of PIP as a process of change enabled me to unlock something about my own process. I became aware that despite years of studying, researching and practising, I need to accept that I will never fully understand what happened between my mother and my sister, nor will I discover how they could have been saved. My sister was studying psychology when she ended her life a year before graduating. For the past sixteen years of my life, I have been postponing my own graduation. I left France when I was twenty-three (the age she was when she died), just before completing my psychology training. Giving myself permission to reach this end point (which on so many levels is also a beginning point) has proven to be extraordinarily difficult. I completed four diplomas between the beginning and the end of this research. I built a flourishing private practice, developed a solid NHS base and got involved in various charities. I surprised myself by my determination and capacity to expand professionally, and yet my systematic inability to move this research forward (in other words my inability to bring my psychology training to an end).

By accepting their pain, mothers became able to stay present and connected with themselves, their child(ren) and others. By accepting mine, I became able to complete this thesis, that is to say I became able to grow and enjoy this process

of growth through connections. This research journey has been a transformational experience for me like PIP has been for the mothers I met. Like them, I am immensely grateful to those who were part of that journey.

Frederikson (2013) redefined love as ‘an interpersonally situated experience marked by momentary increases in shared positive emotions, biobehavioral synchrony and mutual care which, over time, builds embodied rapport, social bonds and commitment’ (p.23). I know from personal and professional experience the therapeutic value of those moments. PIP, and psychotherapy in general, is an opportunity to experience those shared moments of connection which move human beings from isolation to togetherness, from alienation to belonging. The therapist’s capacity to authentically and genuinely meet clients is key to these therapeutic encounters. Coming from a tradition of neutrality, I am growing more confident in my ability to use my humanity; this research project has moved me even further in that direction. As a researcher and as a therapist, I try to use the whole of myself to connect with my clients. I now feel a greater sense of freedom and enjoyment in my clinical work. This ‘I and Thou’ (Buber, 1937/2010) is not new to the world of psychotherapy, but it has definitely been my personal growing edge.

Even though this research project took place within the field of parent-infant psychotherapy, I found myself using what I learnt from it far beyond that field. The importance of the context in which clients live, the meaning of their psychological pain and how they manage it, the need for connection and yet the need to withdraw from the relational space as a way of escaping the pain, the importance of positive relationships, emotions and the possibility of growth. These are not things I had never considered before, but somehow they seem to fit together in a different and more helpful way now. I now have an integrative model that I use to think about my therapeutic work as well as any of my relational engagements with others. I feel free from the restriction of theoretical modalities and able to use my whole self to meet my clients. I work towards remaining connected, with my feet firmly on the ground, my heart and soul aiming high.

Chapter 6. Conclusion

As a qualitative researcher I collect stories – interesting, moving, surprising, exciting stories about human lives. Love-hatred, courage-fear, pain-joy, hope-despair, loss-enrichment, death-vitality, all sorts of emotional polarities are present. The stories I collect are about motherhood specifically, and the complexity of human existence more generally. What I understand from these stories is that curiosity, compassion, care and support experienced through relationships make a difference to people’s experience of themselves and their emotional turmoil. Together, clients and therapists build stories that contain these polarities and help the client to develop a more peaceful relationship between those extremes. The mother that was hated for having given her child to the auntie can also be understood as a mother that must have suffered from this separation as well; the child that evoked so much violence inside the mother and that was made to cry with satisfaction can also be engaged with as a vulnerable and tender child that the mother can comfort and have pleasure with; the husband that was experienced as a monster for not giving what was so desperately needed can be tolerated as imperfect but still loving and loveable.

I will always remember how Bindhy burst out laughing as she recounted how she did not eat for days because her sister-in-law had not told her she was getting married. Now that she knew she mattered to someone (first her psychotherapist, which then made her realise that she did matter to her husband, her mother, her children), she felt so differently about it. Now she said she would laugh about it instead of wanting to die. Now indeed she was laughing yet feeling very compassionate for the child in her that had felt so abandoned and unworthy.

PIP made a difference to each of these women’s lives. It helped them to grow. It helped them to see the beauty of life despite its pitfalls and existential difficulties. Having let mothers’ stories go through me, the story I told about their stories was a story of mental, emotional, social and physical resilience-building through relationships. Mothers left PIP feeling more able to think, to feel, to

relate and to act. That is what I feel is so precious about PIP, or indeed about any psychotherapeutic encounter. I do not believe one needs to be prescriptive about the framework of such an encounter; rather, I believe one needs to be inclusive and authentic.

As a qualitative researcher and doctoral student, I write a story and the story writes me. Doing this research changed me and changed my practice. It challenged me deeply. It got me outside my safe zone. I entered the research with a psychoanalytic, modality-based perspective which had its origins in my personal history and my identification with my sister. Through the research, I opened my mind, expanded my curiosity, welcomed the unexpected and challenged my beliefs. I learnt to accept diversity and polarities, my own and others'. I learnt to integrate myself with my practice. It has been a challenge to be me outside the shadow of my sister and her interest in psychoanalysis. It has been a challenge to give myself permission to go beyond where she had been in order to find out who I am as a person and as a practitioner. I moved beyond my narrow conception of PIP and psychotherapy to embrace a fully integrative approach which transformed my professional identity and practice. I believe that this personal and professional journey through freedom and integration represents the journey that will enable PIP to also move beyond where it has been. It is my hope that this research will facilitate this move.

References

Aron, L. (2000). Self-reflexivity and the therapeutic action of psychoanalysis. *Psychoanalytic Psychology*, 17(4), 667-689 (originally presented at the APA meeting in Toronto, 1998)

Almond, P. (2009). Postnatal depression: a global public health perspective. *Perspectives in Public Health* 129(5), 221-7.

Alvesson, M. & Skoldberg, K. (2009). *Reflexive methodology: New vistas for qualitative research*. London, Sage.

Angeen, J.M. (2000). Evaluating interpretative enquiry: Reviewing the validity dialogue. *Qualitative Health Research*, 10(3), 376-395.

Ashworth, P. (2003). An approach to phenomenological psychology: The contingency of lifeworld. *Journal of Phenomenological Psychology*, 34(2), 145-156.

Atwood, G.E. & Stolorow, R.D. (1984). *Structures of subjectivity: Explorations in psychoanalytic phenomenology and contextualism*. London & NYC: Routledge.

Badinter, E. (1981). *L'amour en plus*. Paris: Flammarion.

Badinter, E. (2010). *Le conflit: La femme et la mere*. Paris: Flammarion.

Bandyopadhyay, M., Small, R., Watson, L.F. & Brown, S. (2010). Life with a new baby: how do immigrant and Australian-born women's experiences compare? *Australian and New Zealand journal of public health* 34(4), 412-21.

Banyard, V.L. (1997). The impact of childhood sexual abuse and family functioning on four dimensions of women's later parenting. *Journal of child abuse and neglect*, 21(11), 1095-1107.

Bakermans-Kranenburg, M.J., Juffer, F., & Van Ijzendoorn, M.H. (1998). Intervention with video feedback and attachment discussions: does type of maternal insecurity make a difference? *Infant Mental health Journal*, 19(2), 202-219.

Bakermans-Kranenburg, M. J., Van Ijzendoorn, M. H. & Juffer, F. (2003). Less is more: Meta-analyses of sensitivity and attachment interventions in early childhood. *Psychological Bulletin*, 129(2), 195-215.

Baradon, T. (2005). "What is genuine maternal love?": Clinical Considerations and Technique in Psychoanalytic Parent-Infant Psychotherapy. *Psychoanalytic Study of the Child*, 60, 47-73.

Baradon, T., Broughton, C., Gibbs, I., James, J., Joyce, A. & Woodhead, J. (2005). *The practice of Psychoanalytic Parent Infant Psychotherapy: Claiming the Baby*. East Sussex: Routledge.

Baradon, T., Fonagy, P., Bland, K., Lenard, K., & Slead, M. (2008). New Beginnings – an experienced-based program addressing the attachment relationship between mothers and their babies in prisons. *Journal of Child Psychotherapy*, 34(2), 240-258.

Barlow, J. (2007). *Dispelling the ghosts in the nursery: Clients views about parent-infant psychotherapy*. Warwick Medical School: University of Warwick.

Barlow, J., Midgley, N. & Bennet, C. (2013). Parent-infant psychotherapy for improving parental and infant mental health: Review protocol. *Cochrane Database of Systematic Reviews*, 1469-1493.

Barlow, J., Midgley, N., Soili, K. & Yinghui, W. (2015). Parent-infant psychotherapy: a systematic review of evidence for improving parental and infant mental health. [Preprint].

Barnett, W. S. (1995). Long-term effects of early childhood programs on cognitive and school outcomes. *The Future of Children*, 5(25-50).

Barnes, J. & Freude-Lagevardi, A. (2003). *From pregnancy to early childhood: Early interventions to enhance the mental health of children and families*. London, Mental Health Foundation. Available from: www.mentalhealth.org.uk/content/assets/PDF/publications/pregnancy_early_childhood_report.pdf

Barrows, P. (2003). Change in parent-infant psychotherapy. *Journal of Child Psychotherapy*, 29(3), 283-300.

Baruch, G., Fonagy, P. & Robins, D. (2007). *Reaching the hard to reach: Evidence-based funding priorities for intervention and research*. West Sussex, John Wiley & Sons.

Bauer, A., Parsonage, M., Knapp, M., Lemmi, V. & Adelaja, B. (2014). *The costs of perinatal health problems*. London, Centre for Mental Health. Available from: http://www.centreformentalhealth.org.uk/pdfs/Costs_of_perinatal_mh.pdf

Beck, C.T. (1995). The effects of postpartum depression on maternal-infant interaction: a meta-analysis. *Nursing Research*, 44(5), 298-304.

Beebe, B., Jaffe, J., Markese, S., Buck, K., Chen, H., Cohen, P., Bahrnick, L, Andrews, H & Feldstein, S. (2010). The origins of 12-month attachment: a microanalysis of 4-month mother-infant interaction. *Attachment & human development*, 12(1-2), 3-141.

Beebe, B. & Lachman, F.M. (1988). Mother-infant mutual influence and precursors of psychic structure. In: Goldberg, A. (ed.), *Progress in self-psychology*. Hillsdale, NJ: Analytic press, 3, 3-25.

Beebe, B. & Lachman, F.M. (1998). Co-constructing inner and relational processes: Self- and mutual regulation in infant research and adult treatment. *Psychoanalytic Psychology*, 15(4), 480-516.

Beebe, B. & Lachman, F.M. (2014). *The Origins of Attachment: Infant Research and Adult Treatment*. NYC: Routledge.

Beeghl, M. & Tronick, E. (2011). Early resilience in the context of parent-infant relationships: A social developmental perspective. *Current problems in pediatric and adolescent health care*, 41(7), 197-201.

Berlin, L.J., Cassidy, J., Appleyard, K.C., Shaver, P.R. (2008). The influence of early attachments on other relationships. In Cassidy, J. & Shaver, P.R. (ed), *Handbook of attachment: Theory, research, and Clinical Applications*, 2nd edition. New York, NY, Guilford Press, pp.333-47.

Berman, M. (1981). *The reenchantment of the world*. Ithaca, NY, Cornell University Press.

Bion, W.R. (1962). *Learning from experience*. London, Heinemann.

Bloom, P. & Keil, F.C. (2001). Thinking through language. *Mind and Language*, 16(4), pp.351-367.

Boroditsky, L. (2011). How language shapes thought. *Scientific American*, 304, pp.62-65.

Bowlby, J. (1969). *Attachment. Attachment and loss Vol. 1*. New York, NY, Basic Books.

Bowlby, J. (1973). *Separation. Attachment and Loss Vol. 2*. New York, NY, Basic Books.

Braud, W. (1998). An expanded view of validity. In: Braud, W. & Anderson, R. (eds.), *Transpersonal research methods for social sciences*. Thousand Oaks, CA, Sage.

Breslau, J., Kendler, K.S., Su, M., Gaxiola-Aguilar, S., Kessler, R.C. (2004). Lifetime risk and persistence of psychiatric disorders across ethnic groups in the United States. *Psychological Medicine*, 35(03), pp.317–327.

Breslau J, Aguilar-Gaxiola S, Kendler KS, Su M, Williams D, Kessler RC. Specifying race-ethnic differences in risk for psychiatric disorder in a USA national sample. *Psychological Medicine*, 2005;36(01), pp.57-68.

Brown, L. & Ballou, M. (1994). *Personality and psychopathology: Feminist reappraisals*. Guilford: Guilford Press.

Bruner, J.S. (1969). Modalities of memory. In: Talland, G.A. & Waugh N.C. (eds.), *The pathology of memory*. New York, NY, Academic Press, pp.253-259.

Brunstein-Klomek, A., Marrocco, F., Kleiman, M., Schonfeld, I.S. & Gould, M.S. (2007). Bullying, depression, and suicidality in adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry*, 46, pp.40-9.

Bryant, D., & Maxwell, K. (1997). The effectiveness of early intervention for disadvantaged children. In: Guralnick, M. (ed.), *The effectiveness of early intervention*. Baltimore, MD, Brookes, pp.23-46.

Buber, M. (2010). *I-Thou*. New York, NY, Bloomsbury Edition. (Original work published 1937).

Burlingham, D. & Freud, A. 1(1942). *Young Children in War-Time*. London, Allen & Unwin.

Burlingham, D. & Freud, A. (1944). *Infants Without Families*. London, Allen & Unwin.

Burr, V. (2002). *The person in social psychology*. Hove: Psychology Press.

Butt, T. & Lang ridge, D. (2003). The construction of self: the public real into the private sphere. *Sociology*, 37(3), 477-94.

Bylington, D. (1997). Applying relational theory to addiction treatment. In: Straussner, S. & Zelvin, E. (eds.), *Gender and addictions: Men and women in treatment*. Northvale, NJ: Jason Aronson, pp.33-45.

Cacioppo, J.T., Hughes, M.E., Waite, L.J., Hawkley, L.C. & Thisted, R.A. (2006). Loneliness as a specific risk factor for depressive symptoms: cross-sectional and longitudinal analyses. *Psychology and Aging*, 21(1), 140-52.

Caldwell, G. (2008). *Theory with a capital "T": Exploring the various roles of theory within IPA research process*. Available from: <http://groups.yahoo.com/group/ipanalysis/files>.

Camino Rivera, C., Asquith, K. & Prutzel-Thomas, A. (2011). Thinking about my toddler: Can a psychoanalytic toddler group enhance reflective functioning capacities in parents? In: Zaphiriou Woods, M. & Pretorius, I.M. (eds.), *Parents and toddlers in groups, A psychoanalytic developmental approach*. London: Routledge.

Campbell, F. A. & Ramey, C. (1995). Cognitive and school outcomes for high risk African American students at middle adolescence: Positive effects of early intervention. *American Educational Research journal*, 32, 743-772.

Carlson, E. & Sroufe, L. A. (1995). Contribution of attachment theory to developmental psychopathology. In: Cicchetti D. & Cohen, D. J. (eds.), *Developmental psychopathology*. New York, NY: Wiley.

Chaffin, M., Kelleher, K. & Hollenberg, J. (1996). Onset of physical abuse and neglect: psychiatric, substance abuse, and social risk factors from prospective community data. *Child Abuse and Neglect*, 20(3), 191-203.

Chamaz, C. (2006). *Constructing grounded theory: A practical guide through qualitative research*. London: Sage.

Chodorow, N.J. (2013). "Too late": ambivalence about motherhood, choice, and time. *Journal of the American Psychoanalytic Association*, 51(4), 1181-98.

Cicchetti, D. & Lynch, M. (1995). Failures in the expectable environment and their impact on individual development. In: Cicchetti, D. & Cohen, D. J. (eds.), *Developmental psychopathology*. New York, NY: Wiley.

Cicchetti, D., Rogosch, F. A. & Toth, S. L. (2000). The efficacy of toddler-parent psychotherapy for fostering cognitive development in offspring of depressed mothers. *Journal of Abnormal Child Psychology*, 28(2), 135-148.

Cicchetti, D., Toth, S. L. & Rogosch, F. A. (1999). The efficacy of toddler-parent psychotherapy to increase attachment security in offspring of depressed mothers. *Attachment & Human Development*, 1(1), 34-66.

Cohen, N.J., Muir, E., Lojkasek, M., Muir, R., Parker, C.J., Barwick, M. & Brown, M., (1999). Watch, Wait and Wonder: Testing the effectiveness of a new approach to mother-infant psychotherapy. *Infant Mental Health Journal*, 20, 429-451.

Cohen, N.J., Lojkasek, M., Muir, R. & Parker, C.A. (2002). Six month follow-up of two mother-infant psychotherapies: convergence of therapeutic outcomes. *Infant Mental Health Journal*, 23(4), 361-380.

Conrad, P. (1987). The experience of illness: recent and new directions. *Research in the sociology of Health care*, 6, 1-31.

Cooper, P.J. & Murray, L. (1997). Effects of postnatal depression on infant development. *Archive of Disease in Childhood*, 77, 99-101.

Cooper, P.J. & Murray, L. (1998). Postnatal depression. *British Medical Journal*, 316(7148), 1884-6.

Cooper, P. J., Murray, L., Wilson, A. & Romaniuk, H. (2003). Controlled trial of the short- and long-term effect of psychological treatment of post-partum depression 1. Impact on maternal mood. *The British Journal of Psychiatry*, 182(5), 412-419.

Covington, S. (2007). The relational theory of women's psychological development: Implications for the criminal justice system. In: Zaplin, R.T. (ed.), *Female offenders: Critical perspectives and effective interventions* (2nd edition). Sudbury, MA: Jones & Bartlett.

Coyl, D.D., Roggman, L. A. & Newland, L.A. (2002). Stress, maternal depression, and negative mother-infant interactions in relation to infant attachment. *Infant Mental Health Journal*, 23, 145-163.

Cowan, P. A. & Cowan, C. P. (2002). Interventions as tests of family systems theories: Marital and family relationships in children's development and psychopathology. *Development & Psychopathology*, 14(4), 731-759.

Cowan, C. P. & Cowan, P. A. (2000). *When partners become parents: The big life change for couples*. Mahwah, NJ: Erlbaum.

Cozolino, L. (2006). *The neuroscience of relationships*. New York, NY, W. W. Norton & Company.

Crandell, L.E, Patrick, M.P. & Hobson R.P. (2003). 'Still-face' interactions between mothers with borderline personality disorder and their 2-month-old infants. *The British Journal of Psychiatry*, 183(3), 239-47.

Cramer, B. & Palacio Espasa, F. (1993). *La pratique des psychotherapies meres-bebes. Etude cliniques et techniques*. Paris: PUF

Cramer, B., Robert-Tissot, C., Stern, D.N., Serpa Rusconi, S., De Muralt, M., Besson, G., Palacio Espasa, F., Bachmann, J.P., Knauer, D., Berney, C. & D'Arcis, U. (1990). Outcome evaluation in brief mother-infant psychotherapy: a preliminary report. *Infant Mental Health Journal*, 11(3), 278-300.

Cramer, B. & Stern, D.N. (1988). Evaluation of changes in mother-infant brief psychotherapy: a single case study. *Infant Mental Health Journal*, 9, 20-45.

Crotty, J. (1998). *The foundations of social research: meaning and perspective in research*. London, Sage.

Cummings, E.M. & Davies, P.T. (1994). Maternal depression and child development. *Journal of Child Psychology and Psychiatry*, 35, 75-112.

Daszko, M. & Sheinberg, S. (2005). Survival is Optional: Only leaders with new knowledge can lead the transformation.

http://www.mdaszko.com/theoryoftransformation_final_to_short_article_apr05.pdf

Daws, D. (1989). *Sleeping through the night: Helping parents and sleepless infants*. London, Free Association Books.

Daws, D. (1999). Brief psychotherapy with infants and their parents. In: Lanyado, M. & Horn, A. (eds.), *Child and Adolescent Psychotherapy Handbook*. London, Brunner-Routledge.

DeGangi, G.A. (2000). *Pediatric Disorders of Regulation in Affect and Behavior: A Therapist's Guide to Assessment and Treatment*. New York, NY, Academic Press.

DeGangi, G.A., Breinbauer, C., Roosevelt, J.D., Porges, S. & Greenspan, S. (2000). Prediction of childhood problems at three years in children experiencing disorders of regulation during infancy. *Infant Mental Health Journal*, 21(3), 156-75.

- Deming, W. E. (1986). *Out of the Crisis*. Cambridge, MA, MIT Press.
- Dennett, D. C. (1987). *The Intentional Stance*. Cambridge, MA, MIT Press.
- De Wolff, M.S. & Ijzendoorn, V. (1997). Sensitivity and attachment: a meta-analysis on parental antecedents of infant attachment. *Child development*, 68(4); 571-91.
- Dickstein, S., Seifer, R., Eguia, M., Kuersten-Hogan, R. & Dodge, K. (2001). Early Head Start MAP: Manualized assessment of progress. *Infant Mental Health Journal*, 23, 231-249.
- Dozier, M., Stovall, C. & Albus, K.E. (1999). Attachment and psychopathology in adulthood. In Cassidy, J. & Shaver, P. (eds.), *Handbook of attachment: Theory, research, and clinical applications*. New York, NY, Guilford Press, pp.497-519.
- Dubowitz, H., Black, M., Kerr, M., Hussey, J.M., Morrel, T., Everson, M.D. & Starr, R. (2001). Type and timing of mothers' victimization: Effects on mothers and children. *Pediatrics*, 107, 728-735.
- Durlak, J. A. & Wells, A. M. (1997). Primary prevention mental health programs for children and adolescents: A meta-analytic review. *American Journal of Community Psychology*, 25, 115-152.
- Egede, L. (2006). Race, ethnicity, culture and disparities in health care. *J Gen Intern Med*. 21(6), pp.667-669.
- Elliott, R. & James, E., 1989. Varieties of client experience in psychotherapy: An analysis of the literature. *Clinical Psychology Review*, 9, 443-467.
- Emde, R. (2014). The prevention sciences of early development and challenging opportunities for psychoanalysis, In: Emde, R. & Leuzinger-Bohleber (eds.), *Early parenting and prevention of disorder: a psychoanalytic research at interdisciplinary frontiers*. London, Karnac Books.
- Emde, R. & Leuzinger-Bohleber, M. (2014). *Early parenting and prevention of disorder: Psychoanalytic research at interdisciplinary frontiers*. London, Karnac Books.
- Emde, R. & Spicer, P. (2000). Experience in the midst of variation: New horizons for development and psychopathology. *Development and Psychopathology*, 12, 313-331.

Evans, J., Heron, J., Francomb, H., Oke, S. & Golding, J. (2001). Cohort study of depressed mood during pregnancy and after childbirth. *British Journal of Psychology*, 323 (7307), 257-260.

Fairbairn, W.R.D. (1981). *Psychoanalytic Studies of the Personality*. London, Routledge (original work published 1952).

Finlay, L. (2003). Through the looking glass: Intersubjectivity and hermeneutic reflection. In: Finlay L. & Gough, B. (eds.), *Reflexivity: a practical guide for researchers in health and social sciences*. Oxford, Blackwell Publishing.

Finlay, L. (2008). A dance between the reduction and reflexivity. Explicating the 'phenomenological psychological attitude'. *Journal of Phenomenological Psychology*, 39, 1-32.

Fitzpatrick, R. (1984). Satisfaction with health care. In: Fitzpatrick, R., Hinton, J., Newman, S., Scambler, G. & Thompson, J. (eds.), *The experience of illness*. London, Tavistock Publications.

Fonagy, P. (1999). Memory and therapeutic action. *Inter Journal Psychoanalysis*, 80(pt2), 215-23.

Fonagy, P., Gergely, G., Jurist, E.J. & Target, M.I., 2002. *Affect Regulation, Mentalization, and the Development of the Self*. New York, Other Press.

Fonagy, P., Steele, H. & Steele, M. (1991a). Maternal representations of attachment during pregnancy predict the organization of infant-mother attachment at one year of age. *Child Development*, 62(5), 891-905.

Fonagy, P., Steele, H., Moran, G.S. & Higgitt, A.C. (1991b). Measuring the ghost in the nursery: A summary of the main findings of the Anna Freud Centre/University College London parent-child study. *Bulletin of the Anna Freud Centre*, 14, 115-131.

Fonagy, P., Steele, M., Steele, H., Leigh, T., Kennedy, R., Mattoon, G. & Target, M. (1995). Attachment, the reflective self, and borderline states: The predictive specificity of the Adult Attachment Interview and pathological emotional development. In: Goldberg, S., Muir, R. & Kerr, J. (eds.), *Attachment theory: Social, developmental and clinical perspectives*. Hillsdale, NJ: Analytic Press, pp.233-278.

Fonagy, P., Sadie, C. & Allison, L. (2002). *The Parent-Infant Project (PIP) Outcome Study*. London, The Anna Freud Centre (unpublished manuscript).

Fonagy, P. & Target, M. (2002). Early intervention and development of self-regulation. *Psychoanalytic Inquiry*, 22, 307-335.

Fonagy, P. & Target, M. (1997). Attachment and reflective function: Their role in self-organisation. *Development and Psychopathology*, 9, 679-700.

Fonagy, P., Target, M., Cottrell, D., Phillips, J. & Kurtz, Z. (2000). *A review of the outcomes of all treatments of psychiatric disorder in childhood* (No. MCH 17-33). London, National Health Service Executive.

Fonagy, P., Target, M., Cottrell, D., Phillips, J. & Kurtz, Z. (2002). *What Works For Whom? A Critical Review of Treatments for Children and Adolescents*. New York, Guilford.

Fraiberg, S. (1980). *Clinical Studies in Infant Mental Health: the first year of life*. London, Tavistock Publications.

Fraiberg, S. (1987). Infant-parent psychotherapy on behalf of a child in a critical nutritional state. In: Fraiberg, L. (ed.), *Selected Writings of Selma Fraiberg*. Columbus, OH, Ohio State University Press, pp.137-165.

Fraiberg, S., Adelson, E. & Shapiro, V. (1975). Ghosts in the nursery: A psychoanalytic approach to the problems of impaired infant-mother relationships. *Journal of the American Academy of Child Psychiatry*, 14, 387-422.

Fraiberg, S., Nataf, A. & Guedeney, A. (1999). *Fantomes dans la chambre d'enfants: evaluation et therapie des perturbations de la santé mentale du nourrisson*. France, Le Fil Rouge.

Frank, J.D. & Frank, J.B. (1991). *Persuasion and healing: a comparative study of psychotherapy* (3rd ed.). Baltimore, Johns Hopkins University press.

Fredrickson, B. L. (1998). What good are positive emotions? *Review of General Psychology*, 2, 300-319.

Frederikson, B. (2013). *Love 2.0*. New York, NY, Hudson Street Press.

Freud, S., (1940). An outline of psycho-analysis. *SE*, 23, 139-207. London: Hogarth Press.

Freud, S. (1954). *The origins of Psycho-Analysis*. New York: Basic Books.

Gadamer, H.G. (1996). *Truth and Method*. [2nd edition]. London, Sheed and Ward.

Gawelek, O.M., Rodriguez-Nogues, L. (1981) *Feminism and ethnicity: How they intersect in women's lives*. Paper presented at the meeting of the National Women Studies Association, Storrs, CT.

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

George, C. & Solomon, J. (1996). Representational models of relationships: Links between caregiving and attachment. *Infant Mental Health Journal*, 17, 198-217.

Gilligan, C. (1982). *In a different voice: Psychological theory and women's development*. Cambridge, MA, Harvard University Press.

Glaser, B.G. & Strauss, A.L. (1967) *The discovery of grounded theory: Strategies for qualitative research*. New York, NY, Aldine.

Gotlib, I.H. & Goodman, S.H. (1999). Children of parents with depression. In Silverman, W.K. & Ollendick, T.H. (eds.), *Developmental issues in the clinical treatment of children and adolescents*. New York, NY, Allyn & Bacon, pp.415-432.

Golse, B. (2012). Transmettre la transmission. Available at www.carmed.org/page-63-transmettreLTransmission.htm. Retrieved 2014

Gordon, S. (2000). Researching psychotherapy, the importance of the client's view: A methodological challenge. *The qualitative report*, 3(3/4).

Graham, J. E., Lobel, M. & Stein Deluca, R. (2002). Anger after child-birth: An overlooked reaction to postpartum stressors. *Psychology of Women Quarterly*, 26, 222-233.

Granot, D. & Mayseless, O. (2001). Attachment security and adjustment to school in middle childhood. *International Journal of Behavioral Development*, 25(6), 530-41.

Green, J. & Goldwyn, R. (2002). Annotation: attachment disorganisation and psychopathology: new findings in attachment research and their potential implications for developmental psychopathology in childhood. *Journal of Child Psychology and Psychiatry*, 43(7), 835-46.

Greenberg, L.S. (1986). Change process research. *Journal of Consulting and Clinical Psychology*, 54, 4-9.

Gutelius, M. F., Kirsch, A. D., MacDonald, S., Brooks, M. R., McErlean, T. & Newcomb, C. (1972). Promising results from a cognitive stimulation program in infancy. A preliminary report. *Clinical Pediatrics*, 11, 585-593.

Hall, L.A., Sachs, B., Rayens, M.K. & Lautenbacher, M. (1993). Childhood physical and sexual abuse: their relationship with depressive symptoms in adulthood. *Image: Journal of Nursing Scholarship*, 25, 317-323.

Hammersley, P. (1995). Qualitative research – unity and diversity. *Forum Qualitative Research*, 6(3).

Harris, J. R. (1998). *The nurture assumption: Why children turn out the way they do*. New York, NY, Free Press.

Heinicke, C. M., Fineman, N. R., Ruth, G., Recchia, S. L., Guthrie, D. & Rodning, C. (1999). Relationship-based intervention with at-risk first time mothers: Outcome in the first year of life. *Infant Mental Health Journal*, 20, 349-374.

Heinicke, C. M., Fineman, N. R., Ponce, V. A. & Guthrie, D. (2001). Relation-based intervention with at-risk mothers: Outcome in the second year of life. *Infant Mental Health Journal*, in press.

Heinicke, C. M., Goorsky, M., Moscov, S., Dudley, K., Gordon, J., Schneider, C. & Guthrie, D. (2000). Relationship-based intervention with at-risk mothers: factors affecting variations in outcome. *Infant Mental Health Journal*, 21(3), 133-155.

Hertzman, C. & Wiens, M. (1996). Child development and long-term outcomes: a population health perspective and summary of successful interventions. *Social Science and Medicine*, 43, 1083-1095.

Heron, J. & Reason, P. (1997). A participatory inquiry paradigm. *Qualitative Inquiry*, 3(3), 274-294.

Hesse, E. & Main, M. (2000). Disorganized infant, child, and adult attachment: Collapse in behavioral and attentional strategies. *Journal of the American Psychoanalytic Association*, 48, 1097-1128.

Holloway, I. (1997). *Basic concepts for qualitative research*. Oxford, Blackwell.

Hopkins, J. (2008). Infant-parent psychotherapy: Selma Fraiberg's contribution to understanding the past in the present. In Emanuel, L. & Bradley, E. (ed) *What*

the matter be?' Therapeutic interventions with parents, infants, and young children. London: Karnac Books.

Husserl, E. (1931). *Cartesian meditations* (D. Cairns, Trans.) Dordrecht, Kluwer.

Imel, Z. E., Wampold, B. E., Miller, S. D. & Fleming, R. R. (2008). Distinctions without a difference: Direct comparisons of psychotherapies for alcohol use disorders. *Journal of Addictive Behaviors*, 22(4), 533-543.

Iser, W. (1992). The reading process: A phenomenological approach. *New Literary Approach*, 3, 279-299.

Jacobvitz, D., Hazen, N.L. & Riggs, S. (1997). Disorganized mental processes in mothers, frightened/frightening behavior in caregivers, and disoriented, disorganized behavior in infancy. Proceedings of the Biennial Meeting of the Society for Research in Child Development, Washington, DC. *Developmental Psychopathology*, 17, 329-47.

Jester, R. E. & Guinagh, B. J. (1983). The Gordon parent education infant and toddler program. *The Consortium for Longitudinal Studies, As the twig is bent...Lasting effects of pre-school programmes.* pp.103-132.

Jordan, J. (1985). *The meaning of mutuality.* Work in Progress No. 23. Wellesley, MA, Stone Center, Working Paper Series.

Johnson, K. & Ferguson, T. (1990). *Trusting ourselves: The sourcebook on psychology for women.* New York, NY: The Atlantic Monthly Press.

Jordan, J. & Surrey, J. (1986). The self-in-relation: empathy and the mother-daughter relationship. In: Bernay, T. & Cantor, D. (eds.), *The psychology of today's woman: New psychoanalytic visions.* New York, NY, Analytic.

Jordan, J. V., Kaplan, A. G., Miller, J. B., Stiver, I. P. & Surrey, J. L. (1991). *Women's growth in connection: Writings from the Stone Center.* New York, NY, Guilford Press.

Kaplan, A. (1984). *The self-in-relation: Implications for depression in women.* Work in Progress No. 14. Wellesley, MA: Stone Center, Working Paper Series.

Karoly, L. A., Greenwood, P. W., Everingham, S. S., Houbé, J., Kilburn, M. R., Rydell, C. P., Sanders, M. & Chiesa, J. (1998). *Investing in our Children: What We Know and Don't Know About the Costs and Benefits of Early Childhood Interventions.* Santa Monica, CA, RAND Corp.

- Kaufman, J. & Cicchetti, D. (1989). The effects of maltreatment on school-aged children's socioemotional development: Assessments in a day-camp setting. *Developmental Psychology*, 25, 316-324.
- Kendell, R.E. & Chalmers, C.P. (1987). Epidemiology of puerperal psychoses. *British Journal of Psychology*, 150(5).
- Kendrick, A., Tylee, T. & Freeling, A. (1996). *The prevention of mental illness in primary care*. Cambridge, Cambridge University press.
- Kennedy, E. & Midgley, N. (2007). *Process and outcome research in child, adolescent, and parent-infant psychotherapy*. North Central London Strategic Health Authority.
- Keren, M., Feldman, R. & Tyano, S. (2001). Diagnoses and interactive patterns of infants referred to a community-based infant mental health clinic. *Journal of the American Academy of Child and Adolescent Psychiatry*, 40(1), 27-35.
- Kitson, A. (2008). A qualitative study of the experience of parents attending a psychoanalytically informed parent-toddler group. *Early Child Development*, 178(3).
- Klein, M. (1932). *The psycho-analysis of children*. London: Hogarth Press.
- Kvale, S. & Brinkmann, S. (2009). *InterViews: Learning the craft of qualitative research interviewing*. London: Sage.
- Lacan, J. (1958-1959). *The seminar of Jacques Lacan: Book VI: Desire and its interpretation*. Retrieved from <http://hdl.handle.net/10788/157>. (retrieved 2015)
- Langdridge, D. (2004) *Research methods and data analysis in psychology*. London, Pearson/Prentice Hall.
- Larkin, M., Watts, S. & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative research in psychology*, 3, 102-120.
- Lebovici, S. (1988). Fantasmatic interaction and intergenerational transmission. *Infant Mental Health Journal*, 9, 10-19.
- Lemma, A. (2003). *Introduction to the practice of psychoanalytic psychotherapy*. London, John Wiley.

Lemma, A., Roth, A. & Pilling, S. (2013). *The competences required to deliver effective interpersonal psychotherapy (IPT)*. www.ucl.ac.uk/core. (retrieved 2014)

Levenstein, P. & Sunley, R. (1968). Stimulation of verbal interaction between disadvantaged mothers and children. *American Journal of Orthopsychiatry*, 38, 116-121.

Leverson, T. (2003). Parental psychiatric illness: implications for children. *Current opinion in Psychiatry*, 16, 395-402.

Levy, P. (2003) A methodological framework for practice-based research in networked learning, *Instructional Science*, 31, 87-109.

Lieberman, A. F. (1991). Attachment theory and infant-parent psychotherapy: Some conceptual, clinical and research issues. In: Cicchetti, D. & Toth, S. (eds.), *Rochester Symposium on Developmental Psychopathology: Vol. 3. Models and integrations*. Hillsdale, NJ, Erlbaum, pp.261-288.

Lieberman, A. F. (1998). The satisfactions and tribulations of clinical consultation to child protective services. *Zero to Three: Bulletin of the National Center for Infants, Toddlers and Families*.

Lieberman, A. F. & Pawl, J. (1993). Infant-parent psychotherapy. In Zeanah, C. H. (ed.), *Handbook of infant mental health*. New York, NY, Guilford Press, pp.427-442.

Lieberman, A. F. & Zeanah, C.Z. (1999). Contributions of attachment theory to infant-parent psychotherapy and other interventions with young children. In: Cassidy, J. & Shaver, P. (eds.), *Handbook of attachment: Theory, research, and clinical applications*. New York, NY, Guilford Press, pp.555-574.

Lieberman, A., Weston, D. & Pawl, J. (1991). Preventive intervention and outcome with anxiously attached dyads. *Child Development*, 62(1), 199-209.

Lichtenberg, J. (1983). *Psychoanalysis and infant research*. Hillsdale, NJ: The Analytic Press.

Lincoln, Y.S. & Guba, E.G. (1985). *Naturalistic Inquiry*. Newbury Park, CA: Sage Publications.

Lyons-Ruth, K., Bronfman, E. & Atwood, G. (1999). A relational diathesis model of hostile-helpless states of mind: Expressions in mother-infant interaction. In:

Solomon, J. & George, C. (eds.), *Attachment disorganization*. New York, NY, Guilford Press, pp.33-70.

Lyons-Ruth, K., Connell, D. B., Grunebaum, H. U. & Botein, S. (1990). Infants at social risk: Maternal depression and family support services as mediators of infant development and security of attachment. *Child Development*, 61, 85–98.

Lyons-Ruth, K., Yellin, C., Melnick, S. & Atwood, G. (2003). Childhood experience of trauma and loss have different relations to maternal unresolved and hostile-helpless state of mind on the AAI. *Attachment and Human Development*, 5(4), 330-52.

Lyons-Ruth, K., Yellin, C., Melnick, S. & Atwood, G. (2005). Expanding the concept of unresolved mental states: hostile/helpless states of mind on the Adult Attachment Interview are associated with disrupted mother-infant communication and infant disorganization. *Development and Psychopathology*, 17(1), 89-111.

Madigan, S., Bakermans-Kranenburg, M.J., Van Ijzendoorn, M.H., Moran, G., Pederson, D.R. & Benoit, D. (2006). Unresolved states of mind, anomalous parental behavior, and disorganized attachment: a review and meta-analysis of a transmission gap. *Attachment and Human Development*, 8(2), 89-111.

Mahler, M. (1967). On human symbiosis and the vicissitudes of individuation. *The selected papers of Margaret Mahler, Vol.2: Separation-Individuation*. Northvale, NJ: Jason Aronson.

Main, M. & Goldwyn, R., 1985/1991. *Adult attachment scoring and classification system*. Unpublished manuscript. Berkley, CA, University of California.

Main, M., Kaplan, N. & Cassidy, J. (1985). Security in infancy, childhood, adulthood: a move to the level of representation. *Monographs of the society for research in child development*, 50(1-2), 66-104.

Malim, T., Birsh, A. & Wadeley, A. (1992). *Perspectives in Psychology*. Hampshire: Macmillan Press.

Malphurs, J. E., Field, T. M., Larrain, C., Pickens, J. & Pelaez-Nogueras, M. (1996). Altering withdrawn and intrusive interaction behaviors of depressed mothers. *Infant Mental Health Journal*, 17, 152-160.

Margolin, G. & Gordis, E. (2000). The effects of family and community violence on children. *Annual Review of Psychology*, 51, 445-479.

Mason, J. (2002). *Qualitative research*. London: Sage Publications.

Mason, S., Hussain-Gambles, M., Leese, B., Atkin, K., Brown, J. (2003). Lack of representation of South Asian people in randomized controlled trials-a small survey. *BMJ*, 326:1244-5.

McCourt, C. (2006) Becoming a parent. In: Page, A. & McCandlish, R. (eds.). *The new midwifery: Science and sensitivity in practice*. Churchill Livingstone Edinburgh: Elsevier Oxford.

McDonough, S.C. (1996). Interaction Guidance. In: Sameroff, A.J., McDonough, S.C. & Rosenblum, K. L. (eds.), *Treating parent-infant relationship problems: strategies for intervention*. London: Karnac Books.

McDonough, S. C. (2000a). Interaction guidance: An approach for difficult-to-engage families. In: Zeanah, C. H. (ed.), *Handbook of Infant Mental Health (2nd edition)*. New York, NY, Guilford, pp.485-493.

McDonough, S. C. (2000b). Preparing infant mental health personnel for 21st century practice. In Osofsky, J. D. & Fitzgerald, H. E. (eds.), *WAIMH Handbook of Infant Mental Health*. New York, NY, Wiley, pp.538-548.

McGuire, T. & Miranda, J. (2008). Racial and ethnic disparities in mental health care: Evidence and policy implications. *Health Aff (Millwood)* 27(2):393-403.

McNamee, S. & Gergen, K. (1992). *Therapy as social construction*. London: Sage.

McLennan, J. D. & Offord, D. R. (2002). Should postpartum depression be targeted to improve child mental health? *Journal of the American Academy of Child and Adolescent Psychiatry*, 41(1), 28-35.

McLeod, J. (1990). The client's experience of counselling and psychotherapy: A review of the literature. In: Dryden, W. & Mearns, D. (eds.), *Experiences of counselling in action*. London: Sage Publications, pp.66-79.

McLeod, J. (2003). *Doing counselling research*. London: Sage Publications.

Meins, E., Fernyhough, C., Fradley, E. & Tuckey, M. (2001). Rethinking maternal sensitivity: mothers' comments on infants' mental processes predict security of attachment at 12 months. *Journal of Child Psychology and Psychiatry*, 42(5), 637-48.

- Mercer, N. (2000). *Words and Minds: How we use language to think together*. London: Routledge.
- Miller, J. B. (1976). *Toward a new psychology of women*. Boston, MA, Beacon Press.
- Miller, J. B. (1986). *What do we mean by relationships?* Work in Progress No. 22. Wellesley, MA: Stone Center, Working Paper Series.
- Miller, J. B. & Stiver, I. P. (1998). *The healing connection: How women form relationships in therapy and in life*. New York, NY, Guilford Press.
- Miller, J. B. (1990). *Connections, disconnections, and violations*. Work in Progress No. 33. Wellesley, MA: Stone Center, Working Paper Series.
- Miranda, J. & Green, B.L. (1999). The need for mental health services research focusing on poor young women. *The Journal of Mental Health Policy and Economics*, 2(2), pp.73-80.
- Mrazek, P. J. & Brown, C. H. (2002). An evidence-based literature review regarding outcomes in psychosocial prevention and early intervention in young children. In: Mrazek, P. J. & Haggerty, R. J. (eds.), *Reducing risks for mental disorders: frontiers for preventive intervention research*. Washington, DC, National Academy press, pp.215-313.
- Muir, E. (1992). Watching, waiting, and wondering: Applying psychoanalytic principles to mother-infant intervention. *Infant Mental health Journal*, 13(4), 319-328.
- Murray, L. & Cooper, P. J. (2003). The impact of postpartum depression on child development. In: Goodyer, I. (ed.), *Aetiological Mechanisms in Developmental Psychopathology* (in press). Oxford, Oxford University Press.
- Nadeem, E., Lange, J.M., Edge, D., Fongwa, M., Belin, T., Miranda, J. (2007). Does Stigma Keep Poor Young Immigrant and U.S.-born Black and Latina Women from Seeking Mental Health Care? *Psychiatr Serv*, Dec 58(12):1547-54.
- Newman, L. & Stevenson C. (2008). Issues in infant-parent psychotherapy for mothers with borderline personality disorder. *Clinical Child Psychology and Psychiatry*, 13(4), 505-14.
- Nicolson, P. (1998). *Post-natal depression*. New York, NY: Routledge.

Nightingale, D. & Cromby, J. (1999) *Social constructionist psychology: A critical analysis of theory and practice*. Buckingham: Open University press.

Oates, M. (2003). Perinatal psychiatric disorders. A leading cause of maternal morbidity and mortality. *British Medical Bulletin*, 183, 279-81.

O'Connor, T.G., Heron, J., Golding, J., Beveridge, M. & Glover, V. (2002). Maternal antenatal anxiety and children's behavioural/emotional problems at 4 years. Report from the Avon Longitudinal study of parents and children. *British Journal of Psychiatry*, 180(6), 502-508.

Olds, D.L., Henderson Jr, C.R., Kitzman, H.J., Eckenrode, J.J., Cole, R.E. & Tatelbaum, R.C. (1999). Prenatal and infancy home visitation by nurses: Recent findings. *The Future of Children*, 9, 44-65.

Olds, D., Hill, P., Robinson, J., Song, N., Little, C. & Hill, P. (1999). *Reducing risks for mental disorders during the first five years of life: A review of preventive interventions*. Unpublished manuscript, Prevention Research Center for Family and Child Health, University of Colorado Health Sciences Center, Denver, CO.

Orange, D.M. (1992). Perspectival realism and social constructivism: commentary on Irwin Hoffman's "discussion: Towards a social constructivist view of the psychoanalytic situation". *Psychoanalytic Dialogues*, 2, 561-585.

Orange, D.M. (1995). *Emotional understanding: Studies in psychoanalytic epistemology*. London: Guildford Press.

Orlikowski, W.J. & Baroudi, J.J. (1991). Studying information technology in organisation: Research approaches and assumptions. *Information Systems Research*, 2, 1-28.

Overholser, J.C. (2005). Contemporary psychotherapy: Promoting personal responsibility for therapeutic change. *Journal of Contemporary Psychotherapy*, 35, 369-378.

Panksepp, J. (2011). Cross-species affective neuroscience decoding of the primal affective experiences of humans and related animals. *PLoS One*, 6(8), e21236.

Panksepp, J. & Biven, L. (2012). *Archaeology of Mind: The Neuroevolutionary Origins of Human Emotions*. New York, NY: Norton.

Panzarine, S., Slater, E. & Sharps, P. (1995). Coping, social support and depressive symptoms in adolescent mothers. *Journal of Adolescent Health*, 17, 113-119.

Paris, R. & Dubus, R. (2005). Staying connected while nurturing an infant: a challenge of new motherhood. *Family Relations*, 54(1), 72-83.

Pawlby, S.M.M., Clarke, R., Best, E., Weir, D. & O'Keane, V. (2005). Mother-infant interaction in postpartum women with severe mental illness, before and after treatment. *Archives of Women's Mental Health*, 8, 120.

Pawlby, S., Fernyhough, C., Meins, E., Pariante, C.M., Seneviratne, G. & Bentall, R.P. (2010). Mind-mindedness and maternal responsiveness in infant-mother interactions in mothers with severe mental illness. *Psychological Medicine*, 40(11), 1861-9.

Pierce, C.S. (1933). *Collected papers of Charles Pierce. Vol 1-6.* Cambridge, MA: Harvard University Press.

Poobalan, A.S., Aucott, L.S., Ross, L., Smith, W.C.S., Helms, P.J. & Williams, J.H.G. (2007). Effects of treating postnatal depression on mother-infant interaction and child development: Systematic review. *The British Journal of Psychiatry*, 191, 378-386.

Potter, J. & Wetherell, M. (1987). *Discourse and social psychology: Beyond attitudes and behaviour.* London: Sage.

Powell, C. & Grantham-McGregor, S. (1989). Home visiting of varying frequency and child development. *Pediatrics*, 84, 157-164.

Pozzi-Monzo, M. (2007). *Innovations in parent-infant psychotherapy.* London: Karnac Books.

Pringle, J., Hendry, C. & McLafferty, E. (2011). Choosing between phenomenological approaches: a discussion and critique. *Nursing Researcher*, 18(3), 20-24.

Ramey, C.T. & Campbell, F.A. (1991). Poverty, early childhood education and academic competence: the Abecedarian experiment. In: Huston, A. C. (ed.), *Children in poverty.* Cambridge: Cambridge University press.

Reason, P. (1998). Co-operative inquiry as a discipline of professional practice. *Journal of interprofessional care*, 12(4), 419-436.

Reid, K., Flowers, P. & Larkin, M., (2005). Exploring lived experience: an introduction to Interpretative Phenomenological Analysis. *The Psychologist*. 18(1), 20-23.

Rennie, D.L. (1994). Clients' deference in psychotherapy. *Journal of Counseling Psychology*, 41, 427-437.

Richardson, J.T.E. (ed.). (1996). *Handbook of qualitative research methods for psychology and social sciences*. Leicester: The British Psychological Society.

Ricoeur, P. (1970). *Freud and philosophy: An essay on interpretation* (D. Savage, Trans.). New Haven, CT: Yale University press.

Ricoeur, P. (1996). On interpretation, in: Kearney, R. and Rainwater, M. (eds.), *The continental philosophy reader*. London: Routledge ([original work published in 1983]).

Robert-Tissot, C., Cramer, B., Stern, D., Rusconi Serpa, S., Bachman, J.P., Palacio-Espasa, F., Knauer, D., De Muralt, M., Berney, C. & Mendiguren, G. (1996). Outcomes evaluation in brief mother-infant psychotherapies: report of 75 cases. *Infant Mental Health Journal*, 17(2), 97-114.

Ryan, R.M., Lynch, M.F., Vansteenkiste, M. & Deci, E. (2011). Motivation and autonomy in counseling, psychotherapy, and behavior change: A look at theory and practice. *The Counseling Psychologist*, 39(2), 193-260.

Ryan, R.M. & Deci, E.L. (2008). A self-determination approach to psychotherapy: The motivational basis for effective change. *Canadian Psychology*, 49, 186-193.

Salomonson, B. & Sandell, R. (2011). A randomized controlled trial of mother-infant psychoanalytic treatment: II. Predictive and moderating influences of qualitative patient factors. *Infant Mental Health Journal*, vol.32(3), 377-404.

Sameroff, A. (2010). A unified theory of development: A dialectic integration of nature and nurture. *Child Development*, 81(1), 6-22.

Sandelowski, M. (1993). Rigor or rigor mortis: the problem of rigor in qualitative research revisited. *Advances in Nursing Sciences*, 16(2).

Saunders, R. (1999). It has been amply demonstrated that psychotherapy is effective. In: Feltham, C. (ed.), *Controversies in psychotherapy and counselling* London, Sage, pp.294-302.

Schore, A.N. (1994). *Affect regulation and the origin of the self*. New York, NY, W.W. Norton.

Schore, A.N. (1996). The experience-dependent maturation of a regulatory system in the orbital prefrontal cortex and the origin of developmental psychopathology. *Development and Psychopathology*, 8, 59-87.

Schore, A.N. (2003). *Affect Dysregulation and Disorders of the Self*. New York, NY, W. W. Norton.

Schwandt, T. A. (1997), *Qualitative Inquiry, A Dictionary of Terms*. Thousand Oaks, CA, Sage Publications.

Seifer, R. & Dickstein, S. (2000). Parental mental illness and infant development. In: Zeanah, C. (ed.), *Handbook of Infant Mental Health* (2nd edition). New York, NY, Guilford Press, pp.145-160.

Seng, J.S., Liberzon, I., Kane Low, L.M. & Ronis, D.L. (2008). Attachment and postpartum mental health outcomes of women affected by posttraumatic stress disorder prenatally. *International Confederation of Midwives Biennial Meeting*; Glasgow, Scotland.

Sheeber, L.B., Davis, B., Leve, C., Hops, H. & Tildesley, E. (2007). Adolescents' relationships with their mothers and fathers: association with depressive disorder and subdiagnostic symptomatology. *Journal of Abnormal Psychology*, 116, 144-54.

Siegel, D. J., (1999). *The developing mind: How relationships and the brain interact to shape who we are*. New York, NY, Guildford Press.

Siegel, D.J. (2011) *Mindsight: Transform your brain with the new science of kindness*. New York, NY, Bantam Books.

Silverman, D. (1993). *Beginning research: interpreting qualitative data, methods for analysing talk, text and interaction*. London: Sage Publications.

Singleton, J.L. (2004) Parent-infant Interaction Interventions: a meta-analysis. PhD thesis, University of Northern Colorado, CO.

Skovgaard, A.M., Olsen, E.M., Christiansen, E., Houmann, T., Landorph & S., Jørgensen, T. (2008). Predictors (0–10 months) of psychopathology at age 11/2 years—a general population study in The Copenhagen Child Cohort CCC 2000*. *Journal of Child Psychology and Psychiatry*, 49(5), 553-62.

Skovgaard, A.M. (2010). Mental health problems and psychopathology in infancy and early childhood. An epidemiological study. *Danish Medical Bulletin*, 57(10), B4193.

Skolimowski, H., 1994. *The Participatory Mind*. London, Arkana.

Slade, A. & Aber, J. L. (1992). Attachments, drives and development: Conflicts and convergences in theory. In: Barron, J., Eagle, M. & D. Wolitzky (eds.), *Interface of Psychoanalysis and Psychology*. Washington, DC, APA Publications, pp.154-186.

Slade, A. (2005) Parental Reflective Functioning: An Introduction. *Attachment and Human Development*, 7, 769-282.

Slade, A., Belsky, J., Aber, J. L. & Phelps, J. (1999). Maternal representations of their relationship with their toddlers: Links to adult attachment and observed mothering. *Developmental Psychology*, 35, 611-619.

Slade, A. & Cohen, L. J. (1996). Processes of parenting and the remembrance of things past. *Infant Mental Health Journal*, 17, 217-238.

Slade, A., Grienenberger, J., Bernbach, E., Levy, D. & Locker, A. (2001). *Maternal reflective functioning and attachment: Considering the transmission gap*. Paper presented at the Biennial Meetings of the Society for Research in Child Development, Minneapolis, MN.

Slade, A., Grienerberger, J., Bernbach, E., Levy, D. & Locker, A. (2005). Maternal reflective functioning, attachment and the transmission gap: a preliminary study. *Attachment and Human Development*, 7(3), 283-98.

Slaughter, D. T. (1983). Early interventions and their effect on maternal and child development. *Monographs of the Society for research in child development*, 48, (4.serial 202).

Sleed, M., Baradon, T. & Fonagy, P. (2013). New Beginnings for mothers and babies in prison: a cluster randomized control trial. *Attachment & Human Development*, 15(4), 349-367

Sleed, M. & Blank, K. (2007). Parent-infant psychotherapy and research. In: Kennedy, E. & Midgley, N. (eds.), *Process and outcome research in child, adolescent and parent-infant psychotherapy: a thematic review*. London, North Central London Strategic Health Authority.

Smith, J.A., Flowers, P. & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, Method and Research*. London: Sage Publications.

Smith, M.L. & Glass, G.V. (1977). Meta-analysis of psychotherapy outcome studies. *American Psychologist*, 32(9), 752-760.

Smith, J.A. & Osborn, M. (2003). Interpretative phenomenological analysis. In: Smith, J.A. (ed.), *Qualitative Psychology – a practical guide to research methods*. London, Sage.

Solomon, J. & George, C. (1999). *Attachment Disorganization*. New York, NY, Guilford.

Spoth, R.L., Kavanagh, K.A. & Dishion, T.J. (2002). Family-centered preventive intervention science: Toward benefits to larger populations of children, youth and families. *Prevention Science*, 3(3), 145-152

Sroufe, L.A., Egeland, B., Carlson, E. & Collins, W.A. (2005a). Placing early attachment experiences in developmental context: the Minnesota longitudinal study. In: *Attachment from Infancy to Adulthood: The Major Longitudinal Studies*. New York, NY, Guilford Publications.

Sroufe, L.A. (2005b). Attachment and development: a prospective, longitudinal study from birth to adulthood. *Attachment and Human Development*, 7(4), 349-67.

Stern, D., Sander, L.W., Nahum, J.P., Harrison, A.M., Lyons-Ruth, K., Morgan, A.C., Bruschiweilerstern, N. & Tronick, E.Z. (1998). Non-interpretative mechanisms in psychoanalytic therapy. *International Journal of Psycho-Analysis*, 79, 903-921.

Stern, D. (1985). *The interpersonal world of the infant: a view from psychoanalysis and developmental psychology*. New York, NY, Basic Books.

Stern, D. (1995). *The Motherhood constellation: A Unified View of Parent-Infant Psychotherapy*. New York, NY, Basic Books.

Stern, D. (2004). The motherhood constellation. In: Sameroff, A.J., McDonough, S.C. & Rosenblum, K.L. (eds.), *Treating Parent-Infant Relationship Problems*. New York, NY & London: Guildford Press, pp.29-42.

Stiles, W.B. (1993). Quality control in qualitative research. *Clinical Psychology Review*, 13, 593-618.

Stiles, W.B. (1993). Stories, tacit knowledge, and psychotherapy research. *Psychotherapy Research*, 5(2), 125-127.

Stith, A.Y. & Nelson, A.R. (2002). *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Institute of Medicine, Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care, Board on Health Policy, Institute of Medicine. Washington, DC: National Academy Press.

Stolorow, R.D., Brandchaft, B. & Atwood, G.E. (1987). *Psychoanalytic treatment: an intersubjective approach*. Hillsdale, NJ: The Analytic Press.

Stolorow, R. & Atwood, G. (1992). *Contexts of Being: The intersubjective Foundations of Psychological Life*. Hillsdale, NJ: The Analytic Press.

Stolorow, R., Atwood, G. & Orange, M. (2002). *Worlds of Experience: Interweaving philosophical and clinical dimensions in Psychoanalysis*. NYC: basic Books.

St. Pierre, R. G., Layzer, J. I. & Barnes, H. V. (1995). Two-generation programs: Design, cost and short-term effectiveness. *The Future of Children*, 5, 76-93.

Suchman, N.E., McMahon, T.J., Slade, A. & Luthar, S.S. (2005). How early bonding, depression, illicit drug use, and perceived support work together to influence drug-dependent mothers' caregiving. *American Journal of Orthopsychiatry*, 75(3), 431-45.

Surrey, J. (1985). *Self-in-relation: A theory of women's development*. Work in Progress No. 13. Wellesley, MA: Stone Center, Working Paper Series.

Toth, S. L., Maughan, A., Manly, J. T., Spagnola, M. & Cicchetti, D. (2002). The relative efficacy of two interventions in altering maltreated preschool children's representational models: implications for attachment theory. *Developmental Psychopathology*, 14(4), 877-908.

Timmer, S.G., Ho, L.K., Urquiza, A.J., Zebell, N.M., Fernandez, Y.G.E. & Boys, D. (2011). The effectiveness of parent-child interaction therapy with depressive mothers: the changing relationship as the agent of individual change. *Child Psychiatry and Human Development*, 42(4), 406-23.

Toth, S. L., Rogosch, F. A., Manly, J. T. & Cicchetti, D. (2006). The efficacy of toddler-parent psychotherapy to reorganize attachment in the young offspring of mothers with major depressive disorder: A randomized preventive trial. *Journal of Consulting and Clinical Psychology*, 74(6), 1006-1016.

Tremblay, R.E. (2010). Developmental origins of disruptive behavior problems: the 'original sin' hypothesis, epigenetics and their consequences for prevention. *Journal Child Psychology Psychiatry*, 51(4), 341-67.

Tronick, E.Z. (1989). Emotions and emotional communication in infants. *American Psychologist*, 44(2), 112.

Tronick, E.Z. & Weinberg, M.K. (1997). Depressed mothers and infants: failure to form dyadic states of consciousness. In: Murray, L.C.P. (ed.), *Post-Partum Depression and Child Development*. New York, NY: Guilford, pp.54-85.

Tronick, E. Z.; Messinger, D. S.; Weinberg, M. K.; Lester, B. M.; LaGasse, L.; Seifer, R.; Bauer, C. R.; Shankaran, S.; Bada, H.; Wright, L. L.; Poole, K. & Liu, J.. (2005). Cocaine exposure is associated with subtle compromises of infants' and mothers' social-emotional behavior and dyadic features of their interaction in the face-to-face still face paradigm. *Developmental Psychology*, 41(5), 711-22.

Tyler, K. (2002). Social and emotional outcomes of childhood sexual abuse. *Aggression and Violent Behavior*, 7, 567-589.

U.S. Department of Health and Human Services. (2001). *Mental Health: Culture, Race, and Ethnicity-A Supplement to Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

Van den Boom, D. C. (1994). The influence of temperament and mothering on attachment and exploration: An experimental manipulation of sensitive responsiveness among lower-class mothers with irritable infants. *Child Development*, 65, 1449-1469.

Van den Boom, D. C. (1995). Do first-year intervention effects endure? Follow-up during toddlerhood of a sample of Dutch irritable infants. *Child Development*, 66, 1798-1816.

Vostanis, P., Graves, A., Meltzer, H., Goodman, R., Jenkins, R., & Brugha, T. (2006). Relationship between parental psychopathology, parenting strategies and child mental health – Findings from the GB national study. *Social Psychiatry and Psychiatric Epidemiology*, 41(7), 509-514

Vygotskii, L., Hanfmann, E., Vakar, G. (2012). *Thought and Language*. The MIT Press: London.

Wampold, B.E. (2001). *The great psychotherapy debate: Models, methods and findings*. Mahwah, NJ, Lawrence Erlbaum.

Wampold, B.E., Mondin, G.W., Moody, M., Stich, F., Benson, K. & Ahn, H. (1997). A meta-analysis of outcome studies comparing bona fide psychotherapies: empirically, 'all must have a prizes'. *Psychological Bulletin*, 122(3), 203-215.

Watillon, A. (1993). The dynamics of psychoanalytic therapies of the early parent-child relationship. *International Journal of Psycho-Analysis*, 74, 1037-1048.

Webster-Stratton, C. & Taylor, T. (2001). Nipping early risk factors in the bud: preventing substance abuse, delinquency, and violence in adolescence through interventions targeted at young children (0-8 years). *Prevention Science*, 2(3), 165-192.

Williams, D.R. (1996). Race/ethnicity and socioeconomic status: measurement and methodological issues. *Int J Health Serv*, 26:483-505.

Williams, D.R. (2005). The health of U.S. racial and ethnic populations. *Journal of Gerontology Series B: Psychological Sciences and Social Sciences*, Oct; 60 (Spec No 2):53-62.

Williams, D.R., González, H.M., Neighbors, H., Nesse, R., Abelson, J.M., Sweetman, J., Jackson, J.S. (2007). Prevalence and Distribution of Major Depressive Disorder in African Americans, Caribbean Blacks, and Non-Hispanic Whites. *Archives of General Psychiatry*, 64:305-315.

Willig, C. (2008). *Introducing qualitative research in psychology: Adventures in theory and method*. Berkshire: Oxford University Press.

Winnicott, D.W. (1947). Further thoughts on babies as persons. *The child, the family, and the outside world*. London: Hogarth Press, pp.85-92.

Winnicott, D.W. (1965). *The Maturation Processes and the Facilitating Environment*. New York, NY, International Universities Press.

Winnicott, D. W. (1971). Mirror role of mother and family in child development. In: Winnicott, D. W. *Playing and reality*, London: Tavistock Publications, pp.111-118.

Yardley, L. (2008). Demonstrating validity in qualitative psychology. In: Smith, J.A. (ed.). *Qualitative Psychology: A practical guide to methods (2nd edition)*. London, Sage.

Zahn-Waxler, C., Cummings, E.M., McKnew, D.H., Davenport, Y.B. & Radke-Yarrow, M. (1984a). Problem behaviors and peer interactions of young children with a manic-depressive parent. *American Journal of Psychiatry*, 141, 236-240.

Zahn-Waxler, C., McKnew, D.H., Cummings, E.M., Davenport, Y.B. & Radke-Yarrow, M. (1984b). Altruism, aggression, and social interactions in young children with a manic-depressive parent. *Child Development*, 55, 112-122.

Zaphiriou Woods, M. (2000). Preventive work in a toddler group and nursery. *Journal of Child Psychotherapy*, 26, 209-233.

Zeanah, C.H. & Barton, M.L. (1989). Introduction: internal representations and parent-infant relationships. *Infant Mental health Journal*, 10(3), 135-141.

Appendix 1 – Coding an Excerpt of a Transcript

Transcript Excerpt	Notes/Reflections	Emergent Themes/ Codes
I didn't think I could ask anybody or that it was good to share...But attended the group, I became so confident.	Something about what she experienced as her inability pre-GPIP 'she couldn't	Change
You know, other people said, I also got that problem. Other people have problem, other women. That is what I felt after I attended the group.	Normalization – other people have the same problem Again before and after 'I became' – idea of a gradual process of change Becoming a different person	Sameness/Belonging to humanity
That's why I think now, it is normal, it is not just me.	Normalisation – Coming out of isolation/aloneness (self-imposed?)	Normalisation
...And after six week, I felt like a different person like I don't cry anymore...	Idea of difference – became a different person because of her experience in the GPIP	Difference

Appendix 2 – Data Analysis – Case Analysis 6

1. Phase 1 – Reading and re-reading

Reading the transcript make me reconnect with the warmth and enthusiasm of this participant. I remembered feeling terribly moved by her experience and how important it had been for her. It re-fused my interest and enthusiasm for my research. She was so adamant that PIP was key for women that it reminded me my original excitement discovering PIP and how cardinal I felt it was.

Although what came back to me was my experience of mother and baby in the consulting room. She came across as gentle, finely attuned and connected with her child, as if I had under my eyes the outcomes of the treatment. She felt it changed her attachment to her child and I could see it under my eyes.

Very emotional interview where she cried, she laughed, she thought. Her emotions were palpable and contagious. I enjoyed her aliveness and her humour. The notion of difference and change stood out after the reading and re-reading, and also the learning dimension. It seemed that she learnt something important in PIP that changed her life that made a difference.

2. Phase 2 – Initial noting (first and second hermeneutic)

1. Difference - change

I saw a big difference

From the beginning she introduces the idea of a difference

2. Self before and after PIP

yeah, like how I was before. I wasn't confident. And I was scared like what should I do? What should I do? You know like the good food, or to help them you know.

Idea of a before and an after

Felt she did not know how to be a mother (feeding, comforting child etc.)

3. Inability to express herself/her pain prior GPIIP

I was quite depressed and I couldn't talk. I just cried... First time I saw J., I couldn't say any work, I just cried. She went to my home. I couldn't say any work. She was so worried like, if anybody hit me or something. It wasn't, like, it's wasn't. I can't even say how it was before. I don't have any words for that.

Inability to express herself, to put into words her experience/psychic pain, could only cry. Not being able to talk is something that she will express throughout the interview. Before GPIIP, she was notable to talk because she did not understand, she did not 'have any words' for her pain/experiences

4. Mind as a full up recipient

yes so many things like, my mind, my emotions, it was filled up.

Being full up of emotions with no words express them – only tears could release her fullness (economic metaphor)

5.Sharing

when I came to that group, I also felt like..every group, we were having one hour chat and talking and, you know sharing everything like what she find it like? How she finds doing things...

Concept of sharing with the group, sharing everything/openness

6.Normalisation

...Then I learnt, Ok that is quite normal.

7.Not knowing how mother to other prior GPIIP

Before I used to be like, no that's not normal. How am I gonna change her nappies? So small, I'm gonna break his feet. I couldn't...what should I say? I wasn't confident to do things and I was like so worried. Like how am I gonna feed them. Like you know how certain people say that if they don't take bottle, you try to give some water. I even don't know.

Felt abnormal before , GPIIP normalize her/her experience

Idea of a before the GPIIP when she did not know how to be a mother/how to other and felt unconfident and worried

And an after GPIIP when she felt she knew how to be a mother

8.Difficulty to reach out for help prior GPIIP

I did not know. I couldn't like, if anybody like, I've got my mother-in-law, I couldn't say to her 'what should I do?' That time I felt, if I say that to them, they are going to think that I don't know...

Not knowing as shameful, something that she could not admit to her in-laws

9.Normalisation within the group

... And at the group, others people say the same to you so it feels more comfortable to share things. You know, one lady was saying how her partner did not listen to her. Then I compare my partner and felt that is quite a normal thing...

Normalisation, group gave her the possibility of comparing herself, her husband etc. realized she was normal

...Before I thought it was only me. I am so bad, I am so...I am only bad, bad luck. I am the only one that is sad, everybody else is happy. It was only me who was sad, I was crying. Life was ending, it was not anything left for me...

Before she felt out of humanity 'it is only me' all the others were 'happy'. Was alone outside humanity, no life was possible

... Then I came to the group. I can't explain, it was such a big difference. I don't know about other people but for me it was a big difference.

'big difference' express the notion of change, a before and after the GPIIP

10.Difficulty to reach out for help prior GPIIP

Yes like, I can't share with anybody else, you know. That was my personal thing. I couldn't do it. I couldn't ask anybody before.

Before she couldn't ask for help – 'that was my personal thing' personality trait that defined her

I was too preoccupied by what other people would think...

Preoccupation with how she would be perceived/felt she would be perceived as the one who doesn't know, too shameful- Also wonder if the internal object is an object that is not benevolent in the face of difficulty?

...I didn't think I could ask anybody or that it was good to share...

Something about what she experienced as her inability pre-GPIP 'she couldn't

11.Change

...But attended the group, I became so confident.

12.Sameness/Belonging to humanity

You know, other people said, I also got that problem. Other people have problem, other women. That is what I felt after I attended the group.

Normalization – other people have the same problem

Again before and after

'I became' – idea of a gradual process of change

Becoming a different person

13.Normalisation

That's why I think now, it is normal, it is not just me....

Normalisation – Coming out of isolation/aloneness (self-imposed?)

14.Change/Difference

...And after six week, I felt like a different person like I don't cry anymore...

6 weeks being the length of the group

Idea of difference – became a different person because of her experience in the GPIP

...You know, J. she was saying 'oh I feel so confident for you, you are getting so good'. She was saying it in front of the team. You know like, when I was depressed before, this time out of ten, she said I was 4 or 3.

Being told she was doing well and was confident 'in front of the team' was important – Being seen (when she was struggling and needed help hence helped offered) in needs but also being seen in progress/ability –

Process of being seen and seeing – being seen differently and seeing/experiencing herself differently

Before and after 'after six weeks I felt like a different person'

Unconfident vs confident

Isolation vs sharing

Silence vs talking

ask' but also something about her not knowing that 'I was good to share'. Perhaps she lacked experience prior the group?

Self-imposed isolation (others were there but she could not reach out)

15.Change/Difference

yes, a very big difference for me...

Difference, change

16. On becoming a mother/ Finding her voice

... Now I know what is right and what is wrong and I can say it. If another people says 'no that is not right', you know. One day I was trying to give him a bath. In our culture, you bath babies' daytime not nighttime. So if my mother-in-law said before 'don't give the bath', I wouldn't do it. Now I know I can give a bath at any time. Now I feel more comfortable...

Finding her voice/style of mothering/ became less submissive to her cultural norms/family norms – more of a sense of herself knowing what is right as opposed to an external authority

17. Seeing/feeling herself as the mother

... yes I am the mother, now I know what to do, what is good for them.

On becoming a mother/the mother – the one who knows

What makes a woman feel like the mother of her child?

No the second (child). But with the first one (child), I couldn't do anything. My mother-in-law and my husband did it...

Mother could not bond with her first child, she did not mother him. Father and mother-in-law occupied the parental function

...You know, in hospital, that person sensed it and contacted the Marlborough Centre so I went to the group. J. went there and I attended the group...

Perhaps her attachment/bonding difficulties were noticed in the hospital? Hence her referral to the perinatal service

(gave birth) to I. (her second child) yes, after one or two weeks...

Referral took place very early on as they noticed her difficulty to engage with her son

...I went there he was six weeks or something....I was crying because I couldn't feed him. He wasn't trying, he had low temperature. That's why I was crying because he was not taking milk. He was just lying down not doing anything...

Passivity of her child seemed to worry her. Child not engaging with her, taking her milk made her cry (felt she was a bad/failing mother?)

...Then the doctor came and told me it was quite normal. But still, I was quite down...

Was reassured by the doctor who normalise it but it was not enough

...That's why they refer me. Before I was on medication.

After. Before I had it but not that much (laughing and turning to her baby – do you understand baba what I am saying, hein).

Mother talking about depression ante and post-nataly – noticing her child, addressing her child – mother awareness that child has a mind and emotions, awareness that the child can connect to what is said

they contacted the clinic and then the clinic contacted me. J. went to my house.

Referral process – home visit- passivity of the mother

18.Change/New life/Therapy experienced as having someone who cares

R: how was it like to have someone coming to your house?

P: Like, a new life because (crying) before I used to think I did not have anybody because mum...mum is back home. Sorry (crying)

R: no, no that's ok. You felt really lonely?

P:...(crying)

R: you are still very sad

P: Now it is better than before. Before I would have finished you all thing (tissue box).

R: but it seems that you were really moved that someone was interested and came to your house?

P: yes...you think that someone care for you, you know. She used to call me everyday after she saw me. I felt like she was my sister. I don't have a sister. She used to hold me and hug me. You know, she wasn't really related to me but still I felt she was related to me.

Home visit, therapist – having someone noticing, caring, calling, being involved seems to have made a huge different – Much more proactive intervention vs psychodynamic neutrality- interesting theoretical discussion- therapist acting like a caring mother/human being not only in the therapy frame but also outside, in her house – holding, hugging, calling, seeing – replacement of family attention and love – sister/mother

19.Therapy made a difference/experienced what it was like to count for someone

yes...even when I saw her once and she asked me 'do you remember me? I was hugging you". I was like 'but of course I remember you'. I will never forget you. So these kind of things, like me counting for someone made a big difference. Before that time I couldn't, you know, that time I tried to strangle myself because...I am talking about that kind of things, you know.

Difference comes from someone making a difference changing her experience of the world, of humanity – world becomes a place of warmth as opposed to a place of loneliness

20.New perspective developed through GPIP

...Now I know I have got a life, I have children... now I feel confident. I do have a life. I do have people who care for me.

As if having one person who cares (the therapist) made her realize that she had people who cared (husband, family). Having one person changed her experience
Impact: before she had nobody vs now she has someone, someone who cares

If you don't know that sort of things (that she has people who care for her), it makes it very difficult, life...

Loneliness experience when one feels nobody cares, how difficult it is to live your life like this

...And somebody comes to you and says 'no, it is not like this', it can be so good. It makes you happy. You can be happy in your own life....

Therapist offered a different perspective, a different truth about herself and her life which seems to have 'change' how she felt 'it makes you happy'

...You don't have to believe that... you can say to someone there is hope.

Awareness of her belief being a subjective belief and not necessary the truth.
Therapist telling and showing her that someone cared gave her hope. Perhaps it introduced a gap between her belief and her perception, with hope filling that gap.

It also make me think about the mentalising process by which the person is able to differentiate internal and external reality (i.e. feeling alone doesn't necessary means that one is alone

21.Attachment difficulty

You know my older one, I couldn't enjoy him. You know, the children, their the first step, their first laugh and crying... I couldn't, I thought it was quite boring...

She couldn't bond with her first child (enjoyment vs boring)

22.Learning/Being taught

...And they taught us how to play, how to enjoy them, how to give them time. Within few weeks, they taught us how to play with them, you know, how to attach, to get attach to them. How to understand their feelings...

Taught them how to play, to attach, to care, to watch, to see, to look, to focus, to enjoy. On learning about attunement

Active-passive process

Teaching/learning

Telling/Being told

Therapists taught – mothers learnt

Seems to be a cardinal process in GPIP for her

23.Attachment difficulty

...Before I couldn't watch him playing, I thought it was boring., when they are playing, or crying. I found it so boring...

Mother couldn't find her child interesting ('was boring')

24.Teaching/learning through GPIP made a difference

...Now, how they teach us, it makes a big difference...

Importance of the psycho-educational aspect of GPIP. Mother felt she learnt how to be interested, how to see her child differently

Difference in experience, difference in perception, understanding, engagement

...It shows that this is their life...

As if she understood that her baby is a real person, with a psychic life and emotions 'this is their life'

...enjoy this time. That's your life, it is not about thinking about other things. No we don't think about those things...they would remember us, you know, those good things. Don't ignore them you know...

Confirm the idea of her understanding that her baby has an emotional life and therefore the mother-baby interactions matter

...this is the right thing to do.

Moral perspective – right thing for whom?

25. Learning to attune/communicate with child/On becoming a mother

...(they taught us) how to play with them, how to have eye contact. I didn't know that. I always used to look at him like that, and he also looked at me like that. And he gave me a big smile (laughing). I never used to do it with my eldest child. I didn't even know...

Mother-baby gaze – non verbal communication

Smile – love

Identifying her child as a human being with a mind and emotions

Could not do that with her first child

26. On becoming a confident/knowing mother vs Mother who did not know before

...I really enjoyed it. And now I know with him what to do. You know, sometime he was crying my big one, and if I played with him, he even cried...

Mother could not regulate his emotions, could not soothe him

... But they told me, if they want to play, you play with them but still in their own time...

learning to dance with baby d. Stern), acknowledging his desire

...I didn't even know that if you leave them they cry, I didn't know...

Mother did not know baby needed her and that is she left him, it will trigger sadness and distress in him. As if she was unaware that she mattered to her child

27. Being told/taught made a difference

...So many things, we don't know. If someone tells you, it makes a big difference

being told and taught made 'a difference'

Difference for her and for her child/children

28. Learning to engage with her child

in the group. He was six months old, we were on the floor. Everybody sits on the floor. I used to lay down and we looked at each other. Everybody looked at their baby and after few minutes, they were talking like 'what do you feel? Everybody was saying like 'I felt so beautiful like these eyes', and someone was saying like 'how he saw, he saw he is loving me'. He couldn't say it but his eyes were saying things...

Mother acknowledging that she, herself, could not understand her baby's communication but baby indeed was communicating

...First time I was there, I couldn't feel it. Few time I have done it, then I felt 'he is, he is something

'he is something' meaning he is someone and something special

oh first time j. said, the other lady was there, I can't remember her name, she was saying 'he said it', I didn't see it but she said 'how are you going to look at them, you know, with eye contact'. Then I've done it a few times before I knew what it was

Gradual process of learning through repetitive experience

It was absolutely amazing to see him, to feel him. You know, that time I felt, what did I miss? with the big one. Then I felt guilty...

Mother developing a different type of relationship with her second son where she can engage and attune, made her feel guilty about her relationship with her first one with whom she felt disconnected

...But she was saying, don't worry about the past. You've got an other one so enjoy him. Give him your best... yes, you know, you did not give it before, now you try it. You care about them so.

Therapist reassurance and encouragement

...sometimes I blame myself because I did not do the right things like what do we do now. I wasn't doing things like that...

Feeling of guilt, she was not 'doing the right thing'/mothering for her child which led to a lack of bonding- 'the right thing' being perhaps the playing, seeing, attuning that she learnt at the clinic?

29. Therapy experienced as making a difference in regards to her attachment to her children

... If it wasn't for the Marlborough center and J. go to me, the same would have happened to him. So he is, for me it is a big difference.

The treatment and her engagement with the therapists impacted her way of relating to her children which made a 'big difference'. She feels she was not the same mother for the first one than for the second one.

This one was bullying the other one. And I said to him 'no baba', he's gonna cry and he wants me to pick him up. And if I don't pick him up, he's gonna come to me and try to cuddle me and kiss me. The other one, if I told him off, he's not gonna come to me... yes like, I know you are my mum, you have to come to me. You know, I didn't pull him, you know, I didn't do my job, that's why I think he is like that. If it wasn't for my early PIP group, the same would be here.

PIP changed her attachment style. She can noticed the difference in the way her children engage with her. One identifies her as his mother and the other doesn't Sense of guilt as she feels she 'didn't do her job', didn't do her mothering job

30. On becoming a mother - Learning through therapy

I am enjoying being a mother now. Whereas before, if my other one cried, I was so angry and...sometimes I used to say 'I don't want you, you just cry'. Now if he cries, I know how to handle him. If I know he is hungry, I fed him. If I know it is feeding time, or nappy changing time, I do it. If he still cries, I leave him. He wants to cry, give him time. I learnt from the group to give them time. Before `I did not know.

Before her child's cry made her feel angry and made her rejecting him even more With PIP, she learnt to attune to child's emotions, to respond to his communication. Couldn't dance before whereas she feels she can do the attunement dance now. She feels she knows how to read his needs and respond to it. Learning process that took place in therapy, before she 'did not know'

31. Not knowing how to be a mother

I didn't know what to do with my son so I walked away. Because I tried to feed him, to change him like I changed his clothes then he is still crying. I didn't know what to do, I was angry so I just go to sleep...

Mother not knowing how to soothe her child before, felt she was not a good mother? So she walked away and let the mothering to her husband and mother-in-law

...I felt so so much anger. I didn't want to hit him but I felt like hitting him but I didn't. I just left the room... Now do feel angry but I know it is not about him crying. I have good reasons to be angry. I know it is not right that's why I get angry with my husband or anybody. Before I used to have just anger, anger

Anger projected on the child before. Perhaps she left the room to protect her child? Now she feels she can identify the reasons for her anger and not make her child responsible

32. Not knowing/understand oneself

I did not know what was wrong with me. I did not even know depression existed. I did not even know that word (laughing). I did not know what was wrong with me

Not knowing, not understanding was an important feature of her life prior PIP

Big laughter – humour- Able to laugh about herself – real sense of health- New perspective- She can look a herself in a completely different light (*'I was so dumb'*)

Cried-Other end of the spectrum of emotions – Her realizing through PIP that her mum must have suffered to be separated. Before she could only connect with the anger at being abandoned by mother. When she became a mother, she reflected upon her mother's experience from a mother's perspective. It enabled her to develop a better relationship with mother

33. Normalisation – New perspective on husband

Therapy changed my relationship with my husband because you know, I thought it was just him. He doesn't listen to me, he doesn't do what I tell him. What should I do? What should I tell him? Most people, most men do that. But I didn't even know (laughing)... I compare him with the other and he was better. Other people were even worst... he wasn't. You know, everything I say he doesn't listen to me, I used to be so angry. Then I thought, I didn't tell my husband what we discussed in the group because you are not allowed to. There my friend she told me 'you know my husband left that tea, he drinks milk and he leaves the cup'. I thought my husband doesn't even drink tea (laughing), that's the good thing.

PIP changed relationship with husband, also normalized it. Husband is not bad, just an ordinary man and actually no that bad compared to others.

34. Importance of sharing in the group

Because before you don't know other people, you thought you know, you've just seen your face, I saw your face but I don't know what's on your mind. In

the group, we share each other. You know what is it, what is going on in your own life. That's the main helping point I think.

Key point: sharing (knowing what is on the other mind and sharing what is on your mind) and caring

sharing and caring...

That's why she identifies as being key therapeutic features of the GPIIP

35.Sameness/Belonging

...Knowing that you mind can think things and it is not just me, like other people feel the same. It is not just me that is feeling like that...

Normalisation as a helpful therapeutic tool. She feels it is ok, she is not alone and it is normal, great sense of relief.

36.Compairing

...some people can even feel worse. If you compare ten women, you can think five are like you so you feel, I am quite ok. It is not like no, I don't have anything, I have to die. I don't have any life, that's it. I left my mum because of this guy and this guy doesn't even listen to me. What should I do? I can't leave him because I love him. I have to die (laughing).

37.Sharing enabling normalisation and sameness/belonging

Then you come to the group sharing your story and hearing other stories as well. And you think those people also love them, their parents also did not agree for them to get married, people are getting all sort of problems. So that's quite normal...

Felt she had nothing and therefore she had to die

Then realized by sharing that others were like her '*not so bad*'

Normalisation

New perspective on her situation and on how to manage it

Change in her thinking and change in her behaving

38.Normalisation allowing a sense of ability/competency

...Normal, yes and that it is not a big deal. We can deal with it. That's the main thing.

Normalisation, ordinariness and therefore it makes it manageable

...I thought it was terrible and actually I realised it was quite normal.

New perspective through normalisation

Like before if my husband didn't give me a sandwich that I asked for, I didn't have food for two days. I told you, you didn't listen to me, you don't love me. Now if he doesn't bring me what I want, it is ok. I'll do it next time because you know, it is not a big deal. He couldn't manage it and you know, other people, ten days somebody told me. Like she says the same things over and over again but he doesn't listen. But my husband, I told him the second time and he brings it to me. Why shouldn't I eat? (laughing)

Realising that she is punishing herself, becoming aware on a self-destructive element in her way of responding to her needs not being met – wonder if she

realized she needed to be more pro-active and not wait for others to meet her needs?

39. Normalisation leading to new perspective

Husband not obeying was interpreted as him not loving her. **'Now I learnt it is normal. It is not a big deal if he couldn't manage it. It doesn't mean he doesn't love me'**. Learning process in PIP about what is normal and what is not, what is acceptable and what is not. Learning leading to her developing a new understanding on relationships

40. Tolerance/Acceptation of ordinariness

'I really felt he doesn't love me that's why he doesn't listen to me. Now I feel he couldn't manage it and it is ok...

Growing tolerance, change in her expectation

...he is not perfect, nobody is perfect, before I thought he had to be perfect because I choose him and my mum said he was going to be like that. Now my mum is right and I am not, why should I live anymore? (laughing)

Very important insight into the roots of her expectation of perfection. When husband was less than perfect, he confirmed mother's prediction (don't marry him, he is useless). She couldn't bear that hence her desire to die.

41. Humor

I really laugh of myself

developed a humoristic perspective on herself

42. Change in object representation/Object becoming benevolent

you can share things. Before, I didn't even tell my mum what was going on with me because I thought if I say it, they are going to blame me. They're gonna say we told you, why did you get married to him. Now I can think, she is my mum, she will understand

Another change – expect people to understand as opposed to judge and blame/accuse

She became more tolerant and she came to understand and expect the others as more tolerant as well. Link between self-representation and other representation- self and other not being that different, having the same qualities

43. Owning responsibility/Acknowledging her ordinariness

It is a lot of things I have done. And I did do it, she also did things. I can't be perfect. I've done wrong, she also did wrong. I am not saying I am right. Before I used to say 'yes I am right' (burst out laughing). Now I am more like, ok, it is normal. I make mistake. People can make mistake

Same idea of tolerance, of being perfect, self and others being similar in their imperfection- shared responsibility- ownership

44. Malevolent object

If I speak, they are going to cast me

Paranoid expectations – the other will cast her, reject her, blame her if she speaks prevented her to talk and share her problem with others

45.Trust in the other being helpful/supportive

Now I think I should share with them. Because if there is any problem, they can solve it.

Change in expectation and representation of other. The object became helpful in her mind. Is that because she experienced an helpful object/other/the therapist /the group/others mothers in PIP

Her relational experience in the GPIIP seems to have changed her internal object an relational expectation.

46.New perspective/ there is someone out there for her

yes, like there is someone. I can trust him, I can say anything. We have a relationship

47.Inability/unwillingness to express oneself

But I did not say anything, I couldn't say. Because if I say anything he is going to get sad, he's gonna cry. And if he doesn't feel sad, he's gonna blame me. So, lots of things

Again the other is experienced as either potential damaged or attacking if she talks and share. Wondered if she experienced talking and sharing in the group with others that do not get destroyed and damaged, survived her sadness and despair, and were able to provide support and containment – so she then came to expect the same from her family- Her internal object change not the external one as probably

48.Sharing/Togetherness

They will share with you and you can share with them. Even sometimes they would go away and they would leave us, just the mums and gave us lunch. Every single time they gave us lunch. So we could have our lunch and chat to each other.

Generosity of the group/therapists – they will share with us, they gave us lunch

49.Process of engagement in therapy facilitated by the learning happening there

My mind was blank. I didn't have any expectations, I wasn't understanding. I just didn't know what was going on. Then I just went and felt, ok I should go. Should I go or not? Let me go and see what will happen. Then I felt, yeah, it is quite good. She told me how to feed him. I was struggling with him, he didn't sleep all night. Then some mums said, one mum said 'if you give him a bath before going to bed, it would make a big difference'. I did it and he slept. I felt yeah, I should go, I'm gonna learn new things. It encouraged me to go.

Process of engagement with therapy, should I go or not go?

She seems to weighted out the gain and felt it was positive, she would gain something out of coming to the group, it was worth it.

First time, I went because J. came few times in my house. She called me everyday, she came, you know. She pushed me to come. She was saying 'if you don't want to do it after few weeks, it is fine. If you don't want to talk to

the group, we can talk to you alone, just you and me. Then few weeks later I felt comfortable.

Importance of the proactivity of the therapist who 'called and pushed' and persuaded the mother to engage, giving her a choice 'if you don't want to do it after, it is fine. If you don't want to talk to the group, we can talk to you alone, just you and me'. Gave a choice and at the same time encourage her to go, try and see. Mother responded well to it

I wasn't interested so she just said try, and if you don't want to, it is your choice. You can say it to me. Once I talked to her asking 'what should I say?' as I felt someone is there for me. Then if she is caring for me, I should listen to her. I should just give it a try.

Process of engagement – because she trusted the therapist, felt she was there for her so she could listen to her and trust her. Importance of home visit. Having experienced the therapist coming to see her at home, engaging with her in one-to-one, helping and supporting etc. Then she could trust and listen. Therapist had established himself as trustworthy.

Question of engagement of the patient/hard to reach population – this might be an answer. Pre-group work is important and impact the patient's engagement with the group/therapy – We know from research that the patient's characteristic count as the biggest factor of influence (common factors research) including what the patient brings to the therapy before starting (his expectation, his beliefs in the efficiency of the therapy, his attitude to the treatment etc.).

We see here how .

50. Therapist experienced as pro-actively caring/contrast with her home experience

yes because every other day she would call me. She was saying' what is going on? How are you? Do you need anything? How are you feeling?. So...before nobody would ask, nobody would say how are you? If in the house, if I didn't eat for six days, nobody would ask. I was pregnant with him, 7 months, I didn't eat for three days. Nobody said anything

Felt she had no one interested in her before, no one caring- Had an experience of a caring and interested therapist who ask and enquire about her

. It is a silly mistake. It is my fault. Why should I wait for other people to say (laughing)

Movement from passivity to activity, from being the victim of others' lack of interest to realizing that she is the agent of her life, if sh needs food, she needs to eat and grab the food herself.

51. Not understanding herself

My mind was blank. I didn't have any expectations, I wasn't understanding. I just didn't know what was going on (p.10)

Not understanding prevented her to think, to speak, to engage

52.Struggle to express herself linked to her not making sense

sometimes I tried to say it but nothing would come out of my mouth. I wanted to but it couldn't come out. I didn't know that time what was happening to me

When scared, overwhelmed, she can't express herself. Not understanding what was happening to her seemed to prevent her from talking – can only articulate what is understood.

It was so scary ...I couldn't open my mouth, I couldn't say anything.

Same inability to speak, to express herself that we found when she is scared.

Seems that she developed her ability to speak in therapy facilitated by her new way of making sense, of understanding herself, others and her relationships with others.

53.Difference in attachment/bonding experience

Because he was so small when she gave it to me. This one, the other one I can't remember because it wasn't a normal delivery. I was induced. I could hear everything but I couldn't open my mouth, I couldn't say anything. Then after I was tired. I wasn't bothered to hold him. This one, one thing I think they should do with every mother, straight away they gave him to me. And that felt so amazing. I didn't have any clothes that time. They just left him on me. I just felt so amazing. That skin touch, I felt I am, I am a mother.

Mother thinking about the difference of experience between her first and second child – first one she had a C-section delivery, couldn't feel connect, couldn't 'bother', no bond, attachment difficulty leading to disorder – Second one, skin to skin, connection, felt she was his mother (with the first one, she did not look after him, mother-in-law and husband came to look after him). On becoming a mother, reflection on what participate to this process, what makes a mother feel she is a mother? To identify her baby as hers

54.Child benefiting from the GPIP/Before and after for him as well

Yes before he used to be shy and hide, with other people. But in the group he felt, yes it is fine, other people can be stayed with

Her son's experience mirrors her experience- before she felt others where not ok and then with PIP she came to realize it was good to share and others could be trusted and supportive- Like her, her son learnt in PIP that 'others could be stayed with'

yes like it is ok to be shared with other people. He was ok to be around people with me. If he saw other children, he used to cry so much

She pushes the idea further, it is ok to share with other people, it is ok to be shared with others people. Sense of security given to her child 'it is ok to be around people with me'. She identifies herself as a secure base

Every single time he wanted to hold my hand, you know my little finger. We were with other people, you know, so in case I leave him. He would hold my finger (laughing)

Another illustration of her noticing/understanding that she is a secure attachment figure for her child

Every single time he wanted to hold my hand, you know my little finger. We were with other people, you know, so in case I leave him. He would hold my finger (laughing)

Idea of difference for the child as well, with a before and an after the GPIIP
Before he used to cry a lot, then he went to the group, now he doesn't
GPIIP as affect regulation process for mother and baby

55. Seeing oneself/new perspective developing out of therapy

Sometimes we gave them play. Sometimes we played with them and they recorded us. They showed us what we did. It was so amazing...she took a picture. She recorded it and showed us on TV, that was so amazing.

Seeing herself was amazing, I wonder if it allowed her to see herself differently, to see herself as an able mother? Like when she looked at her baby in the eyes for the first time in therapy. She repeated it until she saw him, his communication, his love etc. Also talked about how amazing that was. Process of discovery of herself and her child. Another aspect of the process of change perhaps

56. GPIIP/therapists experienced as helpful

They've done so many things, very helpful.

Sense of gratitude, therapists/clinic did so many things for them (her and her baby, her and the other mothers)

I regret not having asked her what she had found helpful? I feel I missed an opportunity to go deeper

57. Normalisation and acceptance of ordinariness

First time I felt, who are they? Why should I come here? And the baby is crying (laughing), I know, I know. It is really life, with a baby with his boogers. I don't want to see him. Then after I realized, it is normal, babies do have boogers. Even now, I don't like, you know, dirty babies. You know, you don't allow that in the public. It can happen

Process of engagement with GPIIP, at first she wondered why she should come, what would she get, felt put off by babies with boogers. Then she realized it was normal 'it is really life' as if she came to realize in therapy what was normal and ordinary (babies and husband, her as a mother), came to accept her ordinariness and others ordinariness (see when she talked about her not being perfect likewise for her in-laws and husband, made her more tolerant)

58. GPIIP facilitated change

so many things changed, slowly slowly

Process of gradual change

59. GPIIP as a Cathartic process

When I used to come to that group, you know, every week, the whole Monday like every day, things build up in my mind and Thursday I come here, and everything is given away (laughing). Like when I went home, I didn't have anything left, anything to say.

Release in the group, emptying herself, group as recipient, cleansing process

60.GPIP as Sharing Friends Group

That was my sharing, you can say my sharing friends group. You know like everyday when I came here, they would ask how are you? How do you feel? Lots of things they asked, like every question.

61.Learnt to talk/express/share herself

I came here because I had problem talking but we shared everything with each others so I learnt to talk.

Named the therapy group as her 'sharing friends group'

Importance of sharing, others being curious and interested in her, asking questions.

She learnt to talk and share and understood the therapeutic aspect of it

62.Cleansing effect of talking

every single thing, I told them, you know, my husband, my life etc. Then I told everything so there was nothing left to me to think, to get depressed about. I was fresh.

Openness, sharing everything. We found again the idea of emptying herself, releasing herself in the group 'nothing left for me to think' so she can go back home 'fresh'

cleared. You know, if you are stinky, you have a shower and everything goes away. It was like that for me.

Cleansing, dirt goes away

63.Difference/Change/new perspective

I compare what my child does, what my husband does, and our relationships. It made quite a big difference because before I was fussy with my husband.

Comparing process leading to normalisation, she could place herself in humanity

64.GPIP as refreshing day/mother leaving behind her negative emotions

he would say 'oh every week, I would see her new'. Because on Tuesdays, I was full of anger anger anger, on Thursdays, I was fresh. I could tell the difference. He could tell that Thursday was the refreshing day so (laughing)
Refreshing day, cleansing day, goes to GPIP dirty/full (of negative emotions) and comes out clean, empty, fresh

Therapy day as the 'refreshing day'- mother using humor- sophisticated psychic mechanism

65.GPIP benefiting husband as well

you know good Friday? Every Thursday is good Friday for him (laughing). It is good Thursday

Therapy day as 'good Thursday' – Use of humor- she is aware that it was good for her but also good for her husband who used to be the recipient of her anger/attacks-

66.GPIP experienced as a good service that is needed

I would like to say that if you guys can continue those things, please continue! For people like me, like, there are so many mums like me who

really need you guys. I would say 'what you guys are doing, please keep doing it'. It is a really good job.

Mother saying how important it was for her to go to PIP and how important it is to carry on offering such service for other mothers, 'mothers like her'

67.GPIP making a difference in mother's life

Probably you guys can't feel it but I am feeling what it's done so, it is different...

Idea of difference/change

68.GPIP giving a new life

...Probably JJ can forget what she's done because she did her job. But for me, it is my new life...

Changed her life, before and after PIP

69.Awareness of intergenerational transmission/Change/Differencealso for the next generation

...so please keep doing it. And...keep doing it (tears in her voice) because of the next generation...

Awareness of the impact PIP had on her but also on her son/next generation

...those things can happen...

Not sure what she means exactly by 'those things', difficulties? Depression? Parent-infant attachment struggle? Perhaps all those things together

70.Knowing makes a big difference

...Because it is different for...you know, if you know it, it is not different. If you don't know, it is a big difference...

Knowing- she did not know before and she knew after – learning/teaching element of GPIP. PIP equipped her with some important knowledge that changed her life (knowing that she was normal, good enough, ordinary like father and child)

71.Gratitude

...It is quite difficult so I would thank everybody.

Her experience was difficult

Gratitude

72.Recommending GPIP to other mothers

Like for me, I would say 'please go. If you don't like it, probably not everybody is like me, but at least they've got options. If she doesn't want to be in a group, she can be alone as well. They've got options, they are not forcing you to do it so. You've got options, why don't you try? Please, every new mother should try if they struggle like me.

Having a choice was important, not being forced/coerced in doing anything. Voluntary engagement

She was a struggling mother who needed help and found help

Recommends it to other struggling mothers.

73. Being in a group/Belonging as therapeutic tool/Enables you out of isolation

I would preferred a group PIP. Because with individual psychotherapy, you are just talking about you, your problems. You don't know about other people's problem, about the world, that there is a world out there with other people who have the same problems. So if you see other people, it makes a big difference.

Discovering/becoming aware of the world out there and other mothers like her have been cardinal for her – Took her out of her isolation, normalize her experience, taught her the value of sharing/talking.

Group as a cardinal aspect of the therapy

Again the idea of difference

74. Importance of normalisation as a therapeutic tool

You want to go to the toilet and cry because there is nobody like me, like you. There is somebody. There are other people so go to the group and you can see that these things are normal, quite normal. It is not normal but other people had it as well. It is not like just you.

Normalisation, 'it is not like just you'- Perhaps she felt she joined in, came into humanity/the human race with PIP, before she felt outside humanity (she was the only one struggling and she was alone)

Importance of seeing in the group. Seeing and listening, seeing oneself and others.

Seeing others changed her perception of oneself, she is like the others

75. Ordinariness as relieving

it is ordinary

As opposed to extra-ordinary. She is just like everybody else therefore she doesn't need to die, she can have an ordinary existence where she is not perfect, neither her husband, baby, in-laws- Being ordinary also means belonging to humanity

76. Sharing/Improving/Playing/Seeing – KEY FEATURES

There were lots of good things like mainly in the group. So sharing, improving relationship, playing with children, seeing yourself

Sharing, improving, playing, seeing – what she identifies as being the skeleton of her experience seems to summarise the key themes

77. Gratitude/wanted to share

I wanted to talk and say thank you. It is very important for me because they did such a good job, an amazing job. Thank you

Mother's gratitude, felt she received something and wanted to give something back hence her participation to the research.

3. Phase 3: Developing emergent themes

See **Themes in red**

4. Phase 4: Searching for connections across themes

Chronologically ordered themes

- 1.Difference - change**
- 2.Self before and after PIP**
- 3.Inability to express herself/her pain prior GPIIP**
- 4.Mind as a full up recipient**
- 5.Sharing**
- 6.Normalisation**
- 7.Not knowing how mother to other prior GPIIP**
- 8.Difficulty to reach out for help prior GPIIP**
- 9.Normalisation within the group**
- 10.Difficulty to reach out for help prior GPIIP**
- 11.Change**
- 12.Sameness/Belonging to humanity**
- 13.Normalisation**
- 14.Change/Difference**
- 15.Change/Difference**
- 16.On becoming a mother/Finding her voice**
- 17.Seeing/feeling herself as the mother**
- 18.Change/New life/Therapy experienced as having someone who cares**
- 19.Therapy made a difference/experienced what it was like to count for someone**
- 20.New perspective developed through GPIIP**
- 21.Attachment difficulty**
- 22.Learning/Being taught**
- 23.Attachment difficulty**
- 24.Teaching/learning through GPIIP made a difference**
- 25.Learning to attune/communicate with child/On becoming a mother**
- 26.On becoming a confident/known mother vs Mother who did not know before**
- 27.Being told/taught made a difference**
- 28.Learning to engage with her child**
- 29.Therapy experienced as making a difference in regards to her attachment to her children**
- 30.On becoming a mother - Learning through therapy**
- 31.Not knowing how to be a mother**
- 32.Not knowing/understand oneself**
- 33.Normalisation - New perspective on husband**
- 34.Importance of sharing in the group**
- 35.Sameness/Belonging**
- 36.Comparing**
- 37.Sharing enabling normalisation and sameness/belonging**
- 38.Normalisation allowing a sense of ability/competency**
- 39.Normalisation leading to new perspective**
- 40.Tolerance/Acceptation of ordinariness**
- 41.Humor**
- 42.Change in object representation/Object becoming benevolent**

- 43.Owning responsibility/Acknowledging her ordinariness
- 44.Malevolent object
- 45.Trust in the other being helpful/supportive
- 46.New perspective/ there is someone out there for her
- 47.Inability/unwillingness to express oneself
- 48.Sharing/Togetherness
- 49.Process of engagement in therapy facilitated by the learning happening there
- 50.Therapist experienced as pro-actively caring/contrast with her home experience
- 51.Not understanding herself
- 52.Struggle to express herself linked to her not making sense
- 53.Difference in attachment/bonding experience
- 54.Child benefiting from the GPIIP/Before and after for him as well
- 55.Seeing oneself/new perspective developing out of therapy
- 56.GPIIP/therapists experienced as helpful
- 57.Normalisation and acceptance of ordinariness
- 58.GPIIP facilitated change
- 59.GPIIP as a Cathartic process
- 60.GPIIP as Sharing Friends Group
- 61.Learnt to talk/express/share herself
- 62.Cleansing effect of talking
- 63.Difference/Change/new perspective
- 64.GPIIP as refreshing day/mother leaving behind her negative emotions
- 65.GPIIP benefiting husband as well
- 66.GPIIP experienced as a good service that is needed
- 67.GPIIP making a difference in mother's life
- 68.GPIIP giving a new life
- 69.Awareness of intergenerational transmission/Change/Difference also for the next generation
- 71.Gratitude
- 72.Recommending GPIIP to other mothers
- 73.Being in a group/Belonging as therapeutic tool/Enables you out of isolation
- 74.Importance of normalisation as a therapeutic tool
- 75.Ordinariness as relieving
- 76.Sharing/Improving/Playing/Seeing - KEY FEATURES
- 77.Gratitude/wanted to share

New gestalt

Struggle to understand and express one self

- 31.Not knowing how to be a mother
- 32.Not knowing/understand oneself
- 47.Inability/unwillingness to express oneself
- 51.Not understanding herself
- 52.Struggle to express herself linked to her not making sense

Mother-Child relational difficulties

- 21.Attachment difficulty
- 23.Attachment difficulty
- 44.Malevolent object

Therapy/therapist experienced as good object

- 50.Therapist experienced as pro-actively caring/contrast with her home experience
- 56.GPIP/therapists experienced as helpful
- 59.GPIP as a Cathartic process
- 65.GPIP benefiting husband as well

On becoming an able mother

- 2.Self before and after PIP
- 16.On becoming a mother/Finding her voice
- 17.Seeing/feeling herself as the mother
- 26.On becoming a confident/knowing mother vs Mother who did not know before

Ordinariness

- 40.Tolerance/Acceptation of ordinariness
- 43.Owning responsibility/Acknowledging her ordinariness
- 75.Ordinariness as relieving

Learning process in therapy

- 22.Learning/Being taught
- 24.Teaching/learning through GPIP made a difference
- 25.Learning to attune/communicate with child/On becoming a mother
- 27.Being told/taught made a difference
- 28.Learning to engage with her child
- 61.Learnt to talk/express/share herself
- 30.On becoming a mother – Learning through therapy
- 49.Process of engagement in therapy facilitated by the learning happening there

Normalisation

- 9.Normalisation within the group
- 13.Normalisation
- 38.Normalisation allowing a sense of ability/competency
- 39.Normalisation leading to new perspective
- 36.Comparing
- 33.Normalisation – New perspective on husband
- 57.Normalisation and acceptance of ordinariness
- 74.Importance of Normalisation as a therapeutic tool

New perspectives

- 20.New perspective developed through GPIP
- 46.New perspective/ there is someone out there for her
- 42.Change in object representation/Object becoming benevolent
- 55.Seeing oneself/new perspective developing out of therapy

63.Difference/Change/new perspective

Sharing process in therapy

34.Importance of sharing in the group

37.Sharing enabling normalisation and sameness/belonging

48.Sharing/Togetherness

60.GPIP as Sharing Friends Group

61.Learnt to talk/express/share herself

62.Cleansing effect of talking

64.GPIP as refreshing day/mother leaving behind her negative emotions

Sameness/Belonging/

35.Sameness/Belonging

12.Sameness/Belonging to humanity

73.Being in a group/Belonging as therapeutic tool/Enables you out of isolation

Transformation/Change/Difference

1.Difference - change

11.Change

14.Change/Difference

15.Change/Difference

18.Change/New life/Therapy experienced as having someone who cares

19.Therapy made a difference/experienced what it was like to count for someone

58.GPIP facilitated change

53.Difference in attachment/bonding experience

67.GPIP making a difference in mother's life

69.Awareness of intergenerational transmission/Change/Difference also for the next generation

68.GPIP giving a new life

29.Therapy experienced as making a difference in regards to her attachment to her children

54.Child benefiting from the GPIP/Before and after for him as well

Gratitude

71.Gratitude

77.Gratitude/wanted to share

41.Humor

76.Sharing/Improving/Playing/Seeing - KEY FEATURES

Bringing together the new gestalt into the main overarching themes

1.Self experienced as unable prior therapy

Struggle to understand and express one self

Mother-Child relational difficulties

2.GPIP as a transformational experience

Transformation/Change/Difference

New perspectives
On becoming an able mother

3.The importance of learning in GPIP
Learning process in therapy

4.Togetherness/Sameness/Belonging
Sharing process in therapy
Normalisation
Sameness/Belonging
Ordinariness

1. Self experienced as unable prior to therapy

Inability to make sense

The participant experienced herself prior to therapy as the one that does not know and does not understand what is going on for her **'I did not know what was wrong with me. I did not even know depression existed. I did not even know that word (laughing). I did not know what was wrong with me'**

She could not make sense of her personal experiences using her mind **'My mind was blank. I didn't have any expectations, I didn't understand. I just didn't know what was going on'**.

Inability to express oneself

It seems that she wanted to express herself but her inability to make sense internally prevented her from finding the words to express her psychic pain **sometimes I tried to say it but nothing would come out of my mouth. I wanted to but it couldn't come out. I didn't know that time what was happening to me'**.

Not understanding what was happening to her seemed to prevent her from talking. Perhaps one can only articulate what is understood **'It was so scary ...I couldn't open my mouth, I couldn't say anything'**. This same inability to speak, to express herself was found again when she is scared.

Object as damageable and malevolent

What seemed to prevent her from expressing herself as well was the representation of the other, her internal object experienced as potentially attacking/retaliating if she dared to speak and express her pain. She also seemed concerned by the damaged her expression could do to the other **'But I did not say anything, I couldn't say. Because if I say anything he is going to get sad, he's gonna cry. And if he doesn't feel sad, he's gonna blame me'**.

Inability to mother

Mother experienced herself as not knowing how to mother her child **'I didn't know what to do with my son so I walked away. Because I tried to feed him, to change him like I changed his clothes then he is still crying. I didn't know what to do, I was angry so I just go to sleep'**.

She came across as not knowing how to soothe her child before. It made her feel so inadequate that she would rather walk away and leave the mothering to her husband and mother-in-law: **'with the first one, I couldn't do anything. My mother-in-law and my husband did it'**. This inadequacy, inability made her feels so angry that she had to leave her child to abuse him **'I felt so so much anger. I didn't want to hit him but I felt like hitting him but I didn't. I just left the room'**. She seemed completely lost in regards to mothering, as if she had no internal model and map of ordinary good mothering **'Before I used to be like, no that's not normal. How am I gonna change her nappies? So small, I'm gonna break his feet. I couldn't...what should I say? I wasn't confident to do things and I was like so worried. Like how am I gonna feed them. Like you know how certain people say that if they don't take bottle, you try to give some water. I even don't know'**. She could not think creatively about what

to do. The unable self gradually became an able self in therapy. The therapeutic process was experienced as transformative.

2. Therapy as a transformational experience

On becoming a mother

Throughout the interview, the mother talked about her sense of difference **'I saw a big difference... yes, a very big difference for me'** which she associated with the idea of change **'so many things changed, slowly slowly'**, almost an unperceivable change for the other but so cardinal for her **'Probably you guys can't feel it but I am feeling what it's done so, it is different'**.

She seemed to experience this change on a behavioral level **'And after six week, I felt like a different person like I don't cry anymore'** but also at a psychological level **'I wasn't confident...But attended the group, I became so confident'**. Prior the group she thought and experienced herself as the one that did not know, which was so uncomfortable that she abdicated her maternal function to her mother-in-law. Coming to the group enabled her to feel and identify herself as the mother of her child **'I am the mother, now I know what to do, what is good for them'** and to enjoy being a mother **I am enjoying being a mother now'**. She came to trust her mothering capacity **'Now I know what is right and what is wrong and I can say it. If another people say 'no that is not right', you know. One day I was trying to give him a bath. In our culture, you bath babies' daytime not nighttime. So if my mother-in-law said before 'don't give the bath', I wouldn't do it. Now I know I can give a bath at any time. Now I feel more comfortable'**. She tells the story of a woman becoming a mother **'now I know what to do with him'**, reflecting back upon what it was like when she felt she was not **'before, if my other one cried, I was so angry and...sometimes I used to say 'I don't want you, you just cry'. Now if he cries, I know how to handle him. If I know he is hungry, I fed him. If I know it is feeding time, or nappy changing time, I do it. If he still cries, I leave him. He wants to cry, give him time. I learnt from the group to give them time...Before 'I did not know'. I didn't even know that if you leave them they cry, I didn't know'**. It is as if she could not comprehend at the time that she mattered to her child. Having had attachment difficulty with her first child **'You know my older one, I couldn't enjoy him. You know, the children, their the first step, their first laugh and crying... I couldn't, I thought it was quite boring'**, she felt the treatment changed her experience of herself as a mother and therefore impacted her relationship with her children **'If it wasn't for the Marlborough center and J. go to me, the same would have happened to him. So he is, for me it is a big difference'** She feels she was not the same mother for her first child than for the second one, with some awareness of the intergenerational transmission of attachment difficulty **'so please keep doing it. And...keep doing it (tears in her voice) because of the next generation...**

On having a new life because you matter to someone

We have seen that this mother felt alone, unable to reach out **'before I used to think I did not have anybody because mum...mum is back home** but having experienced being important for the therapist **'She used to call me everyday**

after she saw me. I felt like she was my sister. I don't have a sister. She used to hold me and hug me. You know, she wasn't really related to me but still I felt she was related to me' made her feel she was not alone anymore 'You think that someone care for you, you know' and that changed her life, it gave her 'a new life because...probably J. can forget what she's done because she did her job. But for me, it is my new life'. Very powerful therapeutic process, which transformed her existence to its core 'me counting for someone made a big difference. Before that time I couldn't, you know, that time I tried to strangle myself because...I am talking about that kind of things, you know. It is as if having one person who cares (the therapist) made her realize that she had people who cared (husband, family) 'Now I know I have got a life, I have children... now I feel confident. I do have a life. I do have people who care for me' with the world (internal and external) becoming a place of warmth as opposed to a place of loneliness and people (internal objects) becoming benevolent 'Before, I didn't even tell my mum what was going on with me because I thought if I say it, they are going to blame me. They're gonna say we told you, why did you get married to him. Now I can think, she is my mum, she will understand'. The difference and change she repeatedly referred to seemed to be about her intrapsychic and interpersonal world 'there is someone now. I can trust him, I can say anything. We have a relationship'. She experienced the therapists/therapy as giving her a different perspective, a different truth about herself and her life which seemed to have changed how she felt 'somebody comes to you and says 'no, it is not like this', it can be so good. It makes you happy. You can be happy in your own life' Therapist telling and showing her that someone cared gave her hope. Perhaps it introduced a gap between her belief and her perception, with hope filling that gap 'You don't have to believe that (I am alone in the world)... you can say to someone there is hope'. It indicated an awareness of her belief being a subjective belief and not necessary the truth which contrasted with the blankness she described prior the therapy. She gave further evidence of her growing mentalising capacity when she describes her new way of understanding her mental states 'now I do feel angry but I know it is not about him crying. I have good reasons to be angry. I know it is not right that's why I get angry with my husband or anybody. Before I used to have just anger, anger'.

3. The importance of learning

Learning as a factor facilitating engagement

At first she was unsure about coming to therapy 'should I go or not? Let me go and see what will happen' but feeling she would learn something gave her an incentive to engage with the treatment 'then I felt, yeah, it is quite good. She told me how to feed him. I was struggling with him, he didn't sleep all night. Then some mums said, one mum said 'if you give him a bath before going to bed, it would make a big difference'. I did it and he slept. I felt yeah, I should go, I'm gonna learn new things. It encouraged me to go'.

Learning as a factor facilitating change

Not knowing seemed to occupy an important place in this mother's existential being in the world which may relate to her experiencing the learning process as

key in parent-infant psychotherapy **'so many things, we don't know. If someone tells you, it makes a big difference'**. Both the learning process **'how they teach us, it makes a big difference'** and the content **'they taught us how to play, how to enjoy them, how to give them time. Within few weeks, they taught us how to play with them, you know, how to attach, to get attach to them, how to understand their feelings'** mattered.

Learning to discover and engage with her child as a emotional being

She knew her limitations and felt that the teaching provided corresponded to her needs **'I came here because I had problem talking but we shared everything with each other so I learnt to talk'**. She learnt to communicate and to attune to non-verbal communication with her child **'I used to lay down and we looked at each other. Everybody looked at their baby and after few minutes, they were talking like 'what do you feel? Everybody was saying like 'I felt so beautiful like these eyes', and someone was saying like 'how he saw, he saw he is loving me'. He couldn't say it but his eyes were saying things. First time I was there, I couldn't feel it. At first it was difficult and she struggled but she persevered with the help and support of others 'oh first time j. (the therapist) said, the other lady was there, I can't remember her name, she was saying 'he said it', I didn't see it but she said 'how are you going to look at them, you know, with eye contact'. Then I've done it a few times before I knew what it was', learning to establish contact through the gaze. It was experienced as a powerful process **'It was absolutely amazing to see him, to feel him'** that led to her becoming able to meet her child **'Few time I have done it, then I felt 'he is, he is something'** and see in him someone special who she could not see before.**

The psycho-educational aspect of GPIIP was experienced by mother as cardinal to her becoming a mother. She learnt how to be interested, how to see her child differently. She understood that her baby is a real person, with a psychic life and emotions **'It shows that this is their life'** which also impacted her understanding of her life as a mother **'enjoy this time. That's your life, it is not about thinking about other things. No we don't think about those things...they would remember us, you know, those good things. Don't ignore them you know'**. She understood that being preoccupied with the past was not helpful to the child who needed to be hold in mind by an available mother, and that these early interactions mattered and will be remembered by her children.

4. Togetherness/Sameness/Belonging

The therapeutic power of sharing

The mother identified the key therapeutic aspects of GPIIP as **'sharing and caring'**. She came to the group not knowing, not understanding herself and feeling rather lonely and isolated. Being in the group, she developed a bond with other mothers through sharing **'that was my sharing, you can say my sharing friends group. You know like every day when I came here, they would ask how are you? How do you feel? Lots of things they asked, like every question'**. Sharing was modelled by other mothers who were interested in her

and willing to talk about themselves. They taught her **'how to talk'**. **'They shared everything with each others'** which gave her a sense of togetherness. She shared the content of her mind **'you come to the group sharing your story'** as well as herself **'we share each other'**. Sharing was experienced as a reciprocal process **'They will share with you and you can share with them'** which enabled her to understand herself **'You know what is it, what is going on in your own life. That's the main helping point I think'**. She realised that her mental states were ordinary **'Knowing that your mind can think things and it is not just me, like other people feel the same. It is not just me that is feeling like that'**. Sharing her story but also **'hearing other stories as well'** was helpful as it normalized her experience **'you think those people also love them, their parents also did not agree for them to get married, people are getting all sort of problems. So that's quite normal'** which appeared to give her a great sense of relief **'every single thing, I told them, you know, my husband, my life etc. Then I told everything so there was nothing left to me to thing, to get depressed about. I was fresh'**. She came to the group feeling dirtied by her negative emotions. She experienced the sharing as a cleansing process **'You know, if you are stinky, you have a shower and everything goes away. It was like that for me'**. This cleansing process through sharing was noticeable to others, especially her husband **'he would say 'oh every week, I would see her new'. Because on Tuesdays, I was full of anger anger anger, on Thursdays, I was fresh'**. Her transformation process through therapy changed her sense of self but also her relational dynamic with her family which was important for all of them **'I could tell the difference. He could tell that Thursday was the refreshing day'. You know good Friday? Every Thursday is good Friday for him (laughing). It is good Thursday'**.

Normalisation enabling belonging

Before coming to the group she felt out of humanity **'before I thought it was only me. I am so bad, I am so...I am only bad, bad luck. I am the only one that is sad, everybody else is happy. It was only me who was sad, I was crying. Life was ending, it was not anything left for me'**, which made life seemed impossible. She was hopeless. **'Then I came to the group. I can't explain, it was such a big difference. I don't know about other people but for me it was a big difference'**. Although she started by saying she could not explain that feeling of difference, she came to unpack it **'and at the group, others people say the same to you so it feels more comfortable to share things. You know, one lady was saying how her partner did not listen to her. Then I compare my partner and felt that is quite a normal thing'**. Being part of the group gave her the opportunity to hear about other people's stories, to compare her experience **'you compare ten women, you can think five are like you so you feel, I am quite ok. It is not like no, I don't have anything, I have to die. I don't have any life, that's it'** and to feel she was like to others **'it is ordinary'** so she could speak and replace herself back into humanity **'it is normal, it is not just me. Other people have problem, other women'**. It shifted her assessment of her situation **'I thought it was terrible and actually I realised it was quite normal'**, her perception of herself **'you want to go to the toilet and cry because there is nobody like me, like you. There is somebody. There are other people so go to the group and you can see that these things**

are normal, quite normal. It is not normal but other people had it as well. It is not like just you' and her perception of others, mainly her husband 'now I learnt it is normal. It is not a big deal if he couldn't manage it. It doesn't mean he doesn't love me'. It is as if accepting her ordinariness made her more tolerant with others. Like her they are ordinary and fallible 'It is a lot of things I have done. And I did do it, she also did things. I can't be perfect. I've done wrong, she also did wrong. I am not saying I am right. Before I used to say 'yes I am right' (burst out laughing). Now I am more like, ok, it is normal. I make mistake. People can make mistake'. There is a sense of shared responsibility, ownership and togetherness that made life more bearable and manageable 'that it is not a big deal. We can deal with it. That's the main thing'. This sense of belonging, being part of an ordinary humanity where people love, struggle, forgive and give was at the heart of her therapeutic journey 'I would preferred a group PIP because with individual psychotherapy, you are just talking about you, your problems. You don't know about other people's problem, about the world, that there is a world out there with other people who have the same problems. So if you see other people, it makes a big difference'.

Appendix 3 – Superordinate themes showing presence by interview

Superordinate themes (61)	Interviews							Total/7
	1	2	3	4	5	6	7	
Antenatal therapy	0	0	0	0	1	0	0	1/7
Core experience words	1	1	1	1	1	1	1	7/7
Ending as a subjective process	1	1	1	0	1	1	1	6/7
Passive engagement leading to nothingness	0	0	0	1	0	0	0	1/7
Presence of the child in PIP experienced as problematic	1	0	0	0	0	0	0	1/7
Maternal Functions								
Care	0	1	1	0	0	1	1	4/7
Encouragement	0	1	1	0	0	0	1	3/7
Help & support	1	1	1	0	0	0	1	4/7
Listening/Being listened	0	1	0	0	0	1	1	3/7
Loving/Enabling love	0	1	0	0	1	0	1	3/7
No judgement	0	0	1	0	0	0	0	1/7
Reassurance	0	0	0	1	0	0	0	1/7
Respect	0	0	0	0	0	0	1	1/7
Trust	0	0	0	1	0	0	1	2/7
Understanding/Being understood	0	0	1	0	1	0	1	3/7
PIP as positive experience								
PIP as a chance	1	0	0	1	0	0	0	2/7
PIP as good	0	0	1	0	1	0	1	3/7
Goodness for mothers and babies	0	1	1	0	0	1	0	3/7
Gratitude	0	0	0	0	0	0	1	1/7
PIP as helpful	1	0	0	0	0	1	0	2/7
PIP as nice	0	0	1	0	0	0	0	1/7
Recommended to others	0	1	1	0	0	1	0	3/7
PIP as useful	1	0	0	0	1	0	0	2/7
PIP as wonderful	1	0	0	0	0	1	1	3/7
Therapeutic Factors								
Belonging/Sameness	1	0	1	0	1	1	0	4/7
Normalisation	1	1	1	0	1	1	0	5/7
Psycho-educational interventions	1	1	1	0	0	1	1	5/7
Second group	0	0	0	0	0	0	1	1/7
Sharing	1	1	0	0	1	1	1	5/7
Talking/Opening up	1	1	1	0	1	0	1	5/7
Togetherness	0	1	1	1	0	0	1	4/7
Therapists as good object								
Therapist as family member	1	1	0	0	0	1	1	4/7
Therapist as good object	1	1	0	0	1	0	1	3/7
Knowing what is needed	0	1	1	0	0	0	1	4/7
Pre-PIP relational engagement	1	1	1	1	1	1	1	7/7

with therapist

Past

negative/disconnected/unable
sense of self

Disconnection to the child	0	1	1	1	0	1	1	5/7
Inabilities	1	1	1	0	1	1	1	6/7
Isolation/Relational difficulties	0	1	1	1	1	1	1	6/7
Motherhood as difficult/negative experience	0	0	1	0	0	1	0	2/7
Perinatal depression	1	1	1	1	0	0	1	5/7
Struggle to engage with PIP								
Ambivalence/struggle to engage with help offered	0	1	0	1	0	0	1	3/7
Despair	0	1	1	0	0	0	1	3/7
Doubts	1	0	0	0	0	0	0	1/7
First group as preparation for the second	0	0	0	1	0	1	0	2/7
Individual therapy easing in mother into PIP	0	1	1	0	0	0	0	2/7
Initial emotional turmoil	1	0	0	0	0	0	1	1/7
Overcoming reservation/resistance	1	1	1	0	0	1	1	5/7
Participation as co-therapist	0	0	0	1	0	0	0	1/7
Resistance	0	1	0	0	0	0	0	1/7
Struggle to talk/open up	0	0	0	1	0	0	1	2/7
Transformation & Change								
PIP as Life saving experience	0	0	0	0	0	0	1	1/7
New perspectives	0	1	1	1	0	1	1	5/7
On becoming a competent self	1	1	0	0	1	1	0	4/7
On becoming a different person	1	1	1	0	1	1	0	5/7
On becoming a good enough mother	1	1	1	0	1	1	0	5/7
Reflectiveness	0	1	1	0	1	1	1	5/7
Responsibility & choice	0	1	0	0	0	0	0	1/7
Relational change	1	1	0	0	1	1	1	5/7
Rupture of negative intergenerational transmission	0	1	0	1	1	0	1	4/7
Transformative experience	1	1	1	0	1	1	0	5/7
Will to engage in order to change	1	1	1	0	0	1	0	4/7

Appendix 4 – Consent Form for Participants in Research

Please complete this form after you have read the Information Sheet.

Title of Study:

Parent-Infant Psychotherapy: A qualitative exploration of mothers' experience

- Thank you for considering taking part in this research. The person organising the research must explain the project to you before you agree to take part.
- If you have any questions arising from the Information Sheet or explanation already given to you, please ask the researcher before you decide whether to join in. You will be given a copy of this Consent Form to keep and refer to at any time.
- *I understand that if I decide at any other time during the research that I no longer wish to participate in this project, I can notify the researcher involved and be withdrawn from it immediately.*
- *I consent to the processing of my personal information for the purposes of this research study. I understand that such information will be treated as strictly confidential and handled in accordance with the provisions of the Data Protection Act 1998.*

Participant's Statement:

I _____

agree that the research project named above has been explained to me to my satisfaction and I agree to take part in the study. I have read both the notes written above and the Information Sheet about the project, and understand what the research study involves.

Signed

Date

Investigator's Statement:

I _____

confirm that I have carefully explained the nature, demands and any foreseeable risks (where applicable) of the proposed research to the volunteer.

Signed

Date

Appendix 5 – Participant Information Sheet

Study Title

Parent-Infant Psychotherapy: A qualitative exploration of mothers' experience

Invitation to participate

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

What is the purpose of this study?

Parent-Infant Psychotherapy is an early intervention that has been proven to be efficient in helping mothers and babies to develop a positive relationship.

It has been well researched which led to great progress in understanding how and why it works.

Yet each mother and baby brings their own history and personality to it which gives a unique dimension to the experience.

The purpose of this research is to explore mothers' subjective experience of parent-infant psychotherapy and the meaning they attach to it

It is our hope that this research will provide insights into mothers' subjective experience of parent-infant psychotherapy. It will expand our understanding of parent-infant theory and practice, and therefore it will facilitate more client-centered practice.

Why I have been chosen?

You have been chosen because you have an experience of having been in parent-infant psychotherapy. We believe that we can learn from your experience in order to improve the quality of the service that will be provided to women in the future.

We are giving the opportunity to participate to every woman that was referred to parent-infant psychotherapy, and that attended the treatment partly or fully.

Do I have to take part?

It is up to you to decide whether or not to take part. If you decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are free to withdraw at any time and without giving a reason.

What will happen to me if I take part?

You will be invited for an interview that will take place at the St Mary's hospital, or at your home if it is more convenient. The interview will last approximately an hour. You will be asked open questions about your subjective experience of parent-infant psychotherapy.

The interview will be recorded and erased within five years of the research project being written. The tape will be kept in a secure place until then.

You could stop the interview at any point if you decided you no longer wished to proceed, and the tape would be erased.

What are the possible disadvantages and risks of taking part?

Talking about a sensitive subject may bring difficult emotions.

It is the researcher/interviewer's responsibility to ensure that the interview does not constitute harm the participants.

What are the possible benefits of taking part?

It will be an opportunity to take some time to think and reflect upon an experience that may have been important to you and your baby, with the possibility of developing new insights.

Will my taking part in the study be kept confidential?

All information that is collected about you during the course of the research will be kept strictly confidential. Any information about you which is used will have your name and address removed so that you cannot be recognized from it.

All data will be stored, analysed and reported in compliance with the Data Protection legislation of the United Kingdom.

What will happen to the results of the research study?

The results of the research will be published as part of a doctoral dissertation. A copy of the final dissertation will be held by Metanoia Institute and Middlesex University, which will be accessible to participants if they wish to access it. Participants will not be identifiable in any report or publication.

Who has reviewed the study?

Metanoia Research Ethics Committee and Central and North West London mental Health Trust Research Ethics Committee have reviewed the study.

Contact for further informationResearcher:

Yasmine Haimovici

Yasmine.haimovici@gmail.com

Supervisor:

Professor Vanja Orlans Programme Leader and Joint Head of Integrative Department

Metanoia Institute

13, North Common Road

Ealing, London W5 2QB

Tel: 020 8579 2505

We would like to thank you for taking the time to read this information sheet and considering taking part.

Appendix 6 – Interview Schedule and Topic Guide

Parent-Infant Psychotherapy: A qualitative exploration of mothers' experience

Topic guide

Mother's experience and making sense process of the referral

Mother's anticipation and expectation regarding PIP

Mothers' variety of experience of the therapeutic process

Interview schedule

Introduction of the project and the research

Warm-up questions

Exploration of topic using interview prompts

Opportunity for mothers to add anything meaningful to them in regards to their experience of PIP and the interview process

Interview prompts

Introductory questions

Few warm-up questions about who they are?

Their family background and set up at the time of the treatment and time of the interview

Social and economical context (at the time of the PIP interventions and at the time of the interview if changed)

Section one: Mother's experience of the referral to PIP

How did you hear about parent-infant psychotherapy?

If referred by a mental health professional, did the referral made sense to you?

Did you think it was relevant to your difficulties at the time?

Section two: Mother's anticipations and expectations

How did you feel before going to the first meeting?

Did you have any expectation about what it would be like?

How yourself and your child would feel?

The impact it would have on you and your baby, and your family?

What did you hope you would get out of it?

Section three: Mother's experience

How did you experience the first meeting with the therapist?

How did you experience being in therapy with your child?

How did you experience the ongoing relationship between the therapist, your child and yourself?

How did you experience the end of therapy?