Portfolio 1 – Major Research Project

Feeling Beyond Words: Exploring the Relationship between Mothers with Eating Disorders and their Toddlers.

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Abstract

Literature on mothers with an eating disorder diagnosis has focused almost exclusively on identification of deficits, for both the mother and the infant. This literature suggests that, from conception through to the postnatal period, a mother with an eating disorder may experience challenges. These may be difficulty conceiving or problems with mood and eating disorder behaviours, both in the pre- and post-natal period. However, few studies provide a context in which to understand the challenges identified for mothers and their infants. This study aimed to counter this by exploring the intersubjective experience of the relationship between mothers with eating disorders and their toddlers. This qualitative psychosocial study conducted three in-depth case studies with mothers with eating disorders and their toddlers. Using psychoanalytic research methods, two infant observations and one free association narrative interview were analysed and interpreted against the backdrop of a robust supervision structure. The case study findings suggest that each mothers' eating disorder can be understood as a response to relational isolation early in life. Despite these difficulties, each mother found ways to cope with motherhood, and to maintain a 'good enough' relationship with their toddlers. Specific aspects of parenting appeared difficult for mothers. These related to underlying difficulties manifested in their eating disorder presentation, and were often seen in interactions around food. These findings have clear clinical implications to rethink training for health professionals as well as supporting the benefits of taking a holistic and inclusive family focused approach to interventions for the treatment of eating disorders.

Keywords: psychoanalysis, clinical psychology, eating disorders, mothers, toddlers, infant observations, qualitative, psychosocial, free association narrative interview

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"The miracle of gratitude is that it shifts your perception to such an extent that it changes the world you see." (Holden, 2013, p. 63)

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Chapter 1 Introduction

1.1 Orientation

This chapter welcomes the reader with a general overview of the topic and presents the researcher's interest in the field and epistemological stance. Key concepts will be defined around perinatal mental health, and then a narrower focus on perinatal eating disorders will be given. A systematic literature review focusing on the relationship between mothers with eating disorders and their children will be conducted before concluding with a rationale for this research.

1.2 Overview of Topic

Approximately 1.6 million people in the UK suffer with an Eating Disorder (ED) every year (Anorexia, & Bulimia Care [ABC], 2016). However, this is thought to be a conservative estimate. The Department of Health puts the figure at more likely 4 million (ABC, 2016). This discrepancy may be because secrecy and denial are dominating features with issues around eating and therefore a proportion of individuals might not actively seek help or treatment (Crisp, 2005).

There are significant consequences physically (problems include heart disease, reduced sex hormones and infertility, skin and hair problems, and decreased bone strength), psychologically (depression, anxiety and obsessive-compulsive disorder) and socially (withdrawal and social isolation) for those suffering with ED (Hjern, Lindberg, & Lindbland, 2006). Often ED's impact an individual's quality of life (Bamford, & Sly, 2010), as well as incurring a high health cost to the individual, carers and the NHS. PricewaterhouseCoopers (PwC) estimates that the cost to society of eating disorders is circa £15 billion per annum (PricewaterhouseCoopers [PwC], 2015).

Recent research focussed on fertility has found that irregular menstruation in women with ED's was strongly associated with childlessness[1] (Maxwell et al., 2011). Whilst Easter, Treasure, & Micali (2011), found that lifetime ED's were linked to higher unplanned pregnancies and negative attitudes to pregnancy. Although this paper suggests that the proportion of women with ED's who have children may be smaller than their counterparts in the general population, accurate figures are hard to find due to the level of nondisclosure in fertility appointments.

It is suggested that family influences can play an important role in the development and/or maintenance of an eating disorder (Marcos, 2013). However, to see the family unit as the primary cause negates the position that family support is key to the successful recovery of any mental health difficulty, in particular eating disorders (Grange, Lock, Loeb & Nicholls, 2009). It is this inclusive attitude that positions the family as a potential resource, both in and outside of therapy. The aetiology of an eating disorder is complex and vary between individuals and in certain cases the involvement of families, in particular for adolescents may require careful assessment, however it is crucial that a non-blaming stance be taken for all therapies, in order that the individual and their support network be given the best chance possible for recovery.

There is a growing body of work around family related interventions which better acknowledges and accounts for the family as a resource to support those with eating disorders (Dare & Eisler, 2000). This model of intervention is typically situated in the community and has significant evidence base for weight maintenance for adolescents above inpatient admission which can be often seen as the only option of treatment (Asen, 2001). A key tenet of this approach is to enable the adolescent and their family to rediscover their own ability to

[1] irrespective of ED classification

overcome their problems. This strength focussed approach allows both adolescent and family to build on their own resilience during therapy. Another key tenet of this approach is its non-blaming approach, in which 'bad parenting' and 'child's bad behaviour' is re-framed as difficulties and challenges that many families share. Multifamily therapy instead see's such behaviours as the result of attempted resolutions to long standing problems that the family unit shares. Through this way of being together, families are encouraged to find new ways to interact in a unified response from the externalised 'problem' (Mensah& Andreadi, 2016).

The multi-family group day programme is a combination of multifamily group therapy and a day programme approach that was developed by Asen (1989). The programme consists of psychoeducation, family therapy, and group therapy focusing on individual and interpersonal dynamics. The treatment schedule has three main areas of focus: First, the parents and adolescent agree a strategy together to manage symptoms, this normally would include regular dietary intake for individuals with disordered eating. Second, there is a focus on the developmental changes that adolescence may bring. This would also include family traditions and developing individuality. Finally, the focus is to encourage families to think in terms of change, and their capabilities to achieve this for themselves.

1.3 My Position

Burr (2003) suggests that knowledge is derived from the lens of one perspective or another and this thesis is an open example of that. I have taken a psychoanalytic stance; it feels intrinsic to who I am as a practitioner. This decision undoubtedly influenced all facets of

this research. In the interest of transparency, I will provide details on how this position was reached, allowing the reader to form their own opinion of how my values have impacted the meaning and/or interpretations presented.

1.4 Personal Stance

"Time present and time past, Are both perhaps present in time future, And time future contained in time past." (Eliot, 1943, p. 42)

I came to this subject through my previous training in psychodynamic psychotherapy and a real passion and commitment to working at the unconscious level in clinical work. I have a fundamental belief that our earliest relationships shape our journeys as individuals by framing how we relate to ourselves and others from a very young age. I first found psychoanalytic thinking when I was working for six years on inpatient wards in East London. It was an intense time that gave rise to a great deal of emotion that I could not always understand. In a need to supplement my provision of supervision, I found myself at the Tavistock Clinic. It was one of the most affirming experiences I have had and draw from still in clinical work.

Psychoanalytic thinking gave me a language to talk about what I was noticing inside and around me. It gave me a framework to hang ideas on and a theoretical structure that helped to shape who I am and how I see the world. In short, a psychoanalytic lens just made sense to me in a way that nothing else had before. My commitment to this way of thinking and working can be seen in the twice-weekly personal therapy with my own analyst that has spanned over eight and a half years. Personal therapy throughout this project enabled me to have some sense of what were my own experiences, what were my interpretations of participant's experiences, and where the two may have met; allowing for further reflection to

understand and detangle myself. When I write reflexively I will write in the first person to help to differentiate between my subjective and objective writing.

1.5 Personal Interest

I came to the topic of eating disorders when I happened to be working through a difficult and painful period in my own therapy. It provided a crossover between personal interest and professional experience. I was working in an assessment clinic in a Child and Adolescent Mental Health Service (CAMHS) with a high referral rate for teens with ED's. At the time, the recommended treatment for was Cognitive Behavioural Therapy (CBT). I had felt, for some clients, it lacked depth and meaning for experiences that were consuming them in a vice like grip. Whilst I was paying attention to some upsetting realities about my own childhood experiences, I couldn't help but notice the relational qualities between the parents and the adolescents that I was working with. It made me think about ED's as relational disorders. There was something representational in the refusal to take in food or emotional nourishment, in the same way that binging of that nourishment occurred in others. There was something interesting about the way we all satisfy our needs, and what food represents to us.

If the way we related to food was considered a representation of how we relate to our internal objects, then further exploration could provide something much more inclusive of the emotional experience. It seemed that in the adolescents I had seen the secrecy and 'murkiness' of the eating disorders were present in the ways of relating between the mother and adolescent. This undoubtedly was due to the focus on my own parenting at the time, yet it gave me the capacity to notice something I may not have ordinarily. Psychodynamic perspectives have seen the relational component within eating disorder presentations for many years (Bemporad, Beresin, Ratey, O'Driscoll, Lindem, & Herzog, 1992). I became

interested in how ED's interact with motherhood and what, if anything, could be seen in the interaction within the primary relationship between mother and child. By spending time thinking about the emotional experience between the two, I perhaps could contribute something preventative for the many children and parents with difficulties, primarily but not exclusive, with eating.

1.6 Language

"Eating disorders are like a gun that's formed by genetics, loaded by a culture and family ideals, and triggered by unbearable distress." (Aimee Liu, 2008, p. 2)

As this quote illustrates a diagnosis of ED can be the final component of a long history of culminating factors. These experiences are distilled into diagnostic terms that assume a place within the medical model. This study acknowledges the widely used medical approach to treatment of ED's but does not subscribe whole heartedly and therefore uses diagnostic categories with care. The current primary diagnostic tool used in the UK is the Diagnostic and Statistical Manual of Mental Disorders 5th Edition (DSM 5) from the American Psychiatric Association [APA] (2013) [2]which broadly categorises subtypes of ED's into the following:

- Binge Eating Disorder (BED): Frequent periods of 'eating significantly more food in a short period of time than most people would eat under similar circumstances, with episodes marked by feelings of lack of control', shame, guilt, embarrassment and/or disgust (APA, 2013).

[2] The European version of this is the ICD10, however this is not used as widely as the DSM5.

- Anorexia Nervosa (AN): Characterised by 'distorted body image and excessive dieting that leads to severe weight loss with a pathological fear of becoming fat' (APA, 2013).

- Bulimia Nervosa (BN): Classified as 'frequent episodes of binge eating followed by inappropriate behaviours such as self-induced vomiting to avoid weight gain' (APA, 2013).

However, Fairburn, Cooper and Shafran (2003) argue for a transdiagnostic approach, stating that there is little stability in the differing categories of individual eating disorders, with all three sharing the same psychopathology, namely a central 'over-evaluation of eating, shape and weight and control' (p. 256). This study adopts this 'transdiagnostic' approach to define ED.

1.6.1 Note on fathers.

Throughout this thesis the focus remains exclusively on mothers with eating disorders. Lamb (1975) reminds us that fathers 'are the forgotten contributors to child development'. Indeed, all mother and infant dyads seen within this project had the influence of a father living in the family home. This project did provide an open invitation to mothers to let fathers participate and be a part of the observations, if they wanted to. However, all mothers reported that the fathers would be unavailable. It was beyond the scope of this piece of research to ascertain father's perspectives directly through interview. It is strongly accepted that the father's presence would have an impact on both mother and infant and the interaction between them.

1.6.2 Unconscious Processes.

"Thus, although we can see the workings of the unconscious in everything we do, especially everything we do wrong, we cannot find the thing itself, the unconscious, because it always hides, it lives nowhere, and it blocks us as we try to know it directly." (Frosh, 2002, p. 12)

In the early 1900's Freud defined his topographical model of the human psyche. A brief mention of this may help to familiarise the reader. The unconscious can be best understood in the context of the conscious, with Freud's analogy of an iceberg. The tip of the iceberg being what is in conscious awareness, for example the reader, currently reading this thesis and aware of his/her surroundings and thoughts and feelings in this moment. Just under the water of consciousness there is a preconscious or memory perhaps, a storage system where things can be easily recalled and brought back into awareness. For example, the reader may recall a client he or she has seen in the past or perhaps a paper that has been previously read where the unconscious was relevant. The final part of the iceberg, according to Freud (1915) was the largest unknowable part of ourselves, the unconscious. This for example may be experienced as an emotional intensity of perhaps anger or feeling enamoured with the client or the paper that has been recalled. It may be difficult for the individual to fully identify and/or understand. The unconscious refers to the mental processes that are inaccessible and out of our awareness. It is the primary source of our behaviour, feelings and motivation for decisions (Wilson, 2004). These are powerfully influenced by our past experiences and may not accurately reflect external reality. For full and more comprehensive coverage of the concept the unconscious please refer to Bateman, & Holmes (2002, p. 28). Throughout this study, terms will be used and then defined in the footnotes as per Rycroft's Critical Dictionary of Psychoanalysis (1995).

1.6.3 Perinatal period.

The British Psychological Society (BPS, 2016) defines the perinatal period as 'during pregnancy (perinatal) and up to one year postnatally' as this is how services are structured and clinical criteria organised. The National Institute for Health and Care Excellence (NICE) guidelines on antenatal and postnatal clinical services (2014) also use this time period, from pregnancy to 12 months after birth.

1.6.4 Mother and toddler.

For this project, 'mother' refers to the biological mother who has 'carried' the child in pregnancy. However, this study acknowledges that this is not always the structure in families. Micali, Simonoff, &Treasure (2009) suggest that pregnancy can also be significant for women with ED so this was thought to be an important factor. The baby is defined as a toddler between 12 to 24 months.

1.7 Understanding the Perinatal Period with attachment theory

"Begin at the beginning', the king said gravely 'and go on till you come to an end: then stop."(Carroll, 1865, p. 23)

This section will introduce the reader to the perinatal period for the mother and infant through a theoretical understanding from an attachment theory and psychoanalytic perspective. Attachment theory suggests that a strong emotional and physical connection to at least one primary caregiver is critical to personal development. This process starts immediately and Axel (1997) indicates that after birth, the key tenet of bonding is in the early interaction between mother and baby. This positions the relationship between the two as

central and the process is achieved through verbal and nonverbal communication by both mother and baby. Women generally, are the main care givers during this period and therefore more likely to first become familiar with the characteristics of the baby (Britton, et al., 2001). This helps to create a sense of intimacy between a mother and her baby, which fosters the development of a secure foundation in the mother – infant relationship.

This is a well-documented area of study and stems from John Bowlby's (1969) work on attachment theory which saw psychological disorder as a consequence of the relationship between the parent and child not meeting the infant's fundamental needs. This was later developed by Mary Ainsworth who gave psychology, amongst other things, 'the strange situation' (Ainsworth, Blehar, Waters, & Wall, 1978), and a framework for different styles of attachment. For example, consistent warm and loving interaction with the mother would likely lead to a 'secure attachment' style in the infant. In this case, the baby gets to know itself and the world around him or her in a way that it can manage and make sense of; their internal world develops in safety. An 'insecure attachment' style may present as baby being preoccupied by the whereabouts of the parent, unable to settle and be soothed after separation. An 'avoidant attachment' could be seen in seemingly 'unemotional' or 'unresponsive' parents, where the baby seeks more stimuli from toys and the environment than the parent themselves. Finally, 'disorganised attachment' may be present in such cases where the baby was maltreated. The baby is unsure of what is safe and what isn't, their experience of the world may be lonely and terrifying, the world around them and within them becomes unmanageable and overwhelming.

Sroufe (2005) has suggested that children who were securely attached to their primary caregiver in their formative years tend to have optimal outcomes across all domains of functioning. These areas include emotional, physical, social and behavioural, as well as academic attainment and developed social skills. Insecurely attached children may be less

confident in relationships, wary of strangers and are more likely to have behavioural problems, and experience high dependency on others (Martin, 2012). Attachment style and ways of relating are not static and subsequent experiences can alter these effects (Iwaniec, & Sneddon, 2001). However, infancy provides the foundation of relational development which can be built upon and in this way, can be seen as the original blue print for all relationships and interaction that follow.

The significance of the early relationship has been recognised in a key government report *'Health matters: giving every child the best start in life.'* The report makes the case for financial investment in pregnancy to ensure that mothers and their infants are given the best start together (Public Health England, 2016). The central areas of focus are a loving and stable relationship, emotional wellbeing, brain and language development, and the capacity to maintain relationships. It is an open acknowledgment of the central importance attachment in relationships plays for the wellbeing of both mother and infant.

1.8 Psychodynamic Understanding of the Early Relationship.

1.8.1 Relationship reverie.

From a Kleinian perspective (1927), the new born baby is seen as utterly dependant and may spend their time moving between opposites of deep gratification and extreme discomfort or even terror. The baby is not only capable of intense love and hate but constantly swings from feeling internally integrated and disintegrated. Klein theorised that when the baby is feeding from the breast with mother's arms around them, hearing her voice and being seen by her eyes and mind, the experience of being loved by the mother (good) will enable the baby to feel loved. This loving feeling will have a sense of coherence, of a firm centre, that the baby can hold on to (temporarily) in the mother's absence. When however,

the baby is deprived of enough of these experiences or mother's absence is for too long, Klein stated that the baby feels the gap, the lack of the mother as an intense persecutory (bad) thing inside of him. The baby oscillates between good and bad moments (ideas of mother) which culminate in a turbulent infantile life. This polar 'paranoid schizoid' state of mind (Klein, 1946), will return at moments of distress throughout the baby's adult life. The result of this oscillation is a sense of anxiety, which the baby will need to learn how to defend themselves against.

Crucial to this relational development is the mother's capacity to hold her own anxiety in the face of unknown distress. The baby will cry, scream, and utilise their entire little frame to rid themselves of difficult and incomprehensible feelings, like hunger. If their mother can draw on her own inner resources despite not always knowing the source of her infant's misery, then the pair of them achieve a state of 'reverie' (Bion, 1962). In this union, her baby can begin to recover, as the mother has made the unbearable manageable, she was not taken over by her baby's distress. Over time this experience of projection and introjection becomes built into the very structure of the baby's psyche. The repeated experiences of terror and joy, of fear and hope are mediated by the quality of the mother's presence. These processes will become internalised and affect how he/she responds to sorrow and joy for the rest of their lives (Waddell, 2013).

1.8.2 Relationship challenges.

It is not possible for any parent, any mother, to be attuned, connected and present with their baby always. In fact, it could be unhealthy for the baby's long-term development to never experience difficulty. From a psychodynamic perspective, babies are seen as requiring a range of defences to survive the painful losses he/she should encounter, of the mother being

momentarily absent or failing to attend to every need. Each painful adjustment will need to be defended against (Klein, 1921). Once mother and baby have achieved a sense of reverie together, the baby is unfairly tasked with giving up the unfiltered access to the mother. This is largely seen in the task of weaning (Klein, 1927). Previously the mother may have been felt as under the baby's control, responding solely to their needs and demand. Yet, Klein states that from weaning it becomes apparent that the mother is an independent being who can come and go depending on her own needs. It is a disappointing and frustrating reality that the baby encounters and may return to many times in his/her adult life in different forms. Included in this dynamic and complex interplay is the conceptualisation of who the mother is, when she is not with the baby. The mother and baby will now negotiate the introduction of the 'third', this may be the father, other siblings, work or simply something else that is not the baby (Klein, 1932).

In summary, attachment theory highlights the key importance of the quality of relationships in an infant's early years. The psychodynamic perspective attempts to explain the key mechanisms occurring at each stage of development. Mothers and babies cannot 'get it right' all of the time and this is where the concept 'good enough' (Winnicott, 1956) is a helpful guide for parents. However, the capacity to bear loss and survive painful experiences will be based on the degree of containment that a baby has felt in his/her primary relationship. It is this relationship that will function as an internalised resource to support and sustain them through new and/or repeated difficult times. The attachment security will depend on the availability of a containing mind that can bear and learn from both good and bad experiences. From a psychodynamic perspective, the baby's internal experience of this will then become the core of the developing self.

1.9 Perinatal mental health

"If we had keen vision and feeling for all ordinary human life, it would be like hearing the grass grow and the squirrel's heart beat, and we should all die of that roar which lies on the other side of silence."(Eliot, 1985, p. 269)

It is important to establish how a disruption in the theorised perinatal period can potentially impact on both the mother and baby. Mental health issues for women during the perinatal period are underestimated. This can mean that women are not assessed or diagnosed and unfortunately then left untreated (Apter, Devouche, & Gratier, 2011). Perinatal mental health issues affect 20% (Buist & Bilszta 2005, Dennis & Chung-Lee 2006) of women and may include women who have had previous psychiatric history or those that develop new difficulties during the perinatal period. This may cover a wide range of issues including (but in no means exhaustive) depression, anxiety, postpartum psychosis, eating disorders, and other mood disorders. A *Maternal Mortality Surveillance* Report (Manktelow et al., 2016) investigated 100 maternal deaths between 2011 and 2013. Findings show that a quarter of all maternal perinatal deaths in the UK are due to mental ill health.

A British Psychological Society (BPS) briefing paper *Perinatal Service Provision: The Role of Perinatal Clinical Psychology* (McKenzie-McHarg et al., 2016) estimated the perinatal mental health cost on average was ten thousand pounds per child born. With most of this cost accumulated due to the adverse impact on the child (Bauer et al., 2014).

It is widely accepted that parental mental ill health has adverse effects on the development of the child (Micali, Stahl, Treasure, & Simonoff, 2014; Nolte & Wren, 2016). Difficulties for the infant can be broad, ranging from insecure attachment patterns, cognitive, behavioural, and social difficulties, and the development of their own mental health problems

(Steinet al., 2014). Due to this, additional funding has been targeted into perinatal services in order to tackle the unmet need and provide early intervention to both mother and infant, hopefully improving access to specialist perinatal provisions in England for an additional 30,000 women by 2020 (NHS England, 2016).

In summary, for mothers who struggle with mental health issues, being consistently sensitive and attuned may be at times just out of reach. For the underrepresented percentage of women who do seek professional help, there is a significant body of research that suggests a myriad of difficulties that may occur for the mother, the relationship between mother and infant and the possibility of negative consequences for the infant as he or she develops physically and emotionally. Specialist perinatal provision is increasing access to support needed.

1.10 Eating Disorders in the Perinatal Period

This section will introduce the reader to ED's in the context of the perinatal period. Current knowledge is presented in chronological order of development. This decision has been taken to illustrate the importance of the process, not just in methodological choice but also in the psychological experience. In line with more analytic thinking, these groupings invite the reader to follow expectant mothers during each stage of their transition into motherhood.

1.10.1 Pregnancy and eating disorders.

1.10.1.1 Mood.

Eating disordered women are between 40-60% more likely to have pre- and postnatal depression compared to controls with no previous history of mood difficulties (Micali & Treasure, 2009). High levels of anxiety and depression in the postpartum period are associated with active eating disorder symptoms during pregnancy (Micali, 2009). Not surprisingly, women who have an eating disorder feel limited control over their own bodies during pregnancy and may be likely to feel despair about how they look (Lemberg & Phillips, 1989). With self-worth and value being tied tightly to perceptions of body image and weight, the prospect of gaining weight during pregnancy can be terrifying (Micali, 2009).

Women in this population can also feel very anxious as Kimmel et al. (2016) highlighted in their systematic review. This can be seen in a qualitative study by Tierney, McGlone & Furber (2013), exploring the subjective experiences of pregnant women with eating disorders. The findings highlighted mother's internal conflict between their child's needs and the demand of their eating disorder. In addition to this there was evidence of difficult feelings of low self-worth, and understandable concern over the health of their child and other's perceptions of their weight control and practices.

1.10.1.2 Symptomology.

Kimmel et al.'s 2016 review also highlighted that, when a transdiagnostic grouping is used, between 29-78% of women with ED, experience a reduction in symptoms during pregnancy (Easter et al., 2015). However, research also shows that for some women with a history of ED, particularly those with a BED diagnosis, pregnancy is a critical trigger point and can lead to relapse, or emergence of new disordered thinking (Bulik et al., 2007).

Recent research has indicated that the prevalence for eating disordered thinking during pregnancy is much higher than previously thought (Micali, 2013). 27% of the general population of women displaying behavioural and psychological traits whose questionnaire scores are conducive to DSM-IV criteria for an eating disorder diagnosis. Of those women, 93% stated that they did not disclose this information to healthcare professionals during their pregnancies (Broussard, 2012). This perhaps illustrates the complexity of the problem Western society provides in its narrative for pregnancy as a wholesome and nurturing experience. Women who experience pregnancy as something less than that may feel silenced (Orbach & Rubin, 2014).

1.10.2 Pregnancy outcomes.

There is conflicting research on pregnancy outcomes for women with eating disorders. Some studies show maternal eating disorders were associated with slow foetal growth, premature birth, smaller gestational size, low birth weight, perinatal death (Linna, 2014), and caesarean section (Bulik, Sullivan, Fear, Pickering, Dawn, & Cullin, 1999). However, in stark contrast population based studies of women with symptoms of disordered eating found no differences in pregnancy outcomes when compared to the general population (Micali, 2007; Micali et al., 2012). Kimmel et al. (2016) suggested that the conflicting findings may be due to the severity of illness in clinical samples as opposed to population based samples. However, it is important to note that studies focusing on pregnancy outcomes, particularly birth weights and sizes indicated conflicting results, and varied in quality. Either the matched comparisons being inadequate, studies being underpowered (Micali et al., 2009), or alternatively different diagnostic tools being used which complicate self-reporting questionnaire data.

However, what is especially relevant to the mother-infant relationship in the postpartum period is the resurgence of eating disorder symptomology after childbirth (Fairnurn, Doll, Welch, Hay, Davies & Connor, 1998; Broussard, 2012) and higher rates of post-natal depression. Mothers with ED's are three times more likely than their general population counterparts to experience depression (Franko, 2001). 50% of those who sought mental health support for difficulties adjusting to motherhood had an ED? (Koubaa, Hällström & Hirschberg, 2008). Kimmel et al.'s 2016 review was able to identify that eating disorder histories were present in over 1/3 of admissions to a perinatal mental health unit and those with a BN diagnosis reported more severe depression and histories of physical and sexual trauma (Meltzer-Brody, Zerwas, Leserman, Holle, Regis & Bulik, 2011).

1.10.3 Feeding difficulties and eating disorders.

The literature reported feeding difficulties between mothers with eating difficulties and their infants in a noticeable amount. This area highlighted a dynamic interplay between both mother and baby, which moved the focus from the physical to a subtle introduction of the relational. Some women with AN subtype eating difficulties were more likely to breastfeed but have problems feeding infants 0-6 months old, whereas women with a BN diagnosis were more likely to have overweight babies with faster growth rates at 9 months old (Micali, 2009). During feeding of new-borns to toddlers, there could be an absence of positive comments when interacting and eating together (Waugh and Bulik, 1999), with feeding also showing unintentional modelling behaviour (Palfreyman et al, 2013) which indicated that across diagnosis, mealtimes could be difficult and/or detached experiences for mothers.

Stapleton (2008) explored the decision making process for women with eating disorders with the incorporation of their male partners. This is one of the few studies that pays attention to the system around mother and infant and was a strength. Male partners

predominantly insisted on bottle feeding new-borns, perhaps as a way of ensuring quality and quantity of food input. This suggests a triangular dynamic between mother, infant and father which other studies have neglected. When mothers with eating disorders did breastfeed, it was found to last longer and used as a coping strategy. This delayed practices associated with eating disorders whilst also permitting a higher calorie diet. According to Stapleton (2008), breastfeeding appeared to provide an additional function, the experience of motherhood that was more 'wholesome' and nurturing than perhaps they had previously felt. Stapleton's study supports other research that indicates feeding decisions involve a complex mix of morality as well as nutrition (Murphy, 1999). However, it was difficult to standardise the perspectives of women who typically 'misjudge' or 'overestimate' in their perspectives. Also it is worth stating that over exposure to medical practices, and fear of consequences from professionals could have impacted the answers.

Infants of mothers with eating disorders were found to suck significantly faster and weaned 9 months later than controls (Agras, 1999), this does support Stapleton's findings on weaning, but extends this to also include a relational aspect. For example, these mothers fed their children on a less regular schedule and for non-nutritional reasons. There was higher concern of their daughter's weight and shape illustrating that mothers in this clinical group do interact differently with their daughters than non ED mothers. Perhaps mothers had a tendency to project their own concerns onto their daughters, as when compared to controls, there was no evidence to support these mother's concerns. Infants who suckled faster often 'dawdled' during feeds which may indicate that there was something happening in the spaces between the mother and infant. One can only wonder how the infant was experiencing these feeds, a clear hunger which required more effort to get the feed he or she required, yet some time was taken perhaps due to the lack of positive comments or engagement from mother. Agras himself suggests that:

"*on the other hand, the avidity may be due to an interaction between mother and infant. For example, it may be that ED mothers delay their infants feeding in an attempt to keep them thin resulting in more rapid sucking*."

(Agras, 1999. Pg. 260)

This could be seen as providing initial questions regarding the unconscious spaces in-between mother and infant that requires additional investigation. Despite yielding interesting findings this study was limited in the small sample size and due to the nature of the project being nutrition focused which may have been attractive to this population of mothers and therefore we must exercise caution when relying on or attempting to replicate these findings.

Mothers with eating disorders show increased difficult patterns of interaction in relation to reciprocity, compared to controls whilst also showing less sensitivity to infant's cues (Stein et al, 1999) and making less positive comments. In these relationships, mothers were experiencing more dissatisfaction and uneasiness during feeding, and in turn their infants were observed appearing stressed and overwhelmed by mother's emotions (Squires et al, 2014). The experience of these feedings may indicate that for the new-born, he or she is taking in far more of the world than simply milk. Whilst this study did display an overreliance on a small sample of white middle class women, it does highlight a potential unconscious transmission that may impact the development of the infant's internal world.

Few studies have explored the internal world of infants, and maternal eating disorder can alter the development of this for their infants (Park, 2008). Children of mothers with eating disorders were more likely to show positive representations of mother through play than controls. Whilst this used a small sample and findings taken with caution, the strength of this study was moving the focus through the lens of relational context by the vehicle of observational play. Although initially these findings appear positive, the absence of positive representations in the control group could indicate that the child's play is an attempt to work through unconscious desires and wishes with idealisation. Given the potentially emotive and pressured interactions around feeding reported in the literature, this current research decided against creating an artificial and 'loaded' situation for participants.

Although these studies were valuable in exploring how stages of perinatal mental health can evolve during pregnancy for those with ED, they do not fully answer questions around what is happening between mother and child within the relationship. Therefore, a literature review was conducted focused specifically on the relationship between mothers with ED and their children. The search terms, research location and time period were kept deliberately wide due to the small amount of research published in this area. The inclusion and exclusion criteria for the literature search are displayed in table 1.

Table 1

Inclusion and exclusion criteria for research papers to be included in the literature review

Inclusion	Exclusion
Peer-reviewed publications of original research.	Dissertations, opinion, theoretical papers
International publications.	Not in English
All publication dates included up to Jan 2018.	After Jan 2018
Paper focusing on Mother's with ED diagnosis or those who rate highly on measures of disordered eating (without a formal diagnosis).	Papers focusing on mothers of adolescent patients with ED's.
Paper focusing on the relationship/ attachment between mothers with ED's and their children. This includes children of all ages, from infant through to adult children.	Lack of relational focus: Focus exclusively on developing infant, for example, their feeding ability. Or focus exclusively on mother with ED's.

Search terms that were used in the systematic search were designed to capture the relational component between mothers and their children.

Table 2

Search Terms used in systematic literature search

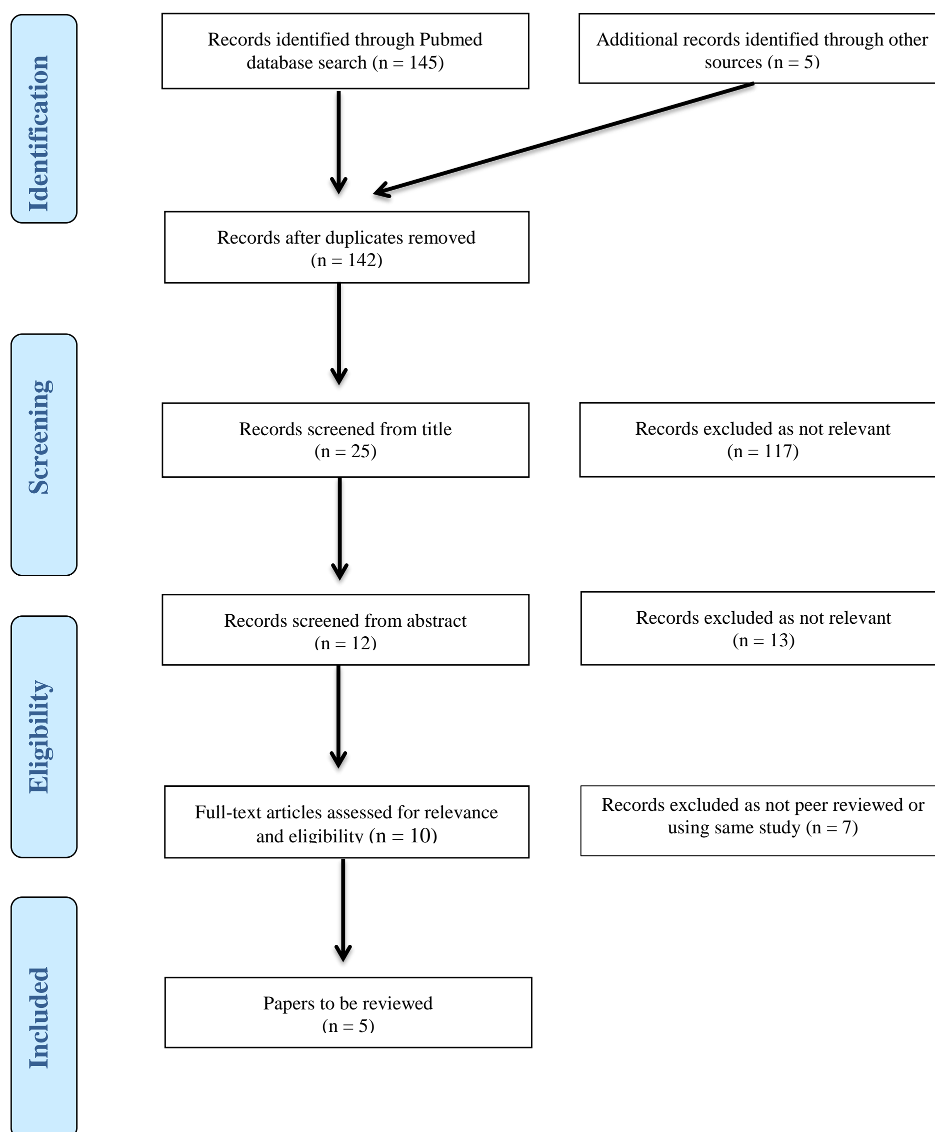
Mothers	Relationship	Children
Mother with eating disorder	Relating	Babies
Mothers with eating disorder	Relationship	Toddlers
Mothers with eating difficulties	Impact	Children
Eating disordered mothers	Attachment	Child
Maternal eating disorder	Processes	Teenager
		Offspring

1.11 Systematic Literature Review

This section will begin by outlining the systematic literature search strategy and then present an evaluation of the papers selected. In light of these findings, a justification for the particular aims and research questions of this piece of research will be offered.

Figure 1

Flow chart of Literature Review



1.12 Findings from the Review

Five studies were included in this literature review. Four of them took a quantitative approach, and one a qualitative approach. One study was conducted in the UK (Stein et al., 2006), two were conducted in the USA (Claydon, Zerwas, Callinan, & Smith, 2016; Sherkow et al., 2009), one was from Israel (Sadeh-Sharvit et al., 2016) and one from China (Lai & Tang, 2008). Only one paper was identified that spoke to the unconscious processes between mothers with eating disorders and their infants (Sherkow et al., 2009).

Elliot, Fischer and Rennie (1999) suggest that all research should meet quality standards. Within their paper, which focuses primarily on guidelines for qualitative research, it was noted that there are certain criteria that both robust qualitative and quantitative research share. Elliot et al. (1999) proposed seven domains that are common in both, such as appropriate methods and respect for participants. These shared qualities form suggested 'publishability guidelines' that can be applied here across all of the studies selected for review. A summary of papers selected can be found in Appendix A, with an evaluation of the quality of the research in Appendix B.

The literature found has been summarised and organised into five themes that spoke of the interaction of mothers with eating disorders and their children. Themes consist of parenting behaviour, intergenerational transmission, play observation, intervention and reflective functioning. These will be discussed in turn.

1.12.1 Interaction between mothers and their children.

1.12.1.1 Parenting behaviour.

(1) Lai (2008) conducted a longitudinal quantitative study spanning two years, investigating the impact of bulimic symptoms on parenting behaviour. Ninety-One Chinese mothers were interviewed at three separate time points; whilst pregnant and 6 and 12 months postnatally. This was interesting as it was the first study to explore the impact of bulimic behaviour on mother-foetal/infant attachment within any culture. Women who attended routine prenatal hospital appointments were interviewed and asked to complete self-report

measures on foetal attachment. At 6 and 12 months into the postnatal period women were interviewed over the telephone focusing on psychological distress and parenting behaviour respectively. The findings show that post-natal bulimic practices heighten maternal distress and appears to lead to stricter parenting behaviours (in comparison to the West). Lai states that this supports existing literature claims of impaired parental functioning for mothers with an ED diagnosis. Lai suggests that bulimic practices may preoccupy mothers and leave little mental space for baby and as such, presents a risk factor for parenting. However, Lai urges caution due to generalizability and attrition rate of 25%. The significance of this study was that a non-clinical population was used. However, this also suggests that bulimic levels of behaviour were low and relied solely upon mother's self-reports, which may be influenced by recall and social desirability bias, as well as the potential of mothers having a skewed perspective.

This piece of research has some strength and met partial criteria for the quality standards that are suggested in Elliott et al.'s, publishability guideline (1999). This would include appropriateness of methods selected, the discussion around culture and the relevance of the findings. Although this piece of research did not exercise an inclusive approach to participation, with single Mothers excluded from the research. This research paper also did not mention consent and confidentiality protocols which meant that it could not meet the criteria set by Elliot et al (1999).

1.12.1.2 Intergenerational transmission.

(2) Sherkow et al., (2009) combined a review of the current psychoanalytic literature relevant to eating disorders and a proposed developmental pathway of intergenerational

transmission. Clinical observational data was presented to illustrate the mechanisms of transmission between mother and child. The literature review presented a summary highlighting the intergenerational cycle of feeding difficulties between mother and infant. From this, Sherkow et al. hypothesised that transmission took place by conscious and unconscious factors in both mother and child that were reciprocal in nature.

Clinical material in the form of case studies was taken from a weekly group in an eating disorder therapeutic nursery. The mothers - who were also in individual therapy - participated in the group for more than two years and the play or discussion sessions included a meal or snacks. The mothers and children were observed, and behaviour during the session was interpreted in the presence of the other, and in relation to each other. Sessions were video recorded and staff watched these after the session, where observations were analysed by all staff in attendance.

The study found that eating disorders can be transmitted between the generations from parent to child through multi-layered mechanisms. These mechanisms include overt and covert behaviour. For Sherkow et al., overt mechanisms included parental attitudes towards food in both feeding and eating that were witnessed by the child, as well as the direct experience of the mother seemingly preoccupied with her own thoughts and feelings. The more covert mechanisms were described as the pathological intrapsychic structures and defences. These covert unconscious messages of identification were transmitted first during early feeding behaviour (for example, shared denial or confusion between mother and baby regarding the identification of hunger or satiation). This was supported with clinical examples of how the children in this study seemed to mirror the mothers 'choice' of defence and symptomology.

It was an interesting presentation of observations and theory that illustrated a relational focus between mother and child in the context of eating disorders. This paper did

not choose to present its work in a traditional academic format in order to widen the research lens and it suggested that an inclusive and comprehensive approach could be adopted when exploring phenomena in this area. The research team was able to work with each mother and child dyad over an extended period of time and in this way, 'got into' each participant with a level of intimacy and thoughtfulness. However, the paper only partially met Elliott et al.'s (1999) criteria due to a lack of standardised ethics process, lack of discussion on limitations of the project, informal presentation of the study, and a negative use of language which seemed to continue the pathologizing nature of psychodynamic work towards mothers in particular.

Despite these points, this study highlighted the efficacy of intimate work, using observations that 'brought to life' both mother and child in the pursuit of exploring what may be happening between them. Sherkow et al. suggested the use of clinical observations as evidence for the unconscious transmissions between mother and child, and uses this to hypothesise a proposed pathway of transmission that could direct clinical interventions. This provides initial evidence that warrants further exploration.

1.12.1.3 Play observation.

(3) Sadeh-Sharvit et al. (2016) focused on interactions between mothers with eating disorders and their toddlers in non-feeding situations. This study was concerned with maternal eating disorders, co-morbidity, mother's perception of the child, and independently rated interactions between mother and child.

28 Mothers were recruited from three eating disorder clinics in Israel, who had a prenatal diagnosis of an eating disorder. Their children were aged between 18-42 months old. The participants were matched to mothers and children with no history of eating disorders

and all were asked to complete two self-report measures on current eating disorder symptomology and co-occurring psychiatric symptoms. Mother's perception of their toddler's behaviour was assessed and a ten minute recorded semi structured play between them was analysed and coded.

The findings show that mothers with an ED diagnosis had greater eating and co-occurring symptoms than their non-clinical counterparts. They also reported a greater number of difficulties in their own children. This study also found that mothers with eating disorders were less sensitive to their children's needs and more controlling of their child's behaviour and rated as less happy than their non-clinical counterparts during interaction with their children. In relation to their toddlers, they were less responsive and less involved than mothers without an ED diagnosis. The trends that were noted in the clinical group were also seen in the control group. Mothers with higher eating disorder symptoms (that may not fit clinical criteria) were associated with lower emotional availability.

This study argued that mothers with ED (or high eating disorder symptomology) and their children could be at risk of experiencing communication and attachment difficulties due to the decrease in emotional availability and perceived level of difficulties with the child's behaviour. The authors concluded that the trends seen across the board for mothers may suggest that in this current climate, mothers are more preoccupied than ever with their size and shape and this may detract from their capacity to be available with their children.

This study partially met the quality criteria (Elliott, et al., 1999). Limitations of this piece of research would be the subjectivity of the single brief observations that was carried out. Again, the sample was small and findings should be interpreted with caution. However, having a matched control group and observing interactions outside of feeding were strengths of this study. An improvement would be an increase in sample size and perhaps different cohorts of participants to consider recovered and subclinical populations. Although these

findings cannot determine a causal relationship between mothers with eating disorders and interaction with their children, it does however, strongly indicate that attachment and the interaction between mothers and their toddlers require further investigation.

1.12.1.4 Intervention.

(4) Stein et al. (2006) evaluated the use of video-interaction interventions aimed at reducing meal time conflict between mothers with ED and their children by helping mothers to become aware of and respond to communication from their child. This study allowed direct observations of the interactions between the mother and child to be used as a clinical intervention, rather than rely on self-report measures from mothers alone.

Eighty mothers with an eating disorder diagnosis were recruited from routine baby clinics with infants aged between 4-6 months old and randomly assigned to one of the two treatment arms. One group received video interaction feedback, and one group received supportive counselling and both received CBT self-help for their eating disorder.

This study concluded that video feedback treatment showed significant improvements in reducing conflict at mealtimes, compared to those who received the supportive counselling treatment. In addition to this, video feedback treatment resulted in better maternal facilitation and appropriate nonverbal responses to their infant and greater infant autonomy during mealtimes. It was shown for the first time that treatment of a postnatal psychiatric disorder could improve the interaction between the mother and child in a controlled trial.

There were clear strengths of this study, one being that most criteria factors were met from the publishability guidelines (Elliott et al., 1999), suggesting that this was a robust piece of research. Comparing treatments and using blind raters for video footage was a strong

positive contribution to the literature. Also, the use of the participant's home provided this study with ecological validity and could account for high participant retention rates. However, there were some limitations, for example family perspectives were not included and the relatively small sample size for a study of this nature meant that not all evaluation criteria could be met. Both groups were prescribed self-help CBT, it would be difficult to attribute all the study's successes to video feedback alone. Although what is clear is that a focus on the interaction between mother and child can significantly improve the relationship itself and can pay dividends in terms of community access for future participants.

1.12.1.5 Reflective functioning.

(5) The final paper in this literature review sought to explore the extent to which a parent's eating disorder can impact their ability to mentalise. Mentalisation is the process of making sense of yourself and others through understanding different mental and emotional states (Skårderud, 2007).

Fifty-nine mothers with clinically significant eating disorder symptomology and with children between the ages of 4-8 years old were recruited in this secondary analysis study. Each mother was asked to complete a self-report scale measuring reflective functioning. A psychiatric interview was also conducted establishing diagnostic criteria. Results showed that twenty-five percent of participants had clinically significant eating disorder symptoms. Interestingly, there was a trend that for those participants with more significant eating disorder symptoms, there was higher reported levels of reflective functioning. This contradicts previous ideas of parental impairment in eating disorders. The authors urge

caution and suggest that there could be many other areas of the attachment relationship that could be affected.

This study partially met the evaluation factors for quality criteria suggested by Elliott, et al. (1999) and although these findings cannot be generalised, it is optimistic to see that reflective functioning may not be as impaired in mothers with eating disorder symptomology, as existing literature on perinatal mental health suggests. However, it is important to note that participants were recruited from another study and the impact of this was not discussed, full details of consent were not given and ratings of reflective functioning were self-report, and were not supplemented or supported with other forms of data. An improvement of this study would be to provide hypotheses around the meaning of the findings to aid the reader to situate the findings within the current literature. In addition, the relationship between parent and child is multifaceted and reflective functioning may be just one component of a complex and dynamic series of interactions. The authors conclude that it is essential to further understand the mechanisms that feature in the parent-child relationship within the context of ED. This leaves a gap in the current research to understand the interaction between mothers with ED's and their children.

1.12.2 Synthesis of findings.

These five studies provide an insight into the complexity of interaction between mothers and their children ranging from just after birth and up to eight years old. There has been a diversity of research methods, including self-report interviews, standardised measures, and qualitative and quantitative methods of observation. These suggest space for creativity and thoughtfulness when addressing this under-researched area both for now and in the future. It would seem that from these studies findings are mixed. Three papers indicated that

for a mother with an ED, parenting could be at risk of being impaired, by displaying stricter parenting behaviour, transmitting conscious and unconscious eating disordered psychopathology to their children or displaying less emotional responsiveness and sensitivity. One study suggested an observation based intervention to address some of the potential difficulties in the primary relationship. The final study suggested that one aspect of parenting, the reflective functioning, was not impacted, and in fact appeared improved in Mother's with an ED.

All authors advocated for greater sample numbers in future research and this may speak to the literature that acknowledged secrecy and denial being prominent features of ED's. This secrecy may impact on participant's willingness to be recruited for research, or even seek help and engage in services in the first place. These factors contribute to the documented difficulties in recruitment and retention of participants. Sadly, there was no mention of what mothers with ED thought they were doing well. There is a responsibility for the research community to acknowledge a population that has been historically 'hard to reach' and seek to understand this in greater depth. If for example, a mother with an eating disorder feels pathologized and demonised, she is much less likely to step forward and allow access to her life for others to perpetuate this negative trend.

The research reviewed went across subtypes of eating disorder diagnosis and involved mainly self-reporting. This has a danger of missing key stages or changes in a woman's presentation and relying on a perception which by the nature of her difficulties can be skewed. There is little qualitative research available that aims to explore the relational interaction between mothers with eating disorders and their children. This is not necessarily a weakness. However, it is the unavailability of a different or inclusive perspective that suggests it could be. There seemed to be an absence of thought for the support networks or systems around the mother and/or the infant, often neglecting the meaning of the caregiving

relationship to each. There was only one study that included an analytic frame of thinking. This may suggest a wider issue with psychoanalytic research and its accessibility in disciplines outside of itself.

Finally, these findings cannot be taken with full generalised confidence but cannot be utterly disregarded either. With modern mothering involving more 'roles' and 'duties' than ever, it is easy to see how 'normative' samples of mothers are scoring as clinically significant on ED measures. If mothers without a diagnosis are similar in their experiences to mothers who have met diagnostic criteria then perhaps additional research in this area is needed now more than ever.

1.13 Summary of Introduction

It appears that for women who experience life through an eating disordered lens, pregnancy and motherhood is a time that, to varying degrees, can be difficult. This has been seen in the importance of the perinatal period through an explanation of attachment theory and specifically psychoanalytic theory.

At each stage of a woman's journey into motherhood an eating disorder could negatively impact on her mood, her symptomology, and ultimately on her experience of being a mother in the postnatal period. After a thorough systematic literature review of studies that spoke to the relationship between mothers with ED's and their children, mixed results were found. Some studies highlighted deficits in the primary relationship and one study suggested that there was no impact on the relationship.

Whilst thoughtfulness is recommended, this does contribute to a picture of what the reality may be like for an eating disordered woman who enters motherhood.

Chapter 2 Rationale

Only five studies have considered the relationship between mothers with an eating disorder diagnosis and their children. Of these, one was an intervention and the others were focused in on the impact of the mother's ED on the developing infant. Results were inconsistent. As such, there is a clear need for more research in this area, which this project will begin to address. An intersubjective perspective will be taken to consider the mother and child relationship, with a focus on the detail of interactions. The research will be exploratory, without a preoccupation on deficit or the specific impact of the eating disorder. The only focus will be on learning about how mother and child are with each other.

2.1 Research Aims

The primary research aim was to explore the relationship between mothers with ED's and their toddler's, providing a contextual and in-depth account of their experiences together. The findings from this research could contribute to the design of services for Mothers with ED's and their families.

The following research questions will be addressed:

1. How do mothers with an eating disorder diagnosis and their toddlers relate to each other?
2. What impact, if any, do eating disorders have on how the mothers and toddlers relate to each other?
3. Which concepts in psychoanalytic thinking best make sense of the intersubjective process between mothers who experience eating disorders and their toddlers?
4. What do we learn from using a multi-method research design?

Chapter 3 Methodology

"The quality of knowledge that any piece of research can produce is fatally shaped by the choices made in methodology." (Hollway, 2015, p. 89)

This section will introduce the research design, considering its theoretical underpinning and practical application. This will be followed by a description of the data collection and data analysis process. A description of the recruitment method, participant demographics, ethical considerations, as well as issues of quality control will then be presented.

3.1 Research Design

"The worst thing that contemporary qualitative research can imply is that, in this post-modern age, anything goes. The trick is to produce intelligent, disciplined work on the very edge of the abyss." (Silverman, 2015, p. 221)

This research takes a qualitative, multiple case study design, with theoretical foundations in a psychosocial approach, informed by psychoanalytic research methods. In seeking to understand the mother and toddler relationship within the context of eating disorders, the study used a complementary blend of data collection methods, using two Infant Observations (IO) and one 90-minute Free Association Narrative Interview (FANI). Data from both observations and the interview were subject to FANI analysis, and comparison was then made between cases.

A Psychoanalytic research approach was most appropriate for this topic as the techniques are derived from clinical methods that aim to explore conscious and unconscious material. There is a wealth of data available non-verbally between a mother and child and these methods allowed for explicit but also implicit communication to be seen, experienced and recorded. This was very much in line with the epistemological underpinnings of the project.

3.2 Epistemological Position

"The domain of the 'real' is distinct from and greater than the domain of the empirical". (Bhasker, 1998, p. 12)

When considering my epistemological position, I thought about the processes that I believe occur within and outside of me but remain unseen. These experiences ground me in a

critical realist position, being able to allow for a truth to exist, yet accept that the meaning of that truth may be numerous.

Bhaskar (1978) highlighted three levels of reality; the empirical level of experienced events, the actual level of all events, whether experienced or not, and lastly the causal level, the mechanisms that generate events. It is the third of these that offers a unique and important perspective on this project's epistemology. The central premise of this being that even though the causal level of reality may not be open to direct perception it is still 'real' because it causes things to happen.

The causal level of reality is compatible with psychoanalytic ideas of the unconscious (Kran, 2015;Pilgrim, 2017). I for example, cannot see my unconscious, yet I do accept that the unconscious wishes and phantasies I have will be the mechanisms through which actions will occur. This does not mean that my unconscious will always determine my actions, but nonetheless provide 'tendencies' for me to act in a certain way, suggesting that an individual has a degree of agency and is not merely responding to stimulus.

Psychoanalysis as well as a critical realist position allows for mechanisms of change (in this case the unconscious) to include the possibility of producing a distorted perspective. This suggests that the participant, as well as the researcher themselves can never gain a full and accurate picture of the world.

Psychoanalytic research celebrates subjectivity, as it is through the researcher's subjectivity that the internal world of another can be consciously known. However, it is important to note that whilst differing researchers will undoubtedly affect the degree to which the participant will readily reveal his or her psychic structure, the researcher cannot influence its existence, or the motivational forces that will inhabit there. Conducting psychoanalytic research from a critical realist perspective will mean holding ongoing uncertainties as well as any specific distortions that the researcher will be required to address in themselves.

3.3 Theoretical Position and Underlying Principles

3.3.1 A psychosocial foundation.

"We intend to argue for the need to posit research subjects whose inner worlds cannot be understood without knowledge of their experiences in the world, and whose experiences in the world cannot be understood without knowledge of the way in which their inner worlds allow them to experience the outer world." (Hollway & Jefferson, 2013, p. 4)

This project took a psychosocial approach acknowledging the importance of both an individual's internal psychological world and the impact of the social experience. The focus of research was therefore on 'psychological processes that occur in a social world' (Martikainen, 2002).

3.3.1.1 The importance of the social context.

No mother enters a relationship with her child without the social influence of those who have come before, and who are around her. Furthermore, the transition into motherhood is a time requiring many social adjustments (Hollway, 2015) not only in how a woman may view herself or in how others see her, but in how this is expressed in the words and meanings that are chosen. Her own meanings and expression will depend on how she has understood and experienced her life and the world around her up to that point. However, to consider the social context alone is to neglect the intrapsychic processes of conflict, ambivalence, loss,

and separation. This would perpetuate the dualism of the individual and the social (ibid). Hollway and Jefferson (2013, p. 17) state common social discourses are "rendered unique by being inflected with meanings in which they are invested because of the tensions and conflicts in their own biography."

3.3.1.2 The importance of the psychological.

For psychosocial researchers, the internal world of the participant is made up of both conscious and unconscious content (Hollway & Jefferson, 2013). Drawing on psychodynamic ideas, psychosocial researchers therefore do not assume that a participant has full access to the whole 'truth' of their experiences. As such, the researcher's role is to begin to understand the unconscious intrapsychic processes through which participants understand their social world. The idea that "an interviewee can 'tell it like it is' still remains the unchallenged starting point for most of this qualitative, interview based research." (Hollway & Jefferson, 2013, p. 9). Psychosocially influenced psychoanalytic research acknowledges the complexity of researching participants who may themselves, as well as the researcher, be 'defended participants'. Hollway and Jefferson (2013) speak of the need to sometimes evaluate the material that a participant may provide, unaware at how influenced their responses may be at times. That participant's may not have full understanding of the complexity of their own experiences, seemed particularly pertinent in researching mothers with ED. Due to the secret and hidden nature of ED practices, socially desired responses may be given. In fact, it was likely, considering the societal pressure around 'mothering' and 'getting it right'. The invested responses from participants could therefore potentially be unconscious and

defensive[3]. A FANI data collection and analysis method is designed to access participants unique stories, whilst at the same time considering the participant's motivations and investments of the meanings that they offer the researcher.

3.4 Psychoanalytic Research.

"One may postulate that psychoanalysis is, first and foremost, an epistemology and methodology. This is the chiefest of its permanent contributions to science". (Devereux, 1967, p. 294)

There were two key features in this project that supported access to participants internal world. Both were drawn from psychoanalysis, and as such, position this project as psychoanalytic research. Firstly, 'Capacities of Mind' (COM) were used to observe, record and make sense of unconscious processes (Cooper, 2016). Secondly, 'Clinically Derived Methods' (CDM) from the consultation room were utilised to make sense of the data. These two techniques are not mutually exclusive and for the researcher, utilising COM allowed data to be collected through clinically derived methods.

3.4.1 Capacities of mind (COM).

Psychoanalytic research focuses on 'beneath the surface' phenomena which traditionally have only been accessed during clinical work (Hoggett & Clarke, 2009). In research, 'clinical capacities' use the 'thinking' mind of the researcher to tease out meaning from the unconscious interaction and tentatively give a digestible idea back to the participant. In this research, the researcher brought her emotional and cognitive faculties to the process of data collection and analysis (Cooper, 2016) to consider the unconscious processes between mothers and their toddlers.

[3] A general designation for the techniques that the ego makes use of in conflicts. The function of a defence is to protect the ego. Defences may be instigated by some form of anxiety. (Rycroft, 1995, p. 32)

3.4.2 Clinically derived methods.

"***Psychoanalysis is an emotional engagement, for both therapist and client, often involving the "(…) shifting, ambiguous, uncertain, elusive, slippery, and perhaps finally unknowable realm of unconscious process and phantasy as it shapes human functioning".*** (Cooper, 2016, p. 35)

Psychoanalytic research must therefore attempt to engage with participants unconscious processes and utilising clinically derived methods that observe and monitor these exchanges. There are several features that Cooper (2016) suggested would be of interest to the researcher:

1. *Overt behaviours:* This would include communication, pauses, silences and overt exchanges 'on the surface' of interaction.
2. *Emotional atmosphere*: Any changes in the emotional state during the surface level interaction with the participant.
3. *Researcher's changing emotional state:* What the researcher notices in themselves and where this may be in parallel or contradiction to the participants.
4. *Difficult to name emotional/intellectual responses:* The researcher's own feelings towards the participant.
5. *Participant's transference*: The researcher's awareness of being pulled into or reacting to something not their own.
6. *Researcher's counter-transference:* The researchers own personal response to the participant's material.

3.5 Summary of Methodological Position and Underlying Principles

"It is rooted in the psychoanalytical tradition, in which the purpose of enquiry is the emotional world and its impact upon individual development and relatedness". (Briggs, 1997, p. 12)

Unconscious processes between mothers and toddlers are perhaps one of the topics most inaccessible by language. The methodological positioning suggested above does vary from more traditional qualitative research in Clinical Psychology. However, if all research were concerned with semantics and cognitive understandings of mothers with ED's and their children, we would run the risk of only ever seeing this dyad through well-worn lenses. This could do a disservice to the pregnant women and new mothers that may be without the tools to understand what might be happening between and within them and their toddlers. As described above a theoretically psychosocial study, drawing on psychoanalytic research techniques has the potential to bring an alternative lens. This project's unique perspective offered the possibility of a deeper, more intricate way of exploring this primary relationship on different levels of awareness.

3.6 Data Collection Methods

3.6.1 Infant observations (IO).

"We are, I suppose, on dangerous ground when we start to speculate about the infant's experience; but if we do not allow ourselves to imagine and wonder about such things, we may well be closing the door to understanding elements of adult experience that are preverbal yet deeply important". (Wright, 1991, p. 12)

This project needed a method that could capture and make sense out of an experience that is universal and uniquely subjective. Observation was incorporated as a data collection

strategy to highlight important aspects of how mother and toddler relate to each other, this involved three components; observation, written report and seminar.

Infant observation methods were 'born' out of training for child development programs at the Tavistock Clinic (Bick, 1964). Trainee observers could become attuned to the development of babies in a way that noticed embodied communication which indicated the development of the internal world. This project followed others who have adapted this method to fit in line with the rigors and realities of research requirements by moving the emphasis from the infant emotional development to focus on the relationship between mother and toddler (Urwin, 2007).

3.6.2 Procedure.

3.6.2.1 Operationalising infant observations (IO).

This project used two sixty minutes IO sessions with mothers and their toddlers. It was important to have more than one observation to acknowledge that interactions are not necessarily stable over time and to safeguard against over interpretation based on just one experience with the participants. Observations took place in the mother and toddler's home with the researchers focus to "maintain a reliable, non-intrusive, friendly and attentive presence" (Miller, 2002, p. 8). Time and resources did not permit additional observations to be carried out. Although this would have deepened the material gathered, it was unlikely that a completely new way of relating would have been observed.

3.6.2.2 Observation.

"… a babe, by intercourse of touch, I held mute dialogues with my mother's heart … ." (Wordsworth, 1978-1979 p. 102)

During the 60-minute observation the researcher was open to the emotional temperature of the room, the passing of feelings whether mindless or hostile or loving and connected. Being emotionally available to these exchanges allowed a deeper level of observation to take place (Caron et al., 2012). The researcher did not take notes or video record the observation. The task was to simply watch and to be as open to the emotional experience as possible. This decision followed a well-documented methodology established in Ester Bick's (1964) infant observation training and is currently the techniques still utilised at the Tavistock Clinic. A central component for the researcher is to be fully immersed in the process of 'being with' mother and toddler, free from the distraction of writing or the possible defensive distancing, that video cameras and/or notebooks could potentially introduce into the observations.

Another disadvantage to this method was the inability to view the observations multiple times, either as a researcher or for supervision. This meant that some behaviours and interactions remained unseen and were not able to be fully explored or verified through the supervision process. In an attempt to remedy this in part, notes were taken immediately after the observations, in the same quiet and contained space. A factor that was considered throughout this process was that the researcher's task was not to simply record events, but in essence, live those moments with mothers and toddlers. Those intimate moments spoke of something between the triad of those involved. Each free to feel that they would not be replicated or replayed outside of the moment that they existed.

3.6.2.3 Written report.

"In verse, not only did I seem to move at once deeper and more steadily into reliving the experience, but every detail became much more important". (Hughes, 2008, p. 48)

Following the observation, the researcher recalled and recorded the meeting in simple language, detailing events in a descriptive form, without attributing meaning. The report required that a way was found to communicate a predominantly sensory experience. Thoughts and feelings that had occurred to the observer during the observation were important to note. This could include feelings brought up in the researcher in their own countertransference, as well as what was felt in the transference with mother and toddler. An example of an infant observation is included in Appendix C.

3.6.2.4 Seminar space.

"It takes two minds to think a person's most disturbing thoughts." (Ogden, 2009, p. 91)

The seminar space that was occupied by the researcher and field supervisor provided a place where the private and intimate material collected could be shared. This enabled the observation to be thought about in greater depth and detail, whilst making sense of the transference and counter transference that was felt during the observation. The discussions in this space were a way to guard against over interpretation, to validate growing ideas as well as let go of others where they were not supported. The seminar discussions were recorded and transcribed, before being subjected to data analysis.

3.6.3 Free association narrative interviews (FANI) method.

"Interviewees preparedness to open out intimate material also reflects the building up of expectation that stories are what the researcher wants – that they are interesting, relevant, and valued". (Hollway & Jefferson, 2013, p. 41)

Free association interviews were chosen to encourage mothers to talk in an unfiltered way, following the idea that every thought leads itself to what is significant (Kvale, 1999). In addition to the free associative techniques, in the FANI approach, the interviewee is the story teller. The narrator's (participants) story will develop in unique ways based on their own life experiences. In telling a story, the narrator holds the responsibility for making the relevant points clear (Chase, 1995). The freely associated comments or utterances that occur in the narrator's story will add additional information to the observed experiences. By conducting an interview in this way, mothers were less influenced by the researcher's agenda or direction of questioning.

3.6.4 Procedure.

3.6.4.1 Operationalising FANI method.

The interview was conducted after the second observation, so that researcher and participant would not start out as strangers[4], and lasted up to 90 minutes. The interview schedule (see Appendix D) used three open questions relating to the mother's history; her transition to motherhood, her described relationship with her child, and aimed to elicit stories. "Why" questions were avoided, as they can elicit explanations rather than freely associated thoughts. Prompts were used to follow up or elicit further stories. The individual questions and choice to follow up were used flexibly, dependent upon the moment to moment mood of

[4] Which was the rationale for Hollway and Jefferson (2013) to conduct more than one interview.

the interview. This was in line with Hollway's (2015) argument that standardised research procedures are unhelpful: "the idea of standardised delivery for all interviewees derives from an experimental scientific framework and is antithetical to our emphasis on co-meaning making and intersubjectivity." (p. 45). The FANI method was chosen; in particular, as it was not standardised or prescriptive, neither did it imply that the mother's relationship with her toddler was being explicitly evaluated. Much regulation is imposed within the experience and treatment of eating disorders and this method contributed a reflexive approach that was experienced as non-intrusive by participants. This was in contrast to alternative defensive marking systems such as the adult attachment interview, where there is standardised prescriptive protocols and an explicit focus on the attachment. All of which may have further increased anxieties of mothers who already had repeated narratives of 'bad mothering' in their minds.

3.6.4.2 F.A.N.I. analysis.

Although in title FANI is explicitly related to an interview data collection technique, FANI is much more than this. It is a complete method of data collection and analysis. In the FANI method of data analysis, Hollway and Jefferson (2013) argued for the importance of keeping the text 'whole'. This is in comparison to other more dominant qualitative methods that tend to break down segments of the data for coding. Keeping the text 'whole' allows for

a ‘common sense’ approach to be used with theory and reflexivity. This allows the researcher to become familiar with the complexities and contradictions of the data. In keeping with the FANI method, psychoanalytical theory was used to provide a way of making sense out of the ‘whole picture’ and allows for crucial (unconscious) motivation of the participant to be considered. Whilst creativity, thoughtfulness and intuition are important features of research, it was imperative to provide a sense of structure when presenting each mother and toddler dyad. In line with Hollway and Jefferson’s (2013) method of analysis, a proforma and a pen portrait were developed so that the reader could be introduced to each case without the need to read every data point. These two documents aided the holistic analysis and provided a clear process that traced the analytical path of interpretation.

The FANI analysis followed the process below.

3.6.4.3 The 6-step process.

1. *Interviews transcribed:* Included within the verbatim accounts were hesitations, laughter, pauses and any emphasis that was placed on words. This was in accordance with Mergenthaler and Stinson’s (1992, p. 129-30) seven principles for developing transcription rules in psychotherapy and related research.
2. *Reading and re-reading of the whole text*: This included both infant observations and the FANI interview whilst listening to audio recordings. The re-reading took place simultaneously to making notes without breaking the text up or fragmenting the sentences.

3. *Immersion in the material*: Making notes of ideas and thoughts that occurred within the readings of the text. Highlighting significant moments in the interaction, this included transference and countertransference feelings.
4. *Proforma compiled*: This was a collection of information gained from meeting the mothers. Standard biographical details and 'factual' information that emerged from the whole process.
5. *Pen Portrait*: The pen portrait brought together the descriptive information and the interpretation. This was a way to make each mother and toddler 'come alive' for the reader. It is essential for the reader to have a sense of the participant in order for the interpretations to be deemed meaningful.
6. *Conceptual comparisons*: This stage was a synthesis of the individual cases. Drawing together the similarities and differences of each mother and toddler. In this stage links were made across the case studies.

3.7 Self-Reflexivity

When working with mothers and babies it undoubtedly stirred up my own experiences of being parented and what it meant to be fed and played with, or not. Different memories and sensations occurred to me at different points throughout the project and these were discussed openly in supervision and personal therapy. It was important to keep a close eye on what was happening within me as it prevented any 'acting out' of my own patterns of behaviour experiences within the research frame.

For example, in one observation, I could feel a sense of indignation and outrage with a participant's partner for interrupting us. This feeling firmly belonged to me, as I have a

history of occupying the parent role as a young child within my own family. The participant's partner was authoritative; I had little experience of this and liked it even less.

Utilising reflexivity throughout the project, and in this instance in analysis, protected against bad interpretations and assisted with good ones. Being aware of internal feelings that were thought about in analysis supported interpretations or gave evidence for being entangled in my own transference. This was discussed in the infant observation seminars in a transparent way to ensure good practice. Talking with this mother about familiar reference points enabled us to bridge other differences between mother and researcher, such as history and experiences. Although there was potential to make the researcher less curious and more likely to assume that experiences were the same, in this interview, it enabled the researcher to be a more informed listener and the emotional experience was perhaps richer because of it.

3.8 Summary Methods Selected

In summary, this project has a psychosocial foundation and uses psychoanalytic research techniques of Free Association Narrative Interviews (FANI) and Infant Observations (IO). The interviews provided mothers with an opportunity to reflect and unconsciously reveal meaning in their stories and the infant observation highlighted the emotional engagement of each mother and toddler, and how each toddler may elicit mother's own transference around being cared for. Both methods were complimentary to the project, giving unique and multi-layered perspectives of the mother and baby relationship (Urwin, 2007). These two epistemologically congruent methods were both analysed using a FANI approach that gave a sense of coherence and robust consistency to the process. This chosen methodology does not disparage or denigrate other more prominent methodologies but offers something different. Whilst the evidence for psychoanalytic research is not particularly well

published in terms of quantity or quality, it is by no means irrelevant. This project sought an opportunity to contribute to the scientific community and to be a part of a body of literature that can be as uniquely diverse and complex as every mother and baby's communication with one another. As each mother and baby develop and get to know the other in their own way, so should our methods of research as we seek to further understand them.

3.9 Ethical Considerations

3.9.1 Ethical approval.

Full ethical approval was granted by East of England - Cambridgeshire and Hertfordshire Research Ethics Committee. Supporting documentation is in Appendix E & F. The decision was made to go through the Integrated Research Application System (IRAS) procedures as this project involved using NHS clients. Having additional structures around the study provided a stronger sense of containment for participants, both when introduced to the project and after the experience of being involved.

3.9.2 Informed consent.

Mothers were given a Participant Information Sheet (Appendix G) which set out information regarding the study and how the research was to be conducted. Mothers were informed of who would have access to their data and what would happen after the study was completed. A total of four weeks was given, for consideration, before being contacted by the researcher. When meeting for the first time a Consent Form (Appendix H) was read together to ensure mothers understood the contents. If mothers decided to continue they would be asked to give written consent before any data was collected. It was reiterated that there was no obligation to take part and that, whether they decided to participate or not

would not alter the treatment or quality of care they received from the eating disorder service. Participants were also informed that they could withdraw from the study at any time, without needing to give a reason for doing so.

3.9.3 Confidentiality.

The issue of confidentiality was paramount for this project and all the participants that agreed to take part in this project. The participant information sheet detailed the ways in which confidentiality was protected. It explained how data would be stored and how long it would be kept. The recordings were transcribed by a professional transcriber mainly due to the researcher being hearing impaired. However, the transcriber was required to sign a Non-Disclosure Agreement (Appendix I). Mothers were told that quotes would be used in further dissemination of the project, however all identifiable information would be removed or changed.

Mothers were aware that there would be no access to their clinical file or details of treatment they had received. Mothers were fully informed about confidentiality and the limits of this. It was explained that should concerns of safety arise about her or the toddler in the first instance (where possible) an open conversation with her would take place. If the concerns persisted confidentiality would need to be broken and her clinical team would be contacted. A protocol for breaking confidentiality is included in appendix J.

3.9.4 Possibility of distress.

There was a risk that being involved in this project could cause emotional discomfort or distress to mothers or their child/family. The interviews invited participants to think about their childhood and being a mother, this may or may not have been areas of discomfort for

mothers. Prior to the study, this was discussed so that mothers could make informed choices. After the interviews were carried out mothers were given a debriefing sheet in case they felt unsettled or wanted to seek additional support after their involvement had come to an end. This is also included in the appendices (K).

3.9.5 Participants

3.9.5.1 Inclusion and exclusion criteria.

Participants were mothers who had been diagnosed with an eating disorder, and their toddlers. Children were two years old or younger. They were recruited from one Mental Health Eating Disorder Service in the South East of England, which was responsible for their care. It was a requirement for each participant to have a care coordinator or keyworker allocated to them to ensure they had support before, during and after the project. Although it was hoped that additional Trusts would join the project, this was the only service that recruited participants. Additionally, one mother was in the process of being discharged from the service and would not be allocated to a team member, and was therefore not included.

3.9.5.2 Recruitment.

The researcher attended the recruitment site to discuss the project. It was important to build this foundation as it was the team that eventually identified potential participants. It was not appropriate for the researcher to be involved in subsequent decisions about who would be

suitable for the project as knowledge of clients and their therapeutic work remained confidential. This also kept the researcher as a separate entity who met the participant 'fresh' and without any previous knowledge or expectations in mind. Information sheets were given to care coordinators/key workers who introduced the project to clients. The clients and the care coordinator/key worker discussed suitability for the project and if the participant agreed to further information, provided the researcher with the participant's contact information. The researcher contacted the potential participant and discussed the research project in greater detail, explicitly discussing what would be required of both parties. Once the participant verbally consented over the telephone, a date was set to meet and an opportunity for questions offered.

3.9.5.3 Participant Information.

Four mothers were identified by the recruitment site. Three of these, participant agreed to take part in the study. This was a small number and for the duration of the project there were no other clients with young children that were seen. See table 4 for details of participants. All identifying details have been modified due to the small and intimate nature of case studies. Two participants were white British, and one was dual heritage. Age ranges of mothers and toddlers are given to aid anonymity.

Table 3

Participant demographics

Mother	Age	Toddler	Diagnosis
Angela	30-40	Amy	Anorexia, Bulimia
Brenda	35-45	Bobby	Bulimia
Carol	30-40	Connor	Anorexia, Bulimia

3.9.6 Quality assurance and structures of support.

It was important throughout this research to document the quality of the project and its processes as well as evidence the supportive structures that were put in place. This section will outline the framework in place to ensure that there has been good quality research undertaken. Following structures will then be discussed to ensure that a rigorous approach was utilised.

3.9.6.1 Quality assurance.

1. This project followed Elliott, Fischer and Rennie's (1999) suggested publishability guidelines for qualitative research: Owning one's perspective; this study adopted a psychoanalytical position. This has been illustrated in the journey which led up to this project being carried out as well as in the way the methods were chosen and the data analysed.
2. *Situating the sample*: Comprehensive detail is provided in the pen portrait to place participants in context. However, for confidentiality reasons there is limited biographical information (Proforma). This project involved a small number of participants, which could make biographical detail identifiable.
3. *Grounding in examples*: Results are presented transparently, drawing on participant quotations and excerpts from observation to demonstrate the path from data to interpretation.
4. *Providing credibility checks*: Please see 'supportive structures' below.

5. *Coherence:* This has been held in mind when selecting the FANI which actively seeks to keep present and paramount the 'whole' rather than individual segments. Presenting 'pen portraits' of each dyad speaks to the need to describe the interactions for the reader so that the experience of being with each mother and toddler can be shared.
6. *Accomplishing general vs. specific research tasks*: This project used a small sample size and the limitations of the generalisability of this are noted. Nevertheless, rich, specific, deep and multifaceted depictions of life of the selected mothers with ED and their toddlers was provided.
7. *Resonating with the readers:* Where possible this research used accessible language so that the reader could navigate his/her way through the project. Providing rich detail of the participants and researcher's experience, supported by quotation was used to allow the accounts to resonate with the reader. Using a psychoanalytic method ensured that the emotional interaction between all involved was captured and presented in a tangible way.

3.9.6.2 Supportive structures.

3.9.6.2.1 Academic Qualification.

The researcher studied Psychodynamic Psychotherapy for three years at the Tavistock Clinic. Through the participation in supervision groups and clinical seminars it was possible

to understand transference and counter transference feelings, as well as formulate interpretations. This provided a basis in theory and skills which was brought to the role as researcher. The academic and clinical experiences ensured that skills had been rigorously checked, observed and assessed by experienced clinicians within the teaching team over a substantial period of time.

3.9.6.2.2 Supervision.

"**The special contribution of supervision ....is the opportunity for detailed and in-depth scrutiny**" (Zachrisson, 2011, p. 78).

For this project, many sources of support were employed to safeguard from meaningless and hasty interpretations. This started with a significant foundation of personal therapy which involved once weekly psychodynamic psychotherapy for eight and a half years. Therapy was increased to twice weekly during this project so that greater attention could be paid to the researchers own emotional experience of the observations and interviews. In addition to personal therapy, a psychoanalytic research workshop group was attended fortnightly for six months with twelve experienced child and adolescent psychotherapists. This gave the opportunity to present the research at various stages for feedback and guidance on design and techniques.

Nine 60 minutes infant observation seminar meetings were held with the clinical field supervisor who specialised in infant observations. In these seminars the written reports were able to be looked at in detail and ideas of theory and practice could be incorporated in a safe space.

In addition to the above, three meetings were attended with a psychoanalytic research consultant who specialised in FANI methodology and was an experienced supervisor of doctoral research projects.

Supervision and guidance was also provided from an ED clinical psychologist and the entire project was overseen by a clinical psychologist and qualitative researcher who was the primary supervisor for this project. This structure demonstrates the various opportunities that were taken up to validate and critique concepts that were highlighted from the interpretation of data through an extended triangulation of thinking, and can be seen in appendices (L).

In summary, this project openly acknowledges the difficulties faced with producing sound research using psychoanalytic methods. Being aware of the shortcomings of these methods enabled a degree of safeguarding against them. This section demonstrated the various ways this project approached quality assurance in a systematic and reliable manner Utilising key techniques and knowledge whilst also drawing on multiple layers of supervision, from direct clinical seminars, to research consultations and including personal therapy. These layers of tiered containment reflect not only the intricate ways in which a mother must get to know her child but also the many layers of containment that she may or may not have around herself. The multifaceted yet meaningful support network around this method choice illustrated the parallel processes that are often involved in raising a child.

Chapter 4 Analysis and Discussion

4.1 Overview

The aim of this chapter is to present the interpretative themes of three mothers with ED’s and their toddlers. All participants, and any individuals associated with them, were allocated pseudonyms to maintain anonymity. Any other identifying information was also

removed or changed. The analysis is presented in three parts. First, individual summarised pen portraits, followed by themes from each mother and toddler dyad and then collective themes from across all three participant dyads. Consistent with Lorenzer's idea of 'scenic understanding' (Olesen, 2012), the summarised individual pen portraits and themes are a way to allow for imaginative interpretation of meaning whilst also providing an avenue for the embodiment of interactions. An example of a full pen portrait is included in the appendices (M). Quotes from narratives of participants are shown in italics. Collective themes are then linked to existing research, before the project as a whole is critiqued and clinical and research implications identified.

4.2 My understanding of Mothers and Toddlers

Before a detailed description of each mother and toddlers pen portrait the global themes are presented in table 3 to give the reader a sense of the global themes that emerged from the data.

Table 4

Themes for each mother and toddler

Angela & Amy	Brenda & Bobby	Carol & Connor
The attuned relationship	The adored relationship	The patient relationship

Taking in some good	Feeling empty	Doing well
Surviving loss	Together or alone	Muscular tautness
Keeping going	Sharing	Toughening up

4.3 Angela and Amy - The Pen Portrait

4.3.1 First Impressions.

I was warmly welcomed by mum and daughter, whom I shall call Angela and Amy. Angela was in her early thirties, a white British professional woman with a history of Anorexia and Bulimia. Angela was tall, thin and with fair skin and brown hair clipped up at the back and was neatly presented. In her arms was Amy, 18-months old with short blonde hair. My instant thought was that she could feature in a cereal advertising campaign. The family home was new and clean; nestled into a small close with 4 surrounding properties. Angela's husband also lived in the home, although he was at work on both visits. I was aware of my own anxiety being invited into Angela and Amy's home for the first time and responded to Angela's professional introduction with my own sense of a business-like approach. Angela had a melody to her tone of speech with short snippets of words ending on a higher note, as if asking a question. She told her story in neat chronological order. This appeared to minimise the impact on me, as if her major life events were not significant, or significant enough to burden me with. It made me wonder whether Angela had learned to down play her feelings in the past. Angela was composed but felt slightly awkward; this was to be expected given the intimate nature of observations. I was aware of a sense of 'wariness' and I wondered, if it could be Angela's natural wariness, as she would have been unfamiliar with observations.

I was humbled that I had been allowed into Angela's home and able to share some of the time that she has with Amy. The toys in the room were in pristine and clean condition.

Everything was neat and tidy, the room and the toys, this was also apparent in Amy's play. At one point in the observation, Amy had been playing with her pens and had "*gotten pen everywhere!!"* Angela felt that she needed to intervene and take the pens away and clean up all the mess that had been made. Angela also linked this to her own early years "... *oh yes control ... yes, I was very neat and particular*". This difficulty tolerating mess was present in both observations, in her frequent cleaning of Amy and her things during playtime.

Very quickly in the interview Angela allowed me to see the more emotional parts of her, and this pulled me closer. When I left Angela and Amy for the last time, I felt an unexpected sadness as I would not see them again, and this disappointed me.

4.3.2 Family context.

Angela's family of origin consisted of her mother and father who were "*still together*", and two siblings. Angela's brother was older than Angela and her sister was younger than her. Growing up, Angela's mother stayed at home and her dad worked hard in the city. Family time was dominated by playing games and Angela said that before she could walk she had "*a hockey stick in her hand,"* Angela gave a depiction of her early childhood as *"busy*" and "*lucky*" as they also "*went on nice holidays*". Though Angela remembers "*looking back*" at how nice things were she also said that "*it was hard to remember that far back"*. It felt difficult for her to remember times that were not so lovely. Angela said that she "*didn't remember things being tricky*" and how it was "*weird*" to think that far back as they all got on.

Angela begun to develop anorexia when she was 15. She said, *"I had to grow up a bit too fast, maybe it was too much responsibility"* referring to helping look after her sister. By

the time Angela was 17 she slowly transitioned to bulimia to "*beat them*". This was so that she could show others she was eating even though she would purge afterwards. This time sounded a great deal like a war, where there were sides against each other and deep hostilities. Again, this made me curious about the quality of the relationships in the family home. There seemed to be a balancing act between the "*risk of letting control go*" (bulimia) and then after putting on weight an embrace of anorexic symptoms as Angela "*needed to get something back*".

4.3.3 Amy.

Amy was a planned pregnancy and there were no delays or difficulties conceiving. The first trimester of pregnancy was *"hard"* but by the second trimester, Angela "*loved*" being pregnant. When Angela was 8 months pregnant with Amy her sister died in a tragic accident. This was a sudden and deeply painful loss and I wondered how Angela and her family managed to survive such an event so close to giving birth. Amy's delivery required an emergency caesarean and this was described as *"horrific*" and an experience that rendered Angela vulnerable and helpless. After six weeks Angela was working from home one day a week and by 6 months Angela had returned full time to work. During the working week Amy was cared for by Angela's husband Anthony, her mother and nursery arrangements. The weekends were when Angela and Amy got to have *"special"* quality time together, and Angela described the relationship with Amy, as *"close"*.

4.4 My Understanding of Amy and Angela

4.4.1 The attuned relationship.

Angela described the relationship between her and Amy as good, "*she is literally my saviour*". It made me think of how important Amy had been to a family that would have been devastated by loss just weeks before she was born, as well as what it was like for Amy to come into a world full of sorrow. Amy's presence was such a positive that Angela said, "*I look at her and think I don't know what I would do without her*". Angela was mindful of the risk of "*putting too much on her*" and I became curious as to how Amy experienced that in a positive regard or if there would be at times, an element of pressure. The closeness between Angela and Amy was clearly present in the observations. There was often touching attunement between them. There were moments when Angela knew exactly what Amy needed and provided it naturally, knowing when to step in and when to hold back. This was seen in shared enjoyment of just being together, laughing, giggling, and finding so much comfort and contentment in each other's presence.

Angela sits an angle from me (most of the observation she has been quite far away or with her back to me). Amy is on her lap and Angela is reading pop up books to her. This feels like a natural and engaged activity that they are both immersed in. I have a warm and loving sense watching this, and find myself smiling. This continues to the end of the observation with Amy getting a new book when one is finished. Her toes wriggle in her socks on carpet as she is concentrating on the books and her mum's voice. I feel that sense of snuggling down and almost wriggle in my seat in comfort. (1st infant observation)

4.4.2 Taking in something good.

Like any parent, one cannot remain perfectly attuned all of the time, and there were moments that Angela and Amy seemed disconnected and not quite in sync with each other. For this mother and toddler, it was primarily when food came in-between them and was difficult to navigate. Angela spoke about her worries of Amy "*picking bits up*" of her "*eating disorder*" and her inability to "*know*" Amy's hunger. I wondered about Angela's experience of not being able to stay in touch with her own hunger. It seemed an impossible task that Angela successfully managed to negotiate 3 times a day

> *"I worry about it, I think did she have enough? It's just, I mean, I give her fruit and veg. she loves it. But I think am I giving too much? That's what I would have eaten? It's difficult, it's over thinking really?"*

During the observation Angela asked Amy if she wanted food, she provided a list of fruits which quickly seemed too much choice for Amy.

> *Mum take Amy's bowl of mango away so she can play with her and get in the car. Amy looks confused about this. Angela asks do you want more? Amy says 'yes' and then 'no', Mum then asks if Amy 'wants a banana', then 'blueberries' and then 'more mango'. Amy responds to each with 'no' then looks undecided and a little confused. This dialogue goes on for maybe a minute or two. Amy looks unsure as to whether to play or choose food. Amy then points to the bowl of mango and says 'more'. Angela then gently shakes a stuffed doggy in Amy's eyesight and says 'you can have some in a minute'.* (1st Infant Observation)

In these moments the feeling of uncertainty from both was palpable. Both mother and daughter became disconnected and out of sync with each other. However, these moments

were fleeting and both quickly recovered and found each other's rhythm again. This showed how much of a struggle it is for Angela to feel confident in what she is providing Amy and this made me think of how much of a nurturing presence she may believe she can be for Amy in relation to food.

This made me think of Klein's (1952) theory of object relations, in this case through feeding, Amy may take in a feeling of something good and wholesome and contented. In her phantasy she may take inside herself the good or bad parts of Angela. In the case of projection, it is a reversal of this process, any horrible feelings that arise from inside Amy, that she feels are too threatening must be got rid of. Amy would have no mechanisms to contain these feelings, and therefore they must be projected outward. Klein argued that the 'good' breast became the blueprint for everything satisfying and beneficent whilst the 'bad' breast stood for everything lacking and persecuting.

It is understandable that each new mother experiences some level of anxiety around feeding as it is an important emotional interaction between mother and child. For women who already have a confused relationship with food, it can become more complicated. Angela's worry around feeding made me think about her beliefs around how 'good' she felt she could be for Amy. When Angela said, '*It might just be me imparting something bad on her',* I wondered what Angela may feel she was unconsciously projecting into Amy. It seemed that when the time to eat arrived, those could be moments of stress for her. It seemed perhaps food and feeding prevented Angela and Amy from being quite as in tune with each other as they could be.

It was an exceptionally complicated process that Angela had a great deal of awareness about. She was open and willing to talk about food and spoke about the internal conflict that she struggled with,

"you have got this little person you have to think about. That's a reason to get better, for my physical health, my mental health, for her health. But it is still not enough. And it's weird it is not enough because I will do anything for her. Like it is a given, but something won't let me let go of it [the eating disorder]."

Although day to day, Angela tried not to think about it, these thoughts persisted and were understandably upsetting to her. Angela appeared ambivalent and this was shown most when she said, "*there is still a part of me that really does not want to deal with it [the eating disorder], it's not destroying my life at the moment"*. This allowed me to see just how much Angela at times has struggled to carefully manage the needs of Amy, being a mother and balance the competing demands of the eating disorder. This made me think about the tension between these needs and what it might be like for Angela to hold them all.

4.4.3 Surviving loss.

There were significant threads of loss weaved throughout Angela's story that touched me deeply. The distress of growing up with difficulties with food and the realisation of the impact her eating disorder had on her life,

"I missed out on my friendships. Some of my friendships have suffered. I have not spoken to people for a long time, yeah and you know, we grew up together, went to the same schools and stuff. But I missed out with trips in school, I was too weary and too anxious to go, worried about I can't eat or I was just too poorly to go. And experiences... Well, I never wanted to go to Uni and that's fine. But other things like other people going out or going on trips. Just eating out in a restaurant was so //, I was so consumed with my worry about the food and what I do, well with all of that //

attached to that I think maybe I closed myself off too consumed, consumed to find food and.. control that part of my life rather than control other bits of my normal life."

In addition to the sense of loss of 'what might have been', Angela also spoke about the psychological effects of her experiences. Specifically, not being able to remember exactly what happened when she was younger. Angela described being unsure of her memories in her teenage years. This seemed to have caused her deep confusion over what was real and what was not, *"looking back, erm, ... mind has played so many tricks on me, I don't know what's real and what's not".*

Those moments in the interview were followed by lengthy silences where the air felt heavy with sorrow. Angela said that she could remember "*some moments vividly*" and then would break off with "*I don't know, I don't know*".

Listening to Angela in those moments made me feel utterly connected to her. I wondered how profoundly distressing life may have been for Angela whilst she was in the grips of an eating disorder but also how unimaginably difficult life may have been trying to make sense of the past, when she was in recovery.

"*Yeah, and that's what's difficult now. It was a difficult at the time because of the grips of what I was in. But now I just don't, (very quiet) was it real or was it not real, did I do that? Or even did I feel that? It's really bit bizarre. Knowing what is real I think is the problem, my childhood was overshadowed and working out what was real and what was my anxiety or my dreams, that's my world, what did other people experience of that. When I am panicking and thinking I don't wanna eat that and don't wanna eat that, how do other people see me?"*

Angela sounded uncertain as to how she experienced those years and her openness was remarkably painful to hear. It made me curious of the impact this may have had on Angela's sense of self, when the childhood stories that we all rely upon to know who we are, for her were unreliable and untrustworthy. Unfortunately, this was not all the loss that Angela had to endure in her life, Weeks before she was due to give birth to Amy, Angela lost her sister in a sudden accident. Both situations offered opportunities for many outcomes and Angela was able to '*keep going'*, contain her distress, and reclaim the emotional distance needed to protect herself. It was as if some part of her knew that underneath the surface was a little too raw to be exposed for too long. This made me think about the ways in which Angela had found to look after herself and 'kept going' despite significant hurdles placed in her way.

4.4.4 Keeping going.

Angela, like any other woman, had a life history of complex emotional experiences that she brought with her to motherhood. Some moments were tricky for her to negotiate, yet for the majority of the time, Angela and Amy were connected and in tune with each other. Despite the challenges in her life, Angela was thriving in an intensely emotive relationship with Amy, and I was curious as to how Angela managed such a task. Angela just kept going, for Amy:

> *"And being pregnant like you have to carry on. You like, you do what you have to do. It was a massive shock, / and you have to try deal with it. And I think I carried on being okay with my eating disorder till she was born and a little bit after, because I was breast feeding, again you think of someone else".*

One could suggest that there may have been 'messy' feelings that were confusing, difficult or even unbearable connected to the losses that Angela experienced in her life. As a way to cope Angela may have focussed on Amy and her needs to keep herself (and her family) busy and distracted:

"Yes it has been a very challenging time, growing up, obviously learning how to be a mum and / (But you saved us, didn't you to be fair)."

Remarkably, being busy gave Angela the strength to look forward, and she was able to focus on Amy as opposed to being lost and unavailable in her own grief. This made me think about the function of things being clean (the toys and the house) and wiping up mess that I had noticed during the observations. Perhaps Angela utilised this to protect herself against the messiness of emotions that may at times have felt very threatening.

Amy draws on the table again and then on the wall. Angela again tells her 'that we don't do that do we' – the tone is polite, firm and there is a slight irritation underneath. They both play a game of cleaning up as Angela and Amy clean the wall, the table, and the whiteboard with wet wipes. I feel a sense of not wanting to have Amy 'play up' in front of the observer. It looks like Angela may be getting irritated with Amy's 'mess'. Angela moves this on with Amy by picking her up and blowing raspberries on her belly. Amy giggles and the laugh is infectious. It is the sound of joy and excited glee... (1st Observation)

I wondered if perhaps when things felt emotionally messy, Angela may feel better, if she could physically wipe away any messiness that is around her and Amy. This might be Angela's defensive process of projection (Klein, 1952) and for them it works in a positive way, to keep them all going in the face of challenging times. It is important to note that all

mothers (all people) use different ways of coping with life and the various difficulties that present to us all. Those moments during the observation made me think of how effective these defences are for Angela and Amy; being able to clean away sticky hands and mess on the table and walls could enable Angela to wipe away difficult thoughts and feelings and stay in tune with her toddler. Perhaps by doing so, Angela is more able to emotionally respond to Amy and her changing needs. In this observation Angela could distract Amy and initiate a connection of laughter and giggling that felt pure and natural. The moment when something changed in Amy, Angela felt it. She could name it and respond accordingly.

It could be thought about that Angela utilised the defence mechanism projection in order to manage an internal anxiety. The way that Angela's global defensive structure could have been developed may be best understood through containment or lack of. Ester Bick's (1968) theory of 'second skin' is a way to understand this defensive structure. The central function of the skin is as a primary container and can be felt to hold together the internal parts of the baby which have yet no coherence. Maternal containment can support the growth of the baby's psychic skin, and when this is not available, or does not occur for long enough, for whatever reason, the baby may resort to 'second skin' defences which are omnipotent pseudo-independent forms of protection to hold the self together and prevent internal disintegration. In this case, it could be seen in Angela's way of keeping busy, at home or at work and 'on top' of everything. Perhaps her 'busy' skin protected Angela from leaky spillages of anxiety when she was still or there was too much room for thinking and feeling.

It was a pleasure getting to know Amy through her experience of Angela. Together they were a mother and daughter that had faced losses and had survived.

4.5 Brenda and Bobby – The Pen Portrait

4.5.1 First impressions.

I was warmly welcomed by mum and son, whom I shall call Brenda and Bobby. Brenda came to the door with a welcoming smile holding on to one of her legs was Bobby. Brenda was a white 40-year-old British woman with a history of binge eating. Brenda was tall and her physical frame filled the doorway. She had slightly tanned skin, no makeup, and black hair that was loose on her shoulders. Brenda was politely spoken and her tone of speech was soft and light and reminded me of honey. There was a lullaby effect to the quality of her tone, and it was pleasant to listen to. I found myself feeling grateful that Brenda was so friendly. I noticed a sense of wanting to be 'liked'. It made me wonder about Brenda's feelings and thoughts of me in her home and whether she wanted us to be 'friends'. It was Bobby, Brenda's 2 two-year old toddler with chin length thick blonde hair who announced, "*we have oomer*" (boomer the dog). This prompted much discussion and petting of a little fluffy white dog that was spritely jumping from person to person. Brenda was living with her husband and 4 of her 5 children. Brenda's eldest daughter was away at university. Brenda worked part time whilst Bobby was looked after by Brenda's mother and nursery arrangements.

Brenda was very engaging during our time together and there was something quite vulnerable in the way that she accommodated me in her home. Brenda had a childlike, passive quality to her storytelling which was not dissimilar to a fairy-tale. Within the telling of this fairy-tale there were 'evil step-mothers', innocent children and imagined 'evil forces' that could snatch babies away. Brenda spent a lot of time during both visits 'spilling out' her story to me in a way that made me think about the importance of my attention and what that felt like for her. Brenda's story, in relation to the tumultuous relationship with her father and

stepmother, seemed to dominate. There was a parental feeling in the transference to care for her as if she needed looking after and nurturing.

4.5.2 Family context.

Brenda described her childhood in the context of emotional deprivation, and there was a strong sense of a '*lack*' of something. When she was two years old her father left the family home for other women who he was having "a*ffairs*" with. In her father's place was a step father who was experienced by Brenda as "*quite grumpy and he was quite like Victorian. children should be seen and not heard*". This description of Brenda's story made me think of Dickensian deprivation where perhaps her needs had not always been held in mind. When Brenda was 14, she went to live with her father who "*spoiled us*" and her stepmother, "*but then when I lived there /my step mum was emotionally abusive. So, she was just really horrible*". When she was 17, she left her father's house and became involved with a man who was also abusive to her. By the time Brenda was 38 she had an established and complex history with binge eating that stretched back into her late teens.

4.5.3 Bobby.

Despite the challenges over the years, Brenda had four children. Although she had two miscarriages, she secretly wished for another baby. Due to the lack of formal contraception used, Brenda fell pregnant with Bobby. Pregnancy and delivery were marked by intense anxiety and Brenda required treatment from perinatal mental health services, both before and after delivery. Brenda gave birth to Bobby after a 'brutal' two-hour caesarean, and reported no difficulties bonding with Bobby.

4.6 My Understanding of Brenda and Bobby

4.6.1 The adored relationship.

Brenda described Bobby as "*my little man, he is really special*". Bobby was seen by Brenda as her "*miracle baby"*. This made me wonder about the unconscious expectation, if any, that Bobby may have picked up on.

Bella [Bobby's sister] is using a book to lean on to draw the 'animal cages' and Brenda asks for the book. Bobby is interested and goes and sits on Brenda's lap as she reads to him. It is a picture book of animals and they go through each one and point to the corresponding figurines. They sit like this for maybe 10 minutes. It is a lovely bit of interaction, both look engaged and relaxed and I feel warm and privileged to be able to witness this. (2nd Infant Observation).

In both examples, Brenda and Bobby are totally engrossed in the moment and being together. Both Brenda and Bobby were so very generous in the way that they not only engaged with each other but were able to include me in the experience. Watching them together allowed me privileged access to experience how they may be at their best together. The adoration in each other's eyes as they were with one another was heart-warmingly special.

4.6.2 Feeling empty.

Hearing Brenda speak about her childhood made me feel intensely sad and empty. Following what appeared to be an emotionally deprived early life, Brenda moved in with her

Father, expecting to be lavished with attention and filled up with 'spoiling', but instead found herself in an uncontained environment with an abusive step-mother.

She was just / she was just really horrible. One time me and my friends were tie dying some t-shirts and we dyed the carpet and went upstairs and we like laughing nervously about it. She would come in ballistic. So she said right you need to pack your stuff because your mum is come and get you. You can't live here anymore. She would always say your dad never asked if you could live here, I don't want you here".

Her repeated experiences with her step mother made me think about how unsatisfying those years were for her, stuck in a triangle where neither Brenda nor her stepmother seemed to have contained boundaries.

"I went off the rails and like used to, got in with the wrong crowd and took drugs and drank. I used purposely drank so I would not remember all of what was going on. And then my dad was always like, I was so close to my dad, but then she got very jealous and then she got angry. She was just sick, so she just says things like / She said I was using my dad. Then she says things like "Your dad does not think on you when he is having sex with me". She was really fucked up.

I: How do you make sense of why she was saying that to you?

They say, don't they, like if you been not emotional the foundations aren't there. And they weren't".

At this point in her life, Brenda seemed without either of her parents and had left her Father's house for a man who also abused her. It seemed a deeply lonely time for Brenda, exacerbated by the loss of her Nan.

"Before I had (eldest daughter) and I left home at 17 I had no money and I didn't eat at all. Ehm. So like / I kind of, I probably had some issues with eating then. Ehm, and

then when I had (eldest daughter), I probably overate. But the actually binge eating started, I think, when nan died. I felt incredibly lonely / and sad. // ehm / I was at home with the kids, so I used to be like in the house and kind of just walked to the cupboard and back. And I know it was then when like I would eat food. Like when was given us a box of chocolate and I eat it and then have to go and buy and replace it so that (husband) wouldn't know that I have eaten it. So that started then".

It could be understood that Brenda's sense of emotional deprivation had become confused with hunger and the sense of being full confused with security and comfort (Glucksman, 1989). The excessive 'comfort' eating could have been an attempt to provide for herself as an adult with the oral stimulation of 'feeding' and 'good' feelings that she herself felt were not in her "*foundations*". An example of this was after her grandmother passed away. At this point, Brenda may have needed her grandmother more than ever and food, in this sense, became a way to satisfy a longing for emotional containment and closeness.

Feeding therefore, may have become a vehicle of introjection to take something of value in, in an attempt to fill herself up with something substantial. In relation to her children, it seemed that Brenda had a muddle of conflicting emotions about managing her own weight as well as feeding her children.

"I worry, like because sometimes if I binge eat he is with me and he eats it as well. So I don't know if I feed him. And if I binged eat then I don't wanna cook tea and sometimes I am… I wonder if I feed him the correct diet. And I worry that my weight will kill me that I won't be around very long. I am convinced I am going to die in the next five years. So I might not get to see him".

4.6.3 Together or alone.

Brenda's pregnancies were overshadowed by anxiety and a denial that any of her babies would 'stay' with her.

> *"Yes, if I left the blanket the wrong way around, this darkness would take the babies. It wasn't an actual cot death that worried me. I'd say till there was one, I was kind of not convinced that they would stay".*

This use of denial as a defence mechanism could be understood as Brenda providing herself with 'an emotional cushion'. The denial of a baby could have prevented Brenda from emotionally attaching to the baby as the reality of being 'left' after another miscarriage could have been experienced as unbearable. This made me think about the intensity of her fear and the lengths that Brenda had to go to in order to survive her pregnancies.

> *"So with Bobby / I just didn't think we will get him. And with previous pregnancies I suffered really badly with anxiety. But then I had the thing about touching wood. So I end up stop and my feet and my toes and my lips on the door counted to a hundreds and another hundred and another hundred".*

It is therefore understandable that after fearing being left and being separated from her babies Brenda may have wanted to keep those early days of 'fused' reverie for as long as possible. In order to extend that feeling, Brenda delayed weaning and separate sleeping routines, to perhaps satisfy her own sense of emotional hunger.

> *P: Yeah, yeah, well he stayed in my room till he was one, while the others were six months. I remember, like my happiest time was because my husband went into the spare room and she was with me. She still is with me. Ehm, but he used to have his*

little basket here and she was there. I am just surrounded by these guys. / Which is really nice.

I: What did you like so much about that?

P: It just felt safe and knowing they are there. We used to have massive sleep overs. I just feel safe and warm and tucked up. No, No./ No worries.

However, her babies would eventually need to 'abandon' her too as they grow up and continue to separate from her. Brenda, like many mothers, described this as very painful. Perhaps her strong sense of wanting more babies was an attempt to recreate the 'ultimate togetherness' and avoid the deathliness of being alone, when she is forced to share her child with the world.

P: ...Like it is hard to think they will have their own husbands. And like (eldest daughter) going to uni for two days, I mean, I felt suicidal. I was just so, what's the point when they just gonna leave me!. And then I got panicked because I think that she's gonna have this adventure and she's not gonna take me on it. What if I want to go but not allowed to. That was really scary. I mean it made me feel ill. I was like Urgghh why can't I go. They are so important to me. In the future I won't be so important to them. They will have other things. That's scary, that's not cool (laughs). That's a worry.

I: Do you worry about that a lot?

P: Yeah. All the time. I worry (sighs). My biggest worry, not my biggest, I have lots of worries. One of my greatest worries is that I will be old and alone and dark and scared.

Brenda's loneliness (or darkness) understandably would be a difficult experience, and perhaps the use of food alleviated some of the feelings of loneliness (emptiness) that may be too unbearable to manage.

"And I think (eldest daughter) is gone to uni and she has lost weight and I feel a bit jealous. I think maybe I feed her too much on purpose. I don't think I did. Do you know what I mean? There are lots of issues".

4.6.4 Sharing.

As an adult it seemed as if Brenda wanted to be 'coupled' with another, as she said those were the times that felt most comfortable and safe. For example, when she was a 'single parent' with her eldest child, or when she and Bobby were together; both seeking comfort from each other. However, Brenda appeared to become resentful when she had to share the affections and attention of her new desired 'partner'. Perhaps her childhood experiences served as an unconscious reminder of when she was unable to couple up with either parent due to the abusive and painful intrusion of a step parent.

"My husband never helps with the babies at all. Which is fine, because I had (eldest daughter) on my own. So, when I was pregnant with (eldest son) I was worried how I should share him with someone, because I didn't want to. So the fact that I always just breastfed them and just done everything in the night and that's like fine".

Bobby is also approaching a main stage of development which introduces the challenges of sharing. I wondered whether perhaps Brenda's history of having to share her attachment objects and Bobby beginning to understand his own capacity for sharing facilitated a tricky negotiation in which more difficult feelings may have had to have been

pushed away and denied. This made me think of what they unconsciously may have triggered within Brenda.

Brenda then seemingly out of nowhere, asks Bobby to share his game: She asks Bobby for 'mummy's turn' and goes to take his game away. Bobby protests and says 'no'. Brenda says 'you have to learn to share Bobby' and 'now it is mummy's turn'. The pair of them engage in a tug of war briefly until Brenda wins and takes the game, Bobby throws himself backwards and lays on the floor crying, expressing distress and increasing in volume. Brenda continues to show him mummy is having a little turn because you have to share, Bobby's crying intensifies and he sits up and throws himself back again. (1st Infant observation)

The difficult feelings that arose in Bobby could be understood in the splitting off of good and bad feelings that Brenda may have had to do in order to survive difficult emotional experiences. The 'bad' feelings that Bobby shows when he is told to spontaneously share could be seen as Brenda's own frustration and anger that need to be kept separate from her and sent away (perhaps into Bobby) so that they become less threatening to Brenda herself. Bobby then may be left to feel and express the difficulty of these feelings for both him and Brenda. An example of this is when Bobby's difficult feelings of jealousy are sent out of the room, as Brenda cannot contain or allow them.

...then the dog comes in and Bobby says, 'no boomer, go away' and goes to kick him. Brenda tells him no. Bobby goes over to the corner and starts to smack a keyboard that is on a small coffee table. After a few times of Brenda saying no, she goes over to Bobby and picks him up and says no, you need to stop.

Brenda and Bobby were a mother and son that I spent a great deal of time thinking about. It was their sense of inclusion that allowed me to connect so wholeheartedly. I too had come to adore Bobby. Brenda had survived a great deal of inconsistency in her life that ensured she never felt like she fit in, but she was never quite alone either. This may be the worst kind of loneliness.

4.7 Carol and Connor – The Pen Portrait

4.7.1 First Impressions

I was warmly welcomed by mum and son, whom I shall call Carol and Connor. Carol was a dual heritage British woman, with a history of Anorexia, living with her husband and their two-year-old, Connor. Connor was a little blonde-haired boy with a cheeky face. Throughout our time together he had little interest in me and spent his time boisterously moving from one thing to another.

Carol appeared to take care of herself very well. I was struck by her athletic muscular physique and was surprised to notice that I felt 'inferior' in relation to her body. It wasn't just Carol's appearance that first made an impact, her home looked very well presented, despite only recently moving in. Carol was well spoken, and articulate. Interestingly, my first impression was a strong visual of what everything looked like. It seemed 'perfect'. There was a sense within me of comparison; our ages, our status in life, my legs to Carols etc., which was interesting as this was unusual for me to feel.

Appearances seemed to be important both from what I encountered when I first met Carol and Connor and from listening to Carol's story of growing up. Carol told her story through a lens of expectation and competition. She was clear that there was an expectation to do well. However, this left me feeling saddened and I wondered how realistic this may have

been and how it was experienced by Carol, when she inevitably failed to be good at everything.

4.7.2 Family Context

Carol's family of origin consisted of her mother, father and herself. The first thing that Carol said was "*…it wasn't erm… It was very norma.l*" She remembered her mother entering her into beauty and talent shows from about the age of six to nine years old and remembers "*enjoying them although feeling anxious as I wanted to win."* Carol's early school life continued in a competitive manner by attending a private primary school and "trying to get into a good secondary school". Carol said, *",,, it was all about marks, and doing well, even at the age of 10, it was all about what secondary school you went to*.". Once Carol was at secondary school she felt academically inadequate "*I used to wonder why? Why? Why can't I get it when everyone else can, you know?"* It was very important to Carol to be "*really good at something, I was very good at music and was, very good at swimming when I was young. Those were the things I could utilise to my advantage*." At times it sounded like Carol had to strategize her strengths. Carol spent many years competing in swimming and then rowing.

Carol said, that she started thinking about "weight and stuff" when she was about 12 years old, and then in her early teens was competing in sports and began taking laxatives and restricting her eating, and so she dropped to a very low weight. This was also around the time her parents got divorced.

4.7.3 Connor

Since having Connor, Carol has been a full-time mother. Connor was an unplanned pregnancy, although Carol and her husband had discussed starting a family. Whilst pregnant

Carol did not enjoy her body was changing, for example losing muscle tone and her chest getting bigger. Carol did not discuss the birth of Connor and instead spoke about how unwell she was shortly after the birth. During this time her mother came to stay and provided support to both Carol and Connor. Carol said that she was 'rubbish' at breastfeeding and due to mastitis, she stopped altogether. Carol described her relationship with Connor as 'close' due to the time that they spend together. I was pleasantly surprised in the interview with the warmth Carol had shown me and, in return, how my feelings had opened towards Carol. I felt a genuine connection and was sad when I left, as if something felt unfinished. I felt a sense of a weary loneliness after the interview that made me wonder how often Carol shared her feelings with others.

4.8 My understanding of Carol and Connor

4.8.1 The patient relationship.

Carol was with Connor throughout the observations, following him around from room to room, and engaging with Connor with each new activity that he wanted. There were moments in between changing activity where they could be caught 'getting in to' something together.

At around 20 mins into the observation I am standing in the corner watching both mum and son play on the hard floor. They are both saying 'choo choo' and the train is playing a song and making train noises. Mum is building the track and Connor is running the train around it. It is a lovely sight of them both and it feels natural. It looks like fun and I

want to play too, I want to sit cross legged and childlike on the floor and join in (2nd Infant Observation).

However, I wondered what it might be like for Carol, to be around Connor for that amount of time as during both observations Connor had a relentlessly energetic way of engaging with his toys. Nothing held his attention for very long, and his play could be loud and boisterous. Carol was exceptionally patient, tolerant and followed Connor's interest wherever he took her. I was struck by how accommodating she was to Connor throughout both observations. This made me think about the dedication that Carol puts in hour after hour with Connor and that this strength appeared to go unacknowledged within her.

4.8.2 Doing well.

There was a great deal of competition present. Whilst spending time with Carol, both explicitly spoken of in the interview, but also felt in the transference.

> *"I was thinking the other day about competitiveness and I do wonder if that's kind of where it, / I used to, I was not that competitive like as a little one, but I remember thinking that I had to, I had to do well"*

This made me think about where the sense of competition may have come from. Both of Carol's parents came from large families; her dad was one of six and her mum was one of eight. It is of course, difficult to know of their experiences; however, the extent of rivalry felt by me in the transference, and the sense of competition that Carol spoke about, could suggest that this may have been an unconscious family legacy handed down to her. One can only imagine what it would have been like for each parent being raised in families where

everything could have been a source of competition; food, attention, emotional resources, especially with the economic context being "*a very, very poor background*".

As the only child, Carol spoke of an intensity of everything around her, perhaps without siblings to dilute the focus of expectation.

> "*And there is definitely pros and cons to be the only child. I mean on one hand I did not really want for anything. But on the other it was everything on expectation. And ehm, I used to think to myself if I had a brother or sister, either it would have been shared out, or we would have been competing. I don't know if I would have been, ... because I got friends. You know I had a good friend of mine at university and he basically was in competition with his brother his entire live. It was horrific.*"

It is not uncommon for an 'only' child to have phantasies of imagined siblings (with or without the 'ghosts' of her parent's 'nursery'). It is part of every child's development that sharing is to be negotiated (Klein, 1946). Every child will have unconscious wishes to 'kill' off imagined rivals. It is what allows us to see what resource is of value (Arlow, 1972). I wondered if there were times when Carol's sense of competition masked a feeling that I picked up on in the transference, that of inferiority.

"I don't know, but I would have probably compared myself to them. I do wonder. But I do, you mean, especially if it's another girl. At least with a boy, I mean I have a cousin he was five months older than me and ehm, were chalk and cheese but we get on, ehm// but in some ways I am kind of grateful, because he is very different to me. And I think, in some way that helped me a little bit. If he became a super athlete or he was like a huge business successful man I would feel inadequate. And you can't really say these things aloud because you sound like a jealous person (laughs)".

Throughout school, Carol described feeling inadequate in comparison with others:

"Not being perfect I suppose. Because even though I could go to this private school and I had everything that I wanted, we weren't rich and my parents, you know we didn't have like, ehm /, you know, four holidays in a year. Like a lot of my friends… My friends were great, they were very, very brilliant, but they also were a little bit different to me"

I wondered what this perceived inadequacy may have felt like for Carol and how she may have defended against those feelings as a teenager. *"I started taking laxatives the first time. So, ehm, the kind of // It started off as ehm / a way to /// be lighter and more streamlined or something, so you know it was that kind of thing."*

Carols eating could be understood as a vehicle to excellence. Perhaps in 'streamlining' her body she may have unconsciously reduced her feelings of inadequacy by becoming 'better' at sports. Success may have helped Carol to cope with difficult feelings and perhaps has been the language in which the family communicated. This made me wonder how the family spoke about 'failure' or 'losing'. Carol said that her family had not managed to find a way to talk about her parents separating, and the three of them remained slightly disconnected and focused on their own 'life'.

"We all kind of / went off our different ways. My dad moved out, my mum threw herself into work and ehm I threw myself into / sport and school and stuff. So we didn't really interact that much. Ehm.

I: It sounds like no one really wanted to talk about that?

P: No! My mum doesn't. My dad, my dad, you know, 20 years on or whatever, it's kind of a bit. It's still a bit difficult because I think they feel a bit guilty themselves."

As Carol did not have any siblings to share these feelings with, she was left to carry the burden herself. This made me wonder if Carol survived difficult experiences by channelling her feelings into productivity or competition to perhaps avoid a sense of loneliness.

"*Yeah and also I think I throw myself more into it. So, I became very, very focused.*

I: Was that when your mum and dad were separating?

P: Yeah, well I tried not to think about it. And, ehm, again I think that was when, ehm, // that was yeah, when I was bulimic then. Ehm / And I think I was, ehm, desperately trying to / I did feel quite lonely I think, but I wouldn't talk about it to anyone. And like, the girls… My coach didn't know, the girls didn't know, my school didn't know. But also I felt a bit ashamed, you know. Not being perfect I suppose."

Carol's eating difficulties and competitiveness could be understood as a pseudo independent way to perhaps cope with difficult feelings that there may not have been a space for. Carol herself was mindful of what she may do to cope and how that may need to be thought about in relation to Connor.

"*Connor and I we went to, go to swimming lessons just for fun, as he is only two. But I have to remind myself that he is two. Because there are times when I think to myself "why isn't he getting it". And it's almost kind of come on!!, am I d a f t, you know? It's just letting him find, you know, to be honest he might not even enjoy it. We might get to next year and we like, you know, we scrap that and try something else"*

4.8.3 Muscular tautness.

4.8.3.1 Hard surfaces.

The home was full of hard surfaces that were not dissimilar to the muscular physique that Carol presented to the world. It made me think of the way that I had been taken with surface appearances when I first met with them both.

"She looked a healthy weight and was very attractive. Carol was slim build about 5 ft. 6 with dark straight hair. Her makeup was subtle and complimented her features. She looked toned/muscular" (1st Infant Observation).

The hard surfaces that they played on reminded me of two things; firstly, my experience of being with them in their environment left me craving something soft, and secondly comforting and 'breast' like. This 'breasty' feeling was something that Carol rejected.

> *"So, ehm / it was difficult in kind of come to terms of it. And obviously my chest got bigger and I didn't really like it. Ehm, which a lot of ladies do like to have big chest, but I was so used to not having that. And also in my head it was seen as something of being a bit overweight".*

I wondered if Carol had ever been frightened by her own hunger for more, whilst maybe not fully knowing what 'more' was. These questions circled my mind when Carol spoke of the association between 'big chest's' and the 'overweight' greediness of others. In a way, to understand Carol's complex relationship with food, I wondered if Carol did not need to eat as much then maybe she did not need to rely on food (others) as much, perhaps possibly denying her need for nourishment. In this way Carol could look after herself in a way that did not rely on others being emotionally present.

Secondly, the hard surfaces that Carol and Connor played on reminded me of my experience of the ‘surface’ level interaction that was difficult to engage with during the observations. It was hard to absorb myself in either Connor or Carol, in much the same way that they were not able to be absorbed by me as well as any meaningful activity together.

> *This difficult dissatisfaction could describe the second observation as there was something striking about the hard-jagged surfaces on which both Carol and Connor played upon. It left me craving something soft and squishy and containing. The observation was marked by a lack of absorption; Connor could not ‘get in to’ any toys or activities in the same way that I could not ‘get in to’ Connor. There was not much of a sense of who these two people were, there was hard surface level interaction but a real difficulty trying to feel beyond that. (*2nd Infant observation*)*

4.8.3.2 Muscular skin.

The muscular tautness of Carol could be understood in the context of a containing muscular skin, where the process of internal containment may not have been present as often as needed. The infantile experience of the mother containing the baby’s internal distress leads the baby to develop a ‘psychic skin’ which can be felt to hold the internal parts of the baby together. If this process is disrupted, the baby may resort to developing its own ‘second skin’ defences (Bick, 1968). In this case, Carol may have had to develop an omnipotent pseudo-independent way to protect herself, using muscular tension to hold the self together and prevent a feeling of internal disintegration. Perhaps for Carol eating very little was a way to unconsciously create a thin visible outer layer of containment and maintain a feeling of control. Perhaps as Carol’s weight reduced, her skin may have appeared increasingly taut and

sinewy, and this concrete containment may have been how Carol survived difficult emotional experiences. This defence could have developed when she did not feel as emotionally safe or held and continued as it became an effective way to cope. *"I struggled, I kept it all together, but on the inside ...."*

This may have been in some part the attraction towards physical sports which allowed her to maintain her muscular defence. In much the same way as running builds strength in leg muscles, exercise could have become a way to build strength in Carol's second skin defences. When Carol struggled with the adjustment into motherhood, she had her muscular surface 'second skin' to contain her. *"... he was just a baby, just slept and cried and ate. We would go out all the time. Like we would just walk. That was my release that was my escape".*

4.8.3.3 Busy.

Throughout the interview and observations there were references to 'being busy', Carol and Connor were constantly on the move. As soon as one game/toy was unpacked, Connor wanted to move on to another one. Nothing seemed to hold his attention for a great deal of time, and Carol herself followed him through the observation in this way. This also included reports of the weekly routine outside of observations.

Carol was talking to me the whole time explaining that she likes to be busy and so does her husband, Connor's dad. They are always doing something and perhaps Connor gets this from them. Carol then tells me that perhaps her husband will paint around the front door and side wall and points to show me what he will be doing at the weekend. 'there is always

something to do' and I get the impression that she likes that about both her and her husband (1st Infant Observation).

This seemed to suggest that keeping still was very difficult for anyone in this family, perhaps for Carol and Connor in particular. When Carol was pregnant and unable to 'do' as much, she found losing her muscle tone quite difficult. Carol was familiar with the concept of working to maintain muscle tone, and being 'busy' and 'doing' could be a way to keep the second skin flexed and toned. However, when she was still, the muscular skin slackened and lost its hard tautness and this could invite a feeling of boundaries slipping and spilling out and perhaps lead to Carol feeling out of control.

4.8.4 Toughening up.

Connors play was 'boisterous' in nature and the volume of play and 'crash' and 'bang' overwhelmed me. Noise needed to fill every second and it appeared that there wasn't anything that could hold his attention for long. Carol followed Connor around and made available activity after activity as soon as Connor became disinterested. This made me wonder what Connor was feeling.

Connors play is loud with banging and emptying things on the floor, he does not make a great deal of noise but the way he handles toys in a way in which they do produce a lot of noise. I wonder how much Carol can deal with every day during the week. I cannot decide if it looks destructive or absent minded or a mixture of both". He [Connor] starts to run from the front door to the back door running and screaming. It is very loud. His scream and running seems to fill me up. (1st infant observation)

It seemed important for Connor to have constant visual and auditory stimulation. It's possible that moments of disconnection from Carol meant that Connor found containment in these inanimate objects.

There was one moment on the floor where mum was helping Connor to play with a wooden bus, and it had wooden figures that went inside. it was only fleetingly but Connor was annoyed with Carol for doing something and it was only a slight grumble and 'uh' from Connor, but Carol withdrew from him immediately, not frightened of her toddler but perhaps frightened by his displeased response to her. It was as if Carol felt in Connors mind she had faltered in some way as his mother. It was only subtle and I could have missed it, but it gave me a glimpse of something I wanted to know more about (1st Infant Observation*).*

In moments of experienced stress, it could be difficult for Connor to learn about his own sense of himself through his mother. In this situation, Connor could be developing his own 'second skin' through a 'toughening up' of external layers. Perhaps not yet a fully established second skin, which for Carol is muscular in nature, but a tough outer barrier none the less. This barrier around himself could help him feel held together. For Connor, the tough skin that could be in its developmental stages seemed to prevent others from knowing him. This was very much the sense I had of Connor. I felt like I could not know him during our interaction.

I am not overly aware at this point of why he is doing this or what is going on for Connor (1st Infant Observation).

*There is a level crossing that Connor stops his train at. Carol tells him to open it so that the train can get through, and Connor seems content to keep the train blocked. This seems significant as it is a repeated part of the game for Connor, but I can't quite grasp what is not being let through? I can't quite make sense of it (*2nd Infant Observation*).*

This 'toughness' could help Connor to resist others projecting feelings into him. Throughout the observations, Connor appeared happy and joyful in the activities that he was doing, uninterested in either of us. Bick spoke of 'rhinoceros hide' defensive process that could keep the fear of disintegration at bay by forming an impermeable shell around the self. This would be seen as the initial stages of second skin formation. Like all defences if this becomes entrenched, the dependence on the maternal containment is given up and replaced by a 'pseudo-independence'. During this process the infant seeks containment through visual or auditory stimulation from inanimate objects, which appeared to be the case for Connor.

Although I suspect that both Carol and Connor rely on second skin defences at times, it is important to note, that we all do. Carol and Connor were a mother and son who welcomed me into their home and showed me parts of who they were, separately and together. It was a deeply humbling experience to witness their shared time, and I left saddened that I would not get to spend time with them again.

4.9 Interweaving Stories

Once individual pen portraits had been completed, they were considered collectively. The following joint themes emerged, which will now be considered.

- The emotion of food
- Difficulty of relationships

- Despite the odds
- Physical spaces
- The tiger that came to tea

4.9.1 The emotion of food.

It seemed that across all three pen portraits food had become intertwined with emotional relationships, and this was consciously acknowledged in the mother's teenage years. Angela, Brenda and Carol spoke of their relationships with food as having been quite consuming and acutely present at times of significant loneliness in their lives. This suggests that for each Mother, there were relational components to food and links could be seen to those that fed or didn't feed them emotionally. The symptomology that the women experienced could perhaps hold the relational context in which each mother's needs were met or dismissed as infants. This might mean that their eating disorders were disorders of need with the physical act of feeding becoming a metaphor for emotional attachment. This fits within the conception of eating disorder's presented by the psychoanalyst Petrucelli.

> *"In which, wanting, longing, hunger, and the vulnerability of reaching with one's appetite toward the world of others has been subverted. Eating disordered patients remain mythically haunted and psychically alone. They live between two worlds: the world of food and the world of people" (Petrucelli, 2015, p. 181).*

Given the Mother's primary relationship to food, it was interesting to think about the emotional interaction that food played between each mother and toddler. For Angela and Amy, their first 12 weeks together were breastfed.

"It was more a nurturing thing. I know I have to, got to eat this because she needs that to have in her milk. For the first time in my life I was probably genuinely hungry. Because this is one thing you lose. Even now I am never too hungry. It sounds weird, it's not normal to me ... and even when I was pregnant and because you don't eat so much more, I was never "Oh my god I am starving". When I was breast feeding I was: I need food now, give me food now".

This made me wonder what part of Angela was stirred into action during this time, as her ability to join Amy on an emotional level was greater than her need to be consumed by her preoccupations with food. Angela's hunger could be seen as a primitive unconscious reminder of her own need as a baby when faced with breastfeeding Amy. Perhaps Angela experienced herself and her body differently being able to answer the needs of Amy rather than solely as a representation of dissatisfaction. For the initial phase of the feeding relationship both Angela and Amy were free to be hungry and be fed, and this could be seen in the attunement of the ways in which they mostly related to each other. There were moments, when food was introduced, when it became something in between and caused their attunement to falter. In those moments both Angela and Amy became confused and out of sync. Despite this they had developed enough of a comforting rhythm of calling and answering to one another that was a pleasure to witness.

For Carol and Connor, like other mothers and infants, feedings started in a tricky way.

"I was breast feeding him, but I was rubbish like, you know. (Sighs) I was talking to my sister in law the other day and I said "all that pressure, why do I listen to people?" You know, because you do. If I am lucky enough to have number two, ehm // I won't care. Well, just do what, but you know at the time you think "I need to breast feed" (in a higher voice). So, ehm, I think I felt like a failure. I got mastitis in both

breasts. It was horrific. And ehm, (talks to child). Ehm, you know all these things happened and it was… it was the worst, I am not just saying this. I actually thought I was dying. Because, you know, I was a crap patient. But everything hurt, my bones hurt and ehm// my mum actually had to come and look after me. At the end I was like: "I need my mum". So she came and she looked after me and obviously Connor.

I was struck by Carol's sense of failure in what was a difficult, however not an uncommon experience. There was a physical barrier to Connors' calls being answered in a certain way. However, I also had a sense of not being able to fully get into either of them. I wondered how this impacted her sense of being a new mother and how this experience may have interacted with her own primitive unconscious infantile feelings, I was left curious about this as well as about many other questions that were left unanswered. This made me think about how hard this might have been for Carol and yet, she stuck with Connor and they found a way to be together. It was a tricky beginning, however the 'patient' relationship persevered.

4.9.2 Relational difficulties.

If food and eating can be seen as relational in nature, it is then unsurprising that women with ED may find aspects of navigating relationships tricky. One aspect that mothers in this project identified as difficult was separation and loss. All three mothers spoke about overwhelming feelings of separation and loss in relation to their own teenage experiences and all three seemed to have held difficult feelings inside without a mind to adequately understand and process them. For Angela, she had a separate teenage life, away from her peers and missing a series of milestones that would have followed the 'normative' process of separation in late teens to university/work. Brenda experienced a great deal of emotional pain

navigating life against the backdrop of her parent's separation and despite her best attempts could not quite manage to connect the imagined idea of her father to the reality of living with him and his wife. Carol also struggled in the context of her parent's separation and this unfortunately allowed separation to weave itself throughout the whole family.

Klein (1952) drew awareness to the impact of separation in an infant's life, beginning with birth itself and then weaning from the breast (or bottle). This is thought to be a difficult time for all babies and the confusing and difficult feelings of separation can and most likely will arise at different stages of life. The containment of the infant's anxieties around separation facilitates the infant to develop their own capacity to contain themselves and their feelings. However, Angela, Brenda and Carol's narratives were marked by a lack of containment within themselves. This was seen particularly by Angela and Brenda voicing a sense of 'not knowing' what was real or not, what was inside them or outside them, or when Carol struggled to articulate what was going on inside of herself during her school years. The difficulties with separation and loss that each mother experienced were paralleled in their toddlers. As toddlers aged between 18-24 months, Amy, Bobby, and Conner were in the developmental stage where separation was a key task for them (Balaban, 2006).

I wondered whether the Mother's early life experiences would be reinforced or contradicted by the experiences of separation that they were in the process of with Amy, Bobby and Connor. Each mother may have had feelings of anxiety in the context of their own early experiences of separation which were stirred awake when all three had the task of negotiating separation from their toddlers. Despite doing something different, each mother may have tried to unconsciously alleviate the intensity of the internal anxiety of the past combining with the present. It seems that this may have resulted in each mother coping with separating from their toddler, using similar or parallel coping strategies to those used to their own early life separations: From six week's Angela started returning to work and by six

months she was working full time out of the house suggesting a way of coping through busyness and withdrawal from the full time primary care role. Brenda had continued breastfeeding and kept Bobby close to her., sleeping with him (and her other children at night), thus managing separation by delaying this as long as possible. Carol spent all of her time with Connor but both kept physically and psychologically 'busy' in their own activities, perhaps coping by avoiding too much psychic closeness.

The difficulty of separation was also paralleled within the researcher once the study was over. There were strong feelings of loss and sadness experienced after leaving each participant, and at the end of the project.

> *It is with great sorrow that once this study is complete I would in my mind have to say my goodbyes to the mother and toddlers that had consumed me for almost three years (*personal reflections*).*

4.9.3 Despite the odds.

The literature suggests that women who experience difficulties with food can find conception to post-natal motherhood at best daunting and at worse severely problematic (Micali,& Treasure 2009), with the focus on emotional and wellbeing deficits in both mother and child. However, this was not what was found in this study. It is without a doubt, that experiencing an eating disorder had a negative impact upon each participant and resulted in a series of stories that they will carry throughout their lives. However, this project encountered three mothers who had battled and struggled against themselves and had, despite the odds, been able to create and maintain functional and meaningful relationships with their toddlers.

There were no emotional deficits observed in the toddlers that could meet any threshold for clinical services. Developmental milestones for each toddler had been met and their social and emotional functioning seemed appropriate and healthy. This has to be seen in the context of the mother's difficulties that weighed heavily on their minds, with each mother voicing worry about the impact of their experiences on their children. This in itself could be a protective factor. The networks around each toddler were extensive, involving fathers, grandparents and/or siblings. All three toddlers had contact and involvement with other children, either in nursery provision or child care arrangements. These extended networks may play a significant role in mediating the life experiences for these toddlers and as a result the influence of others appeared to contribute to a rich and social experience for them. It is beyond the scope of this project to suggest the extent of this mediation.

For the three mothers in this project and to varying degrees, when food was in between them or represented something of their bond with their toddlers, something was temporarily stuck in their relationship. This project used the idea of Sterns (2002) 'Missteps of the dance' to think about these pauses in their togetherness. It was in these moments that there were hints that this is where things could feel difficult. Yet in each instance the stuckness was repaired and this illustrates Winnicott's concept of the 'good enough' mother (1956). This research highlighted the normalcy present in these mothers and toddlers and how, despite a great number of challenges, they were successfully negotiating a way to raise their children. Each mother spoke about their worries and yet from what was observed, these worries were largely unsubstantiated.

4.9.4 Physical spaces.

4.9.4.1 Homes.

There were different levels of understanding to the theme 'Physical spaces'. Initially there were the physical homes that I entered. Each home could be seen as a part of the mother and toddler dyad. For example, Brenda and Bobby's home was relaxed and 'lived in' with a sense that anything could go anywhere and life could continue. In some respects, one could feel a lack of structure or organisation and this made me think about the way I felt Brenda could 'spill out' during the interview. Yet in contrast, Angela and Carol's homes were neat and ordered and there was a sense of reservation when being with them. I experienced Angela's home as tidy and this preference for cleaning away mess had been observed in the interactions between Angela and Amy's play. In addition to this, within Carol's home, hard surfaces became a significant theme within their pen portrait. It is not unsurprising that the experience of being with each mother and toddler was reflected in the physical spaces that surround them. However, it does reflect a consistency to the findings.

4.9.4.2 Pregnancy.

Each mother's womb was occupied for a period by their toddlers. The physical space that the growing foetus occupied was a difficult experience for all three mothers. Angela found the first trimester exceptionally difficult and up until she was visibly pregnant struggled a great deal with feeling overweight. Carol also found the changing shape of her body challenging, as the more socially enforced ideals of motherhood (soft and full breasts) were negative for her. Whereas for Brenda the entire pregnancy was marked by intense anxiety which continued into her postnatal period. The physical spaces that Amy, Bobby and Connor occupied in Angela, Brenda and Carol's bodies were the beginnings of their relationships. Despite all mothers reporting excitement at their wanted pregnancies, one

cannot help but wonder at the unconscious ambivalence that may have reached beyond this beginning and into the post-natal period.

4.9.4.3 Skin.

In the pen portraits, the concept of a psychic skin was applied to mothers in the ways that they individually found a way to cope with their experiences of the world, both inside and outside of themselves. Angela may have utilised a 'busy' skin that was tidy and efficient, and this was not dissimilar to carols 'taut' exercised skin. Brenda's permeable looser fitting skin could be a way to keep others close. The physical skin that they may each have relied upon to hold them psychically together is a way to understand the need for a physical container. This can be thought about in terms of coping strategies that were needed and unconsciously utilised to function and navigate the world around them.

4.9.5 The tiger that came to tea.

"Psychoanalytic literary criticism does not constitute a unified field. However, all variants endorse, at least to a certain degree, the idea that literature ... is fundamentally entwined with the psyche" (Surprenant, 2006, p. 200)

There have been quotes weaved throughout this project in line with the use of literature within psychoanalysis. This follows the idea that literature can represent the inner most workings and desires of our unconscious. In keeping with this tradition and to situate this project findings within childhood experiences, the children's story "The tiger that came to tea" (Kerr, 1968) is used.

In the Tiger that came to tea, a little girl, Sophie, has tea with her mother in the kitchen. There is a knock at the door and there is a tiger that comes in and eats and drinks all the food in the house. He even drains the taps of water. The tiger eventually leaves, and Sophie's father returns home and seeing the cupboards bare he suggests that they go out for dinner. Despite the next day stocking the cupboards with tiger food, the tiger never returns to Sophie's house again.

This book was written by Kerr, who grew up in a fearful Nazi Germany. Rosen also a children's storybook author, suggested that the tiger in Kerr's book could be interpreted as a metaphor of her past - an underlying threat that could rob Kerr's family of everything they own and disrupt the comforting daily routine of a little girl's life (Wallis, 2013),. After spending time with Angela, Brenda and Carol, this book came to my mind. The tiger in relation to these mothers and toddlers could be used as a metaphor for eating disorders. A strange and greedy entity that could come into a home and rob the mother's and toddlers of everything that they need to survive. The tiger in the story is a friendly tiger, yet it is a tiger nonetheless and in this sense conveys the potential danger that eating disorders present.

This made me wonder about the fear of what the tiger (ED) represented for Angela, Brenda and Carol as all spoke of a worry that their toddlers would 'pick up' on their difficulties. In their deepest fears could Amy, Bobby and Connor become little tigers themselves? Like the tiger, the mothers' ED had been all consuming and had robbed their lives of many experiences and at times leaving their psychic cupboards bare. Their lives had now changed and they all had little Sophie's of their own. However, when it was time for tea or togetherness there were hints at something under the surface. Perhaps an eating disorder disguised as a tiger that for a moment comes between the mothers and their little 'Sophie' toddlers, threatening to consume everything.

It is probable that like the mother in the story who said: "I don't know what to do?", the participants had times in which they may have felt without hope or perhaps overwhelmed with their own thoughts about food. Yet a mediating influence is "daddy", who returns home from work and suggests that Sophie, her mother, and himself go out for dinner. This made me think about the impact of the fathers in this study. All mothers were married and lived with their husbands. The fathers played a significant role within the family structure and would have daily contact with the toddlers. Just like the story when "daddy" comes home and takes Sophie and her mother away from the empty kitchen. I wondered what impact the fathers had in Amy, Bobby and Connors homes. Did their daddy come and intervene in difficult moments too?

Angela, Brenda and Carol were living with their own tigers that had in the past been exceptionally dangerous to them and their families. However, despite the odds these mothers had learned ways to tame their tigers and were able to live alongside one another. There may be times that their tigers come between them and their toddlers, but it seems that these were just moments and the relationship recovered quickly. Their ability to do so is a testament to the strength of the relationship.

4.10 Overview

This study sought to explore the relationship between three mothers with eating disorders and their toddlers. In this section the aims of the study will be revisited and in doing so, provide a summary of the key findings that have emerged. The findings will then be considered in relation to existing literature before discussing clinical relevance. Following this, methodological reflections will be presented before implications for future research. Finally, this study will conclude with my personal reflections.

4.11 Summary of Findings

How do mothers with an eating disorder diagnosis and their toddlers relate to each other?

Each mother and toddler had a unique and particular way of relating to one another, which showed something of the story of their lives together. Angela and Amy had a relationship that was in tune with each other for the most part of the observation. There were aspects of taking in something good for both when they were together and this could be seen as a protective factor when considering the losses that they had to endure as a family. There were however moments, where the pair of them lost touch momentarily around food and feeding. Angela perhaps felt more capable as a mother when she was able to be busy and 'doing' as opposed to 'being'. Despite all that they had experienced they kept going and that was essentially through Angela's determination and perseverance.

Brenda and Bobby's relationship could be described as an adoring relationship where Bobby was revered as a miracle baby. Brenda's early life had been exceptionally difficult and Bobby as well as her other children, were part of something restorative. Through this, Brenda could be filled up again with love. Whilst she was with her children she felt comforted and good, but found it very difficult as her children grew up and moved out. Eventually Bobby will need to separate from Brenda and this is where I had to leave Brenda and Bobby, finding their own way in the next steps of his development.

Carol and Connor's relationship illustrated the unrelenting patience that a loving mother requires, especially with an energetic little boy who was curious about the world. Carol brought to her relationship with Connor a need to do well. Through using exercise and activity she could continue being the mother that Connor needed.

Each mother had been able to adapt to her toddlers needs and together they found ways to relate to one another, despite the backdrop of eating disorders that all continued to struggle with. Whilst the mother's stories of food cannot be denied it is also not all of their identity and each were able to form, maintain and repair a relationship with their toddlers, demonstrating the ability to overcome the feared parenting deficits often focused on in the existing literature.

What impact, if any, do eating disorders have on how mothers and toddlers relate to each other?

The mothers in this study all lived with eating disorders that had had a significant impact on their lives. As outlined above, all Mother's found ways to establish and maintain a relationship with their toddlers. Their difficulties with eating did however impact upon their ways of relating with their toddlers. This could be best understood by the concept of 'psychic skin' which can be understood as a second skin that develops as a way to provide the self with a way to contain difficult experiences. Angela's previous history had enabled her to develop a series of coping mechanisms that kept her going. Her second skin could be thought of as a way to keep her confusing 'messy' feelings inside, and not spill out in her conscious awareness. This also mimicked patterns of eating and controlled food intake to avoid the messiness of losing control that she may have felt when she over ate. Whilst the productivity seen in 'busyness' may have led itself to keeping Angela feeling together or on top of things, there was also a limited tolerance for 'messiness' in her and Amy's physical and perhaps emotional environment.

Brenda's psychic skin could be visualised as an emptier, or loser skin, that may not always hold her in a containing way. This permeable layer may allow others to know her and be known by her quite quickly. However, my experience of Brenda was that it could at times

be difficult for her to hold on to feelings of containing 'good' objects. This could be seen as reflected in patterns of eating, a constant hunger for closeness (food), that is never satisfied. Whilst this made room for an ease of feeling comfortably relaxed and 'snuggled' with others, particularly her children, it made holding them inside mentally during physical separation quite difficult for her.

Carol's psychic skin was not dissimilar to Angela's, in the sense that a busy 'taut' skin kept things feeling outwardly manageable. This allowed Carol to be an extremely successful athlete and push herself to compete at a high level. However, for Carol this skin may have been inflexible or rigid. This could be experienced to some degree when observing Carol and Connor being together, as there were times when it felt that they were unable to fully immerse themselves in each other or the researcher.

The intergenerational influence could be seen as similar to the concepts highlighted in "Ghosts in the nursery" (Fraiberg, 1975), where every mother and infant will be visited occasionally from ghosts of the past that may manifest in a moment or interaction from previous relationships. This study could suggest that there is room for ghosts in the kitchen as well as in the nursery for mothers with eating disorders.

Like all mothers with toddlers, there were moments of tension that arose. For these three mothers and toddlers it was around taking something in, normally around food. It was in these instants where flashes of indecision or the pair becoming momentarily out of sync with each other. A way to understand this phenomenon would be what Stern (2009) called 'Missteps of the dance': .

> "The infant is a virtuoso performer in his attempts to regulate both the level of stimulation from the caregiver and the internal level of stimulation in himself. The mother is also a virtuoso in her moment-by-moment regulation of the interaction. Together they evolve some exquisitely intricate dyadic patterns. It takes two to create

these patterns, which sometimes look ominous for the future course of development and sometimes look quite effortlessly beautiful." (Stern, 2009, p. 133).

Both mother and toddler have an established pattern or rhythm with each other and occasionally this is thrown out of sync. For Angela and Amy a misstep could be seen when the choice of food became overwhelming and confusing. When Bobby is content in his separation from his mother, sharing is introduced and he quickly becomes distressed and returns to his mother's breast for comfort. Finally, for Carol there were glimpses of how painful it may feel for her when Connor becomes momentarily displeased with her or what she provided during play.

Perhaps the toddler is encountering a new developmental stage or struggling to leave one behind. Perhaps the mother herself is preoccupied with her life around her child. For whatever reason, there will be moments that the flow of the dance of togetherness is interrupted. Again, it is important to note, that all mothers (all individuals) develop unique ways of coping with life and navigating their experiences. It would be overwhelming and perhaps unhealthy not to have ways to survive difficult feelings or situations. In this sense, these may be some of the ways that these mothers, through their relationships with food had come to navigate their worlds.

Which concepts in psychoanalytic thinking best make sense of the intersubjective process between mothers who experience eating disorders and their toddlers?

Psychoanalytic thinking on the development of an infant's mind and awareness of others (Waddle, 2013 was applied throughout this study due to the focus on the interaction between mothers and their infants, in order to understand the deep and complex relationship that each contribute to. In this sense, the additional facet of eating disorder diagnosis became

irrelevant. Theory from this discipline seeks to understand the relational components present and uses the processes that occur between each mother and baby to provide a context for future patterns of relating. In this instance, food and feeding being a primary stage of being known by another mind and for this reason Klein's theory of object relations was a helpful way to conceptualise the relationship of mothers with ED's and their toddlers.

As illustrated in the theme's above, Bick's (1968) concept of second skin has been key in understanding each mother's early experiences in the context of difficult or absent relationships and the ways in which eating was used for each to negotiate separation or absence. In understanding the defensive structures that each mother developed to manage their adult relationship with their own children, Klein's (1952) concept of 'introjection and projection' has been key particularly with difficulties around feeding and being fed. The reality of inevitable imperfection in mothering was later developed by Winnicott's idea of 'good enough' mothering, and this helped to understand the robustness of the relationships observed. Sterns (2002) 'theory of missteps in the dance' has also been important to understand the particular difficulties that were seen and felt when observing the relationship between mothers with ED and their toddlers.

What do we learn from using a multi-method research design?

This project utilised a combination of methodology which was a non-traditional approach to qualitative research. This way of conducting research assumed, that unconscious processes occur everywhere and not just within a clinical setting and that through sensitive receptivity the relationship between mothers with ED and their toddlers could be to some extent captured and represented.

This projects methodology used triangulation of data for a number of reasons. Primarily to strengthen the findings gained and also to apply multiple perspectives to the

same subject of interest which, in this case, were mothers with ED and their toddlers. In using observations and interviews, this study could collect a more comprehensive picture of the relationship between mothers and their toddlers. It could also provide greater insight and verification of data that was supported by both observations and interviews and in keeping with the critical realist epistemological stance of this project.

What we learn is that research and indeed clinical applications of research can be as creative and as multifaceted as mothers themselves. Psychoanalytic research methods teamed with psychoanalytic theory can provide authentic and robust findings. Research carried out in this way can transcend symptom and deficit identification and highlight the complex processes that may take place in relationships that go some way to contribute to existing literature.

4.11.1 Situating the findings.

The results of this study were presented alongside psychoanalytic theory in order to provide an interpretative frame through which to understand the findings. This section will build on this by returning to some of the literature identified in the introduction to consider where the findings from this study sit within the current literature base.

4.11.1.1 Pregnancy.

Previous research on conception varied for women with an ED and suggested, that women with a diagnosis of AN or BN were more likely to have unplanned pregnancies (Easter et al, 2011). The results of this study go some way to support that argument as two out of the tree mother's pregnancies were unplanned. The findings in this study reflect a

deeper sign of ambivalence in becoming a mother and could be a sign of apprehension due to perhaps conflicting feelings around need and nurture. The quantitative literature study suggests pregnancy fears may be due to imminent weight gain (two of the three mothers experienced this). All three mothers in the current study reported difficulties with mood during their pregnancy. This included low mood, pre-occupation with weight gain and high levels of anxiety, what does resonate with existing research in this area (Micali 2009, Kimmel 2016). However, this study's findings go further than to confirm the presence of these symptoms. It provides a context for the mother's experience, including the experience of a significant bereavement and fears around miscarriage.

4.11.1.2 Outcomes.

All toddlers were born from caesarean section. This fitted with literature, that suggested that women with an ED diagnosis were more likely to have a C section (Bulik, 1999). However, the qualitative experiences surrounding the mother's C sections highlighted traumatic deliveries. This warrants greater attention and investigation as this was an unexpected commonality between the mothers that took part. It would also have marked a beginning for the babies in some way and this may provide an additional reason to explore this further.

4.11.1.3 Postnatal period.

The mothers in this study did struggle in the postnatal period, as literature suggests, with mood (Linna, 2014) and a resurgence of their ED behaviours (Fairburn et al., 1998; Broussard, 2012. However, the quantitative literature should be interpreted with caution as it was difficult to ascertain whether this was entirely due to having an eating disorder diagnosis

or other factors that may have contributed. All three mothers in this study spoke about the recovery from their exceptionally difficult deliveries, and although no formal measures were used, their stories seemed to depict traumatic births. In addition to this, for these women the postnatal period had further difficulties. Angela was bereaved, Brenda required the support of perinatal mental health services and Carol had physical complications after the birth. These individual experiences illustrate, that despite physical and mental health difficulties postnatally these mothers found a way to cope with their new additions to the family.

4.11.2 Clinical relevance and implications.

This study situates eating disorders within a relational framework, focusing on the internal representations and repetition of earlier attachments. Therefore, the clinical implications put forward will focus on the practical applications of a relational imperative. This research proposes a two-tiered model of recommendations. The first two suggestions make no distinction between mothers with mental health difficulties and their non-clinical counterparts. This acknowledges the challenges that are present in the transition into motherhood for all women and goes some way to normalise this process without contributing to deficit focussed rhetoric.

4.11.2.1 National perinatal initiative – first tier.

4.11.2.1.1 Training for healthcare professionals.

For all women, especially those who have lost touch with their own hunger, suddenly using their bodies and minds to feed another could feel difficult. Postnatal care from hospital during the first eight weeks recommends mothers to breastfeed (NICE, 2015). Yet there are no recommendations for the emotional difficulties that may arise either during this or in the

decision to stop. This research found that for the mothers that took part in this study food could be tricky. An increase of psychoanalytic infant development training, in particular around feeding, would enable experienced midwives and health visitors to situate their existing knowledge within a relational framework. Professionals could then mirror the feeding relationship and 'feed' mothers with the resources they may need emotionally. As a consequence, mothers could feel more contained as they got to know their infants mind.

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4.11.2.1.2 Community provision.

For the mothers that generously took part in this research there were moments where their rhythm with their toddlers had to tolerate connection and separation. It wasn't always easy for them to do so. As a result, it would be helpful to develop 'wellbeing' classes that focus on this 'bonding dance'. Space within this program could be given to the inevitable missteps of the dance that they will encounter. This provision could be facilitated by collaborating health professionals so that greater access to early interventions and referral pathways were available to those families that were identified as requiring additional support. This may be the first opportunity for some adults to think about their own attachment history in relation to the developing bond with their own child. This clinical implication could offer a level platform, so that each parent is offered the best chance of success in their relationship with their child.

4.11.2.2 Clinical interventions - second tier.

4.11.2.2.1 Therapeutic work.

For some mothers, first-tier provision will be sufficient to increase awareness and encourage the primary relationship to flourish. Perhaps others may need additional support.

This can be seen in second tier recommendations. For a mother with an ED diagnosis in the perinatal period NICE guidelines suggests 'providing nutritional guidance' before, during and after birth (NICE, 2014). This seems to over simplify the difficulties that mothers may experience and fails to acknowledge the relational context. The mothers in this research were aware of the food that they 'should' and 'should not' put into their bodies during that time. Therefore, simply providing more information would have been a waste of resources. Perhaps this could be developed further with low level therapeutic work, carried out at mealtimes. A mentalisation framework could be applied, when working clinically with mothers and their children. This would arm mothers with the skills needed and be a timely alternative to a deficit based model when thinking about ED's in motherhood. This could also be seen as a provision of non-judgmental 'mealtime clubs'. This could be a place where facilitators could model appropriate portions and snacks for parents so that the experience of not knowing hunger can be gently addressed as perhaps part of therapeutic intervention.

Firstly, it is essential that non-blaming attitudes prevail in the recommendations of this research project. As the Academy for eating disorders position statement suggests family involvement seems to reduce both the psychological and medical morbidity of short term sufferers of eating disorders. In reflection of this study's findings it may be helpful if this suggestion be carried forward in eating disorder interventions for adult sufferers. A clear recommendation is to invite (where clinically assessed) husbands, partners, parents and children into the therapeutic space. This may be intermittently, and with a carers support model as highlighted in Treasure's paper 'Working with families of adults with anorexia' (Treasure, Whitaker, Whitney & Schmidt, 2005).

Secondly, inclusion of children in the adaptation of carers support for adults with eating disorders would enable the developmental processes of the child (regardless of stage of

development) to be held in mind, by both the therapist but also the client in their recovery journey. This would go some way in normalising some of the client's experience of guilt that this research has highlighted.

In addition to the inclusion of children in carers support, eating disorder services could include children in the clinical interventions that are carried out with their adult clients. This would begin to address those family units that present with a higher risk of transgenerational transmission of eating disorders. Children of these families will be able to have ad hoc contact with services so that information and monitoring can occur freely. This may take the shape of multi-family group therapy, where mothers and their children can eat together with the normalising assistance of staff in an adaption of the day programme for adolescents (Dare, 2000). At the very least, the psychoeducational component of this programme, as suggested by Dare (Dare, 2000) would facilitate open discussions with families around complex relationships to food, and how that may impact on the family unit.

A final recommendation, in contrast to Dare's work, would be the implementation of Steins (2006) video interaction feedback intervention (see literature review) within adult eating disorder services would allow for clinicians to directly assess and intervene in family dynamics where there were observed difficulties. This in itself would not centre around food, where this is already a heavily loaded area of interaction. This would target the relationship in itself and enable mothers (and fathers) to have a greater understanding of themselves and how they interact with their child.

NICE guidelines (2014) also recommend CBT as the first stage of psychological intervention for ED's. This perpetuates the notion that the 'problem' is within the individual.

This research argues for a holistic approach across mental health services. This could be implemented in specialist ED provisions, where thinking relationally becomes common place and the focus is not placed solely on the mother. Perhaps family interventions within generic adult and child services could routinely include the family network and think about what happens in the spaces between them.

4.11.2.2.2 A beginning.

This piece of research has been able to demonstrate the complexity and depth within the primary relationship. The clinical implications suggested could be seen as idealistic or optimistic in an economic climate within the NHS that is restricting with every financial year. However, this does not mean that the foundations cannot begin in smaller, more cost-efficient ways. There is currently a commissioning mandate to increase perinatal provision by 2020 within the five year forward mental health plan. This could present a timely opportunity for a small pilot to create a role for a 'perinatal consultant'. This role could liaise with third sector services, GP surgeries, nurseries and other partnership work for formulation, training and consultancy. It is a far cry from a two-tier model. However, it could be seen as a contributing voice in the perinatal conversation.

4.11.2.2.3 Wider implications – All mental well-being.

This research has not attempted to generalise its findings due to the case study nature used. However, it has produced findings that could inform wider recommendations that have potential to be transferred across 'diagnosis'. This research found that the concept of second skin defenses could be used to understand a disruption in the development of a contained internal world. This finding could provide a bridge to other mental health difficulties. A

strong focus on preventative investment in provisions for children across education and care providers could be beneficial. If services could teach children to know themselves and their feelings, so that they continue to develop healthy and flexible inner psychic ‘skins’, they may have an increased chance of being able to thrive in an adult world. In much the same way that sex education is taught, there could be emotion and relational education where safe relating is promoted and early indicators for distress are identified. This could be an inoculation against a number of cases requiring the support by specialist mental health services.

Finally, this study used psychoanalytic methods of infant observations and free association interviews. The clinical relevance can be seen in the richness of the data and consistency of findings. This study was able to speak to each relationship, and this could find its implications in the therapy room. Developing observations and free association as clinical interventions of mental health difficulties could keep alive the developmental processes within an individual, which can be lost as soon as a client crosses the adolescent - over 18yrs of age threshold in services. Therapeutic sessions carried out with these methods could also highlight important areas of tension between couples/parents and wider networks, which may be take longer in traditional 1:1 therapy. However, there may be stipulations of a minimum period of time that observations are incorporated to safeguard hasty clinical judgments based on limited data.

In addition, the process of this research has highlighted the value of a non-judgmental reflexive interview process, for parental situations that may be considered in need of evaluation. The therapeutic effects of the interaction in this research resonates with areas that perhaps need developing. One such example may be in social care evaluations where the maternal sensitivity measure is often used. The conditions under which this is currently carried out may be contributing to an anxiety provoking experience for mothers who may

find that they are unable to 'be at their best' with their children. The methodology of this research may suggest an alternative way to get to know mothers and their children in a more non-intrusive manner.

It is essential that non-blaming attitudes prevail in the recommendations of this research project. As the Academy for eating disorders position statement suggests family involvement seems to reduce both the psychological and medical morbidity of short term sufferers of eating disorders. In reflection of this study's findings it may be helpful if this suggestion be carried forward in eating disorder interventions for adult sufferers. A clear recommendation is to invite (where clinically assessed) husbands, partners, parents and children into the therapeutic space. This may be intermittently, and for a carers support model as highlighted in Treasure's paper 'Working with families of adults with anorexia' (Treasure, Whitaker, Whitney & Schmidt, 2005).

Inclusion of children in the adaptation of carers support for adults with eating disorders would enable the developmental processes of the child (regardless of stage of development) to be held in mind, by both the therapist but also the client in their recovery journey. This would go some way in normalising some of the client's experience of guilt that this research has highlighted. At the same time higher risk children of transgenerational transmission of eating disorders will be able to have ad hoc contact with services so that information and monitoring can occur freely. This may take the shape pf psychoeducational contact as suggested by Treasure (Treasure, 2005) or perhaps take the form of group family therapy as Dare and Eisler (Dare, 2000) advocate for in order to openly discuss with families the complex family dynamics that each unit creates and maintains.

4.11.3 Methodological reflections.

4.11.3.1 Strengths.

A strength of this study was researching 'beneath the surface' (Cooper, 2016) of individual experience and social relationships. The lens that was applied to this research gave some recognition to the experience of mothers and their toddlers and similarly to dimensions of professional experience that lie outside the reach of our familiar research discourses. The methods chosen could access and articulate emotional engagement with the social and individual unconscious lives of both mother and toddler.

Another methodological strength was the novel combination of free association and infant observations. Used together the study could triangulate the data to increase its robustness. This triangulation and the use of a comprehensive supervision structure could support an interpretative methodology whilst still evidencing rigorous research practices. This enabled a bridge to be walked across to clinical psychology from psychoanalysis, hopefully utilising the best of both disciplines.

4.11.3.2 Limitations.

It is important to reflect on the limitations of this research project; the findings of this study cannot be generalised as they were collected from just three mothers and toddlers. It could be suggested that the observations may not be relied upon for a full assessment for the quality of the relationships between the mothers and their toddlers. Perhaps they brought their 'best' to the interaction and this may not reflect everyday life. To address this in a small way, two observations were conducted and then compared to the free association narratives.

However, in the future an adaptation to this process could allow for multiple observations over a longer period of time.

In addition to this, there was only one researcher. Whilst this afforded the luxury of being the sole consumer of the experience, which could be intimately felt and thought about, it also could be a limitation as there was no other research presence in the observations and interviews to compare experiences. It is a hope, that the supervision structure went some way to ameliorate this. The sole researcher also had a limitation on her experience as a researcher, despite smaller scale projects being undertaken pre-clinical training; this was the first incidence of a doctoral research project being conducted. Academic requirements in this sense were unfamiliar to the researcher.

In hindsight, an improvement of this study would be to collate additional background information over multiple interviews. This would provide an opportunity for each mother to explore further and reflect on their experiences fully. Although this would enrich and supplement the existing findings, it is unlikely that a new major theme would be discovered due to the nature of free association placing the narrator in control of their story.

This piece of research focused on the relationship between mothers with eating disorders and their toddlers, however all toddlers also lived in their homes with their fathers too. The absence of fathers in this study is a deep limitation. It was unfortunate that the invitation to be a part of this study was not taken up. One could suspect that this may have altered its findings, perhaps not in a drastic manner, but it might have influenced the richness of data that was found due to the added layer of relational dynamic.

4.11.4 Suggestions for further research.

This research aimed to explore in detail the relationship of a small number of mothers with ED and their toddlers. As such, and as discussed previously, these findings cannot be generalised more broadly. Therefore, the findings gained from this research may be furthered through repetition with a larger sample and for a longer period of time to track the development of the relationship in a longitudinal study. The suggested sample could be inclusive of the unique networks around the child by incorporating fathers, partners and/or extended family. Research focussed on interactions between different members of the family could build on the findings presented here. It would also be beneficial to study the narratives of parents from a more diverse range of ethnic and socioeconomic groups in order to establish a more culturally varied understanding of the impact of eating disorders on the primary relationship.

As highlighted previously, collecting narratives regarding the birthing experiences that mothers with ED have had, could highlight areas of difficulty that was not present in the existing literature. This may not only be a phenomenon for women with ED, but for women in general. Further investigation is warranted in this area. Given that all three mothers described traumatic experiences, this study recommends exploring the quality and efficacy of the postnatal aftercare that is provided. Often internal sense making can differ from the reality experienced, therefore the processes involved are justified for further exploration. Furthermore, while this was found for the mothers in this study, the experience and aftercare for all women with traumatic births is unknown to the researcher and the next steps could be a literature review in this area.

Finally, this study invited mothers who were actively seeking treatment from an eating disorder service, and therefore met clinical thresholds for inclusion. The findings from

this research provide a context of curiosity to explore the relationships of women from the general population that are health conscious and pursue active and healthier lifestyles. Even if they do not meet the criteria for a formal diagnosis, they may be preoccupied and exhibit similar patterns of behaviour. Further research which focuses on women from this population may be important to widen the understandings about bonding and the interaction with food and may inform service provision.

4.12 Personal Reflections

Coming into training with previous experience of psychodynamic training required an identity shift that I found difficult. At the time of writing, I remain unsure what the stuckness was within me that prevented the integration of these two different parts of myself. The understanding of this may reveal itself to me in some way at some point in the future or it may not. The experience of this research felt like 'wading through concrete' as I spent far too many months carrying this conflict and feeling caught between two homes. Having left a psychoanalytic home that now felt watered down, I then struggled to embrace a new and often unfamiliar and uncomfortable home within clinical psychology. Therefore, the journey, that this piece of research has been on, has been perilous, but a necessary process to create a bridge or a halfway house where I can live perhaps even free to visit each at different points

in my career ahead. This, of course, follows any doctoral student and the difficulties that can present itself along the road to completion. However, the idea of homes and where I belong became something quite internally painful. It connected to parts of my experiences that may have often felt ‘lost’ rendering me childlike and helpless in the face of perceived confidence and possibly competence too. As this project draws to an end, it is with great contentment that I can say ……I am the home that I carry with me.

Chapter 5 References

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Chapter 7 Appendices

7.1 Appendix A: Summary of Research Papers

Summary of Studies selected for systematic literature review.

Author, Title and Location	Participants	Research methodology	Summary of study and key findings	Strengths and Limitations
Paper 1 Lai & Tang (2008) "The negative impact of maternal bulimic symptoms on parenting behaviour" China	91 mothers took part in this longitudinal study ranging from 21 – 42 years old. Unclear of psychopathology (if any) of population. Women were recruited from prenatal clinics in 3 large regional hospitals From the original 443 mothers recruited at the start of the study, 91 remained by the final data collection time point. This study was part of a larger project investigating eating psychopathology among Chinese pregnant women.	A longitudinal quantitative study At time point 1 – maternal fetal attachment scale used At time point 2 – maternal psychological distress using the general health questionnaire scale. Bulimia subscale of eating disorder inventory used At time point 3 – mother treatment scale of the parental image differential was adapted. Bivariate correlation analysis was conducted.	Bulimic symptoms were associated with maternal concern and restrictiveness in the first year postnatally. Importance of strong emotional tie with the foetus during pregnancy is related to the quality of the mother infant relationship in postnatal period.	Strengths: Cultural components were discussed throughout this study, especially when discussing more western accounts of eating disorders and parenting The idea of a longitudinal study offers great opportunity when involving mothers and their children In conclusion, there was an attempt to make meaning out of the results for the reader. Limitations: Greater clarity over the original project and the implications of using same sample would have been helpful. It was a significant limitation that the same measures were not repeated through the different timepoints. The experience or voice of the participant was not heard throughout this study

Author, Title and Location	Participants	Research methodology	Summary of study and key findings	Strengths and Limitations
Paper 2 Sherkow, Kamens, Megyes & Loewenthal (2009) "A clinical study of the intergenerational transmission of eating disorders from mothers to daughters" USA	3 case studies were presented of mothers with range of eating disorder diagnosis and their toddlers aged between 18 months and 5 years. Mothers and toddlers were attending an eating disorder therapeutic nursery.	Psychoanalytical clinical case study from a therapeutic nursery. Observations and video recordings of the interaction between mother and toddler during feeding and then paly time were taken, then interpreted with the mother. Further discussion in a staff meeting after the group took place weekly where themes and patterns could be thought about more deeply.	Mothers were unable to model healthy eating habits. It was observed that there was shared ignorance, denial and confusion between the dyads of hunger. Mothers own mothers had shown indications of disordered eating Function of food to manage pervasive undifferentiated anxiety There were significant blurred boundaries between the mother and toddler The mothers were often inflexible and rigid Ultimately eating disorders were transmitted between the generations through two pathways, overtly via learning and covertly through unconscious behaviour and internalising defences.	Strengths: A strength was the emotional connection to the individual cases The presentation of the cases allowed for an emotional dimension to be given to the work Theory was used appropriately to demonstrate findings Provided an alternative way of researching a complex and intersubjective experience. Limitations: This paper was not 'scientific' in its presentation. This would make the finding overlooked by more academic researchers There was not an attempt to provide robust measures or accountability for the interpretations given.
Paper 3 Sadeh-Sharvit, Levy-Shiff, Arnow, & Lock (2016) "the interactions of mothers with eating disorders and their	29 mothers with a prenatal eating disorder were recruited with their toddlers, aged between 18 – 42 months. Recruited from 3 eating disorder treatment centres. Mothers were diagnosed with anorexia (14), Bulimia (13) and eating disorder not otherwise specified (2).	This was a mixed method design Measures included: The eating disorders inventory and the brief symptom inventory. Additionally, the child behaviour checklist was used to assess	The findings suggested that mothers with eating disorders display lea adaptive emotional responsiveness to each other when compared to non-clinical sample of mothers.	Strengths: This was a robust piece of research in an understudied group. Clinicians assessment was a clinically relevant component.

Author, Title and Location	Participants	Research methodology	Summary of study and key findings	Strengths and Limitations
toddlers: identifying broader risk factors" Israel	The participants in this study were matched with a group of control mothers (with no history of eating disorder) both in age and educational attainment	mother's perception of their toddler's behaviour. Video recordings of mother infant interactions were taken and coded using the emotional availability scale. T tests did not indicate significant differences between eating disorder diagnosis. Paired sample t tests and two-way correlation analysis were used to evaluate data. SPSS was used to facilitate this.	Mothers in this clinical group also had higher negative perceptions of their toddlers. There is a high risk of having more communication and attachment difficulties for these toddlers than their non-clinical counterparts. Interestingly, the mothers in the control group who scored higher on their exhibiting eating disorder symptoms (although under the threshold for a clinical diagnosis) were associated with lower emotional availability.	Observing interaction in non-feeding practices was helpful and novel. Matched control group was very helpful. Limitations: However, this was a small study, and other factors in the home were not accounted for. It was a shame that the voice of the mothers was not present in the paper. Was not able to recommend clinical interventions.
Paper 4 Stein, Woolley, Senior, Hertzmann, Lovel, Lee, Cooper, Wheatcroft, Challacombe, Patel, and Nicol-Harper. (2006) "Treating disturbances in the relationship between mothers and bulimic eating disorders and their infants: A randomized, controlled trial of video feedback" UK	84 participants were recruited and accepted into this study. 4 were used in pilot interviews, 80 were in the study. 40 participants were assigned to video feedback treatment and 40 were assigned to counselling treatment.	Quantitative study Randomized control trial with two arms of treatment. Video feedback group consisted of 3 phases: 1- Infant perspective 2- Mothers perspective 3- Video feedback The counselling treatment arm offered mothers empathic listening. Outcome measure: Conflict during mealtimes – coded Infant weight, Ainsworth's original sensitivity measures,	Video feedback treatment led to better outcomes than counselling 73% reduction in the likelihood of conflict at meal times. Higher level in baseline depression in both groups, this improved for both.	Strengths: First postnatal treatment leading too key improvements in mother and infant interaction in an RCT. Two active treatment arms Videos of interaction were rated blind Treatment carried out in mother's homes Limitations: Relatively small sample Mothers in both groups received guided self-help

Author, Title and Location	Participants	Research methodology	Summary of study and key findings	Strengths and Limitations
		appropriate nonverbal responses, infant autonomy, EDE. Statistical analysis was carried out within SPSS.		in relation to their eating disorder during trial.
Paper 5 Claydon, Zerwas, Callinan & Smith (2016) “Parental reflective functioning among mothers with eating disorder symptomology” USA	59 women were participated with children aged between 4-8 years old. These women did not have a diagnosis of an eating disorder. This was a 48% response rate to women who were contacted. This sample came from a cohort of women recruited to a previous study investigating the effect of intra-uterine exposure to substances in child development.	Quantitative Study Secondary analysis Eating disorder symptomology was assessed using EDE-Q Reflective functioning was collated from PRFQ. Bivariate and multivariate analysis used on data.	33% of mothers had a current Axis 1 disorder. 25% of mothers had clinically significant eating disorder symptomology, also these mothers showed higher rates of reflective functioning. However, caution is advised due to the issue of multicollinearity. If RF is un-impaired, treatment is still advised due to the impact eating disorders can have on child development.	Strengths: Good statistical analysis looking at reflective functioning Suggests that non-clinical population of mothers may go untreated (for a variety of disorders The suggestion of clinical interventions and treatments being developed was helpful Limitations: There was no sense of the women or their children in this paper, reducing them to scores seemed insensitive to the nature of the topic. Also, readability of this paper somewhat detracted from the study.

7.2 Appendix B: Quality Evaluation of Papers

Evolving Guidelines Type A: Publishability Guidelines Shared by Both Qualitative and Quantitative Approaches (Elliot et al, 1999)

Author	Explicit scientific content & method	Appropriate method	Respect for participants	Specification of method	Appropriate discussion	Presentation	Contribution of knowledge
Paper 1 Lai 2008 China	Partial: The psychopathology of the participant sample was unclear However: Early illustration of gap in literature regarding impact of mothers with eating disorders and their parenting functioning. Clear outline of aims and objectives.	Yes: 91 participants is reasonable in this area. However, it is unclear of diagnosis or psychopathology of population. With a clear mix of self-report questionnaires as well as telephone interviews and two different time points this was a good longitudinal study covering the perinatal period	No: The project had ethical approval however participant inclusion criteria stated women who were married or living with a partner which implies single mothers were not allowed to be included in the study Improvement: Greater transparency of exclusion criteria as well as highlight consent and confidentiality protocols.	Yes: Good clear description of measures used, information gained, and what was the focus at each of the three time points. However, it was interesting to read the high dropout rate of participants. From 443 to just 91. Curious as to what they made of that.	Yes: The discussion was succinct and offered a view of the limitations of the research	Yes: Method section easy to follow with clear headings	Yes: some clinical relevance due to gaps in literature for this client group. Easy to follow and access the research. Very good descriptions of cultural components with bring the element of cultural appropriateness and generalisability into the forefront of clinicians and researchers mind. Provides a clear invitation that eating disturbance alone may not be the only risk indicator.
Paper 2 Sherkow 2009 USA	No: Review of psychoanalytic literature and psychoanalytic theory, using clinical observational data in the form of case studies.	Partial: Observational data was appropriate looking at the unconscious processes between mum and baby. However, some could argue about the reliability of observation based data	Partial: There was no mention of ethics, however, consent and confidentiality were sought. It would have been interesting to see some verbatim dialogue of mother's impressions of	Partial: It was clear that this is 3 case study's, however those not familiar with this style of writing may dismiss its contribution.	Partial: Discussion brought the reader closer to the emotional experience of the cases. With context and details provided of interactions Improvement: There was no discussion on limitations of study	Partial: Those more familiar with traditional research papers may find this difficult to engage with. It does provide another emotional dimension which	Yes: This paper highlights the developmental journey of toddlers internalising the eating disordered mother, including theoretical concepts and enriched with clinical material. It is a valuable addition to research as it speaks to something much more human than its traditional counterparts.

Evolving Guidelines Type A: Publishability Guidelines Shared by Both Qualitative and Quantitative Approaches (Elliot et al, 1999)

Author	Explicit scientific content & method	Appropriate method	Respect for participants	Specification of method	Appropriate discussion	Presentation	Contribution of knowledge
			the group and the findings.			closely follows clinical work.	
Paper 3 Sadeh-Sharvit 2016 Israel	Yes: Clear aim of looking at interaction between mother with eating disorder and her child in non-eating situations. Highlighted the big gap in literature around this.	Yes: Matched design using control group and standardised measures Very good mix of methods selected.	No: Institutional review board approved the study However, the findings were reported with a focus on deficit and perpetuated the negative and condemning literature of mothers who also experience difficulties with eating. Improvement: better involvement of participant voices throughout the results and discussion.	Yes: Good clear description of measures used and how they were applied. Matched case control and non-feeding interaction were this studies strength.	Partial: Discussion was informative and focused on the possible communication and attachment difficulties that could manifest in the relationship. discussion of limitations was given and caution advised when viewing the results. However the sample was small and findings should be read with caution.	Yes: Very clear to follow and easy to read.	Partial: Clinically useful, mothers with eating disorders were less sensitive to their children, and their children were less responsive to them. These mothers also reported more behavioural problems than those in the control group. Findings suggest that the interaction between mother and child may be linked to a wide range of adverse maternal and child behaviours beyond those associated with eating However, it is important to note that this study continues the conversation within eating disorders research can be demonising to mothers.
Paper 4 Stein 2006 UK	Yes: Clear aim of evaluating video feedback to improve interaction between mother with eating disorder and her child in meal time situations.	Yes: There were two group bulimics and bulimic and other and these both had self-	Partial: Clearly states full ethical approval given, written consent and interviews to	Yes: Very detailed assessment protocols for recruitment of participants.	Yes: Very clear to read and follow. Video-feedback treatment directed specifically	Yes: Very clear to follow and easy to read	Yes: Highlight that eating disorders, occur commonly among women of childbearing age and raise the risk of adverse effects on mother-child

Evolving Guidelines Type A: Publishability Guidelines Shared by Both Qualitative and Quantitative Approaches (Elliot et al, 1999)

Author	Explicit scientific content & method	Appropriate method	Respect for participants	Specification of method	Appropriate discussion	Presentation	Contribution of knowledge
	Highlighted the big gap in literature around this.	guided help throughout the trial. One group had counselling and one group have video feedback	assess eligibility. Includes patient perspectives. However family members around the mother and infant could have been considered.	Full details of intervention and control group and duration. Data was subjected to statistical analysis.	at mother-infant interaction led to greater improvements in outcome than did a counselling treatment focused on the mother. Discusses strengths and limitations of study		interaction and child development. Suggests treatment that can be effective for this.
Paper 5 Claydon 2016 USA	Partial: Clear outline of aims, exploring the relationship between reflective functioning and eating disorder symptomology. Highlights gaps in literature regarding parental eating disorders and attachment. However, the participants were recruited from another study and the impact of that was unclear	Yes: Appropriate quantitative measures used to evaluate eating disorder symptoms and reflective functioning. This is a secondary analysis, there wasn't a strong rationale for this.	Partial: Approval form review board gained. Written consent from participants was gained. There did not seem to be a place for participant voice, neither was it stated that they had a right to withdraw.	Yes: Using the Parental Reflective Functioning Questionnaire (PRFQ), bivariate and multivariate analyses compared PRFQ subscales between symptomatic and asymptomatic mothers. With clear tables where needed.	Partial: The discussion was succinct and offered a view of the limitations of the research. Improvement: Increased suggestions/hypothesis of the meanings of the findings.	Partial: Although Paper written with significant amount of 'research' language, this may alienate some audiences.	Yes: Useful to draw attention to the significant percentage of women with eating disorder symptoms and no diagnosis, as well as attachment and reflective functioning scores of mothers with eating disorders. Encouraging to see these women have higher scores than their controls. Good objectives of future research and also held in mind the need for treatment of the eating disorder symptomology.

7.3 Appendix C: Extract of an Infant Observation

Brenda got on the floor with Bobby who at this point was sitting with his back to me with a wire bead maze on his lap, that mum had given him and Brenda told me that he 'plays for hours with this' bobby was moving the blocks from one side to another. From the back, he looked engaged in the task and was unmoved by his mum joining him. The first few minutes of this observation were excruciating uncomfortable to watch. Brenda sat to the side of Bobby facing him crossed legged and just watched him, making tentative attempts to join his play. Brenda looks strained with a pained smile on her face and looks at me and says 'it's funny because I would normally be doing jobs and stuff, rather than just sitting here', I reassure Brenda and she looks back at bobby and starts to put his socks on and fuss with his clothes. Brenda counts each sock on the foot, '1' and '2' and Bobby continues the counting and says '3' and '4' as he points to some toys on the floor. Brenda looks at me and says 'that's the first time he has counted objects' Brenda is really inviting me into their play session with inclusive comments and good eye contact. I smile and feel a little surprised at her reaction. Brenda goes back to watching bobby and I have a thought of just how painful this feels for me right now watching Brenda, watching bobby. I wondered how she might be feeling, and how Bobby was feeling as he is immersed in his game, and not looking at either of us, or showing his mum or talking. He is quiet, Brenda is quiet. I feel very horrid. Almost as if I am forcing something on them both, in particularly Brenda and wish I wasn't. Bobby sighs and then so does Brenda, and whispers this is hard work, as if naming Bobby's determination with the game, and my thoughts.

7.4 Appendix D: Free Association Interview Schedule

1. Can you tell me about what it was like for you growing up?

2. Can you tell me what it was like for you becoming a mother to (child's name)?

(Optional prompt) How do you remember feeling then?

3. Can you tell me about the relationship between you and (child's name)?

(optional prompt) Can you tell me what that is like for you now?

4. Can you tell me about your experience of being involved in this research?

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7.5 Appendix E: Ethical Approval

Health Research Authority

Dr Tejinder Kondel
Hertfordshire University
Health Research Building
College Lane Campus
AL10 9AB

Email: hra.approval@nhs.net

15 December 2016

Dear Dr Kondel

Letter of HRA Approval

Study title:	**Who is hungry and who is not: Exploring unconscious processes between mothers with eating disorders and their infants**
IRAS project ID:	**207823**
Protocol number:	**LMS/PGT/NHS/02400**
REC reference:	**16/EE/0295**
Sponsor	**University of Hertfordshire**

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

IRAS project ID	207823

It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details and further information about working with the research management function for each organisation can be accessed from www.hra.nhs.uk/hra-approval.

Appendices

The HRA Approval letter contains the following appendices:

- A – List of documents reviewed during HRA assessment
- B – Summary of HRA assessment

After HRA Approval

The document *"After Ethical Review – guidance for sponsors and investigators"*, issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

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

In addition to the guidance in the above, please note the following:

- HRA Approval applies for the duration of your REC favourable opinion, unless otherwise notified in writing by the HRA.
- Substantial amendments should be submitted directly to the Research Ethics Committee, as detailed in the *After Ethical Review* document. Non-substantial amendments should be submitted for review by the HRA using the form provided on the HRA website, and emailed to hra.amendments@nhs.net.
- The HRA will categorise amendments (substantial and non-substantial) and issue confirmation of continued HRA Approval. Further details can be found on the HRA website.

Scope

HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found at http://www.hra.nhs.uk/resources/applying-for-reviews/nhs-hsc-rd-review/.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application

IRAS project ID	207823

procedure. If you wish to make your views known please email the HRA at hra.approval@nhs.net. Additionally, one of our staff would be happy to call and discuss your experience of HRA Approval.

HRA Training

We are pleased to welcome researchers and research management staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

Your IRAS project ID is **207823**. Please quote this on all correspondence.

Yours sincerely

Miss Helen Penistone
Assessor

Email: hra.approval@nhs.net

Copy to: *Professor John Senior, University of Hertforshire (sponsor contact)* *j.m.senior@herts.ac.uk*

Professor Tim Gale, Hertfordshire Partnership University NHS Foundation Trust (lead NHS R&D contact) t.gale@herts.ac.uk

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7.6 Appendix F: Sponsorship Approval

University of Hertfordshire
Higher Education Corporation
Hatfield, Hertfordshire
AL10 9AB

Telephone +44 (0) 1707 284000
Fax +44 (0) 1707 284115
Website www.herts.ac.uk

Dr Tejinder Kondel & Ms Chancy Marsh
Department of Psychology & Sports Sciences
School of Life & Medical Sciences

21 December 2016

Dear Dr Kondel and Ms Marsh,

Re: UNIVERSITY OF HERTFORDSHIRE SPONSORSHIP IN FULL for the following:
RESEARCH STUDY TITLE: Who is hungry and who is not: Exploring the unconscious processes between mothers with eating disorders and their infants
NAME OF CHIEF INVESTIGATOR (Supervisor): Dr Tejinder Kondel
NAME OF INVESTIGATOR (Student): Ms Chancy Marsh
UNIVERSITY OF HERTFORDSHIRE ETHICS PROTOCOL NUMBER: LMS/PGT/NHS/02400

This letter is to confirm your research study detailed above has been reviewed and accepted and I agree to give full University of Hertfordshire sponsorship, so you may now commence your research.

As a condition of receiving full sponsorship, please note that it is the responsibility of the Chief Investigator to inform the Sponsor at any time of any changes to the duration or funding of the project, changes of investigators, changes to the protocol and any future amendments, or deviations from the protocol, which may require re-evaluation of the sponsorship arrangements. It is also essential that evidence of NHS Trust Management Permissions (formerly known as R&D Approval) is sent as soon as they are received.

Permission to seek changes as outlined above should be requested from myself before submission to an HRA (NHS) Research Ethics Committee (REC) and notification to the relevant University of Hertfordshire Ethics Committee with Delegated Authority (ECDA), and I must also be notified of the outcome. It is also essential that evidence of any further relevant NHS management permissions (formerly known as R&D approval) is provided as it is received. Please do this via email to research-sponsorship@herts.ac.uk

Please note that University Sponsorship of your study is invalidated if this process is not followed.

In the meantime, I wish you well in pursuing this interesting research study.

Yours sincerely

Professor J M Senior
Pro Vice-Chancellor (Research and Enterprise)

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7.7 Appendix G: Information Sheet for Mothers and Baby

Iras id: 207823 Version: 5 01.06.17

Information Sheet for Mothers and baby

The Research:
Exploring the unconscious processes between mothers with eating disorders and their infants

The existing research of mothers with eating disorders appears to do a disservice to women who are struggling with their own issues with food, often looking at physical aspects of the pregnancy and baby's development such as weight and growth. Perhaps these approaches miss the quality of the spaces between mother and her infant, and how can women address what they are not conscious of? By spending time with mother and baby, getting to know how each of them make sense of the other would provide the opportunity to see what they do well and to also know how best to support both mother and baby make the most out of their emotional relationship together.

What is the research about?

The overall aim of this study is to meet and talk with mothers who also experience having eating disorder difficulties. The reason this study is being conducted is because most existing research does not look at the emotional relationship between mother and infant and relies heavily on just physical health data (weight and growth etc). This study will focus on this relationship between mothers and their infant. Questions in the interview will focus on your feelings around eating and feeding. This information will be looked at and common themes will be identified that could help organisations think about ways of supporting mothers to share their experiences and think about what future additional support for mother and infant might be helpful.

Why have I been given this information sheet?

You have been invited to take part in a piece of research being conducted by Chancy Marsh, Clinical Psychologist in Training. Before you decide whether you would like to take part in the study it is important that you understand why this research is being conducted and what will be asked of you, if you decide to take part in the research.

Please take your time to read the information below carefully. This aims to answer any questions that you may have about the research. However, if you have any additional questions or if you are unclear on any information on this form, please feel free to contact the researcher - details are given at the end of this document.

What do I have to do?

If you agree to take part in this research, you (and your baby) would meet with me (Chancy Marsh) Clinical Psychologist in Training on two occasions. Your initial contact with me would be over the telephone where I will contact you to introduce myself and explain the key points of this research project and I can answer any questions that you may have.

During the first face to face meeting, I would speak to you about the research and make sure that you understood the information explained to you over the phone. You would then have another opportunity to ask any questions before being asked to sign a consent form that shows that you are willing to participate.

What do I have to do once I am in the project?

Day 1 – approx. 1 hour

I would arrange a convenient time to meet with you, I would like you and baby to be as relaxed and as comfortable as possible, and this is normally in peoples own homes. I can come to you at your home or find a suitable place to meet, at your local health centre or even if you preferred, at your eating disorder service.

I will then video record you and your baby interacting, as you normally would do, for 5 minutes, after 5 minutes I would turn the video recorder off and just watch you and your baby interacting normally (playing, feeding, changing, sleeping etc.) for an hour. This is just so I can start to get to know the two of you, and see what routine daily life is like together.

We would then arrange for our second meeting, usually a week or so after day 1 and when it is most convenient to you and your baby.

Day 2 - approx. 2.5 hours

The second time that you will meet me, it will be for a slightly longer period of time and I will again record you and your baby for 5 minutes, as you would normally be with each other, after this I will again continue to be with you both for approx. an hour. Again this is so I can see you and baby both together to try and make sure I have a good understanding of you both.

I would then like to talk to you about your experiences, so I can get to know what being a mother is like for you. The questions I will ask will be guided by the experiences that you talk about. If you decide to take part, you may be asked about your ideas and thoughts about your eating disorder and if this impacts being a mother in any way. This will last for approx. 90 minutes. I will ask you halfway through if you would like a break and we can pause or stop at any point in this process.

My aim is to make this process as comfortable as possible and to have the opportunity to get to know you and your baby, and this means going at your pace.

What are the benefits of taking part?

To show my appreciation for your time and efforts in allowing me the privilege of getting to know you and your baby I would like to offer a £20.00 Mothercare voucher as a thank you for taking part in this research.

I cannot promise the study will provide immediate help to mothers who have eating disorder difficulties, but the information I get from this study will help us to think about ways we can support mothers with these particular needs. With this we can try to improve the services in the future.

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What are the possible disadvantages of taking part?

There are no dangers involved in taking part, although it is possible that you could get upset if you were talking about something you had found difficult. You can take a break at any time in the interview or decide to finish the interview. If you do find yourself talking about some difficult things, I can provide information on people that can provide you with support.

Do I have to take part?

No. It is entirely your choice to take part. We will describe the study and go through this information sheet. If you agree to take part, we will then ask you to sign a consent form.
If you change your mind about taking part, you can withdraw at any stage, without giving a reasons. This will not affect your involvement with treatment or services that you receive from the adult eating disorder team in any way.

Are the recordings and interviews kept confidential?

Day 1 and day 2 will be with just me, so only I will be visiting you and your baby.

For the 5-minute recordings of you and your baby, I will use a video recorder so I can remember what happened, they will be destroyed once they are analysed. There will be no identifiable information with your recordings, therefore you, and anyone else will not be able to access these.

For our interview on day 2, I will record using an audio recorder, so I can remember what we have talked about. I will delete this once I have typed up a transcript of the interview. The transcript will be anonymous, which means any names that are used, including yours, your friends', your family members' or a professional that you see, will be removed so that the interview cannot be traced back to you. This will also mean that you or anyone else will not be able to access your own transcript. I will keep the consent forms separate from the transcripts to ensure that your details are kept secret. Any personal information will be stored safely either on password-protected computers or in locked cabinets.

Recordings will be transcribed by a confidential transcription service due to the researcher being hearing impaired. The reason this will happen is to ensure that information is not missed during analysis stage. The recordings will be anonymous and confidential.

Finally, anything you tell or show me in our time together will be treated in the utmost of confidence. The only time that I would ever break that confidentiality is if I were to be concerned about you and/or your baby's safety. In this case, where ever possible, I would talk to you first about these concerns. In the event that the concern of risk cannot be resolved I would have to talk to another professional involved in your care (care coordinator or keyworker) within your eating disorder service. I would always try to inform you first that this is going to happen. They would then follow their own risk procedure of contacting you and discussing any further plans that ensures you and your family's safety.

What will happen to the results of the study?

When the study is completed I will write up the findings as an academic thesis that will be submitted as part of the requirements of my course. In addition, I will disseminate the key findings to the adult eating disorder service that you are with and write up an article for publication in a journal.

These publications might use quotes from our interviews, but I will ensure the quotes will not identify you and I will use codes and pseudonyms to ensure your privacy. If you say something during the interview that you don't want to be used, you can ask me to remove this from the transcript. After the study is completed I will send you either by email or post (your preference) a summary of the findings of this study, if you would rather not know the outcome of this research you can tell me when we meet and I will not send these to you.

Who has reviewed this study?

This study has been approved by Cambridge and Hertfordshire NHS Research Ethics Committee (REC reference: 16/EE/0295). It has also been approved by the University of Hertfordshire Ethics Committee (Protocol Number: LMS/PGT/NHS/02400).

Contact information

If you have any questions or concerns regarding this study you can contact me, the researcher (Chancy Marsh) who will do my best to answer your queries. Alternatively, you can contact the research supervisor, Helen Ellis-Caird

Contact details are provided below.

Principal researcher:
Chancy Marsh
Clinical Psychologist in training

Tel: 07909220270

Email: c.marsh3@herts.ac.uk

Research Supervisor
Dr Helen Ellis-Caird
Clinical Psychologist, Research Supervisor
University of Hertfordshire
Tel: 01707 286322

Email: h.ellis-caird@herts.ac.uk

If you are unhappy and wish to complain formally, you can contact the Patient Advice and Liaison Service (PALS). If you would like further independent advice, you can contact the local Independent Complaints and Advocacy Service (ICAS) on 0845 456 1082.

Relevant Trust Contact Details:

East London Foundation Trust

Bedfordshire and Luton Mental Health Services

Charter House

Alma Street

Luton

LU1 2PJ

01582 708999

Hertfordshire Partnership Foundation Trust

The Colonnades

Beaconsfield Road

Hatfield

Hertfordshire

AL10 8YE

01707 253900

7.8 Appendix H: Consent Form

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Consent Form

Title of research: Who is hungry, and who is not?
Exploring the unconscious processes between mothers with eating disorders and their infants

I, the participant, agree with the following statements (please tick the box if you agree)

☐ I confirm that I have read and understood the information sheet provided

☐ I understand what my participation in the project involves. Any questions that I have had have been answered to my satisfaction

☐ I understand I can withdraw at any time without giving reasons and that I will not be penalised for withdrawing nor will I be questioned on why I have withdrawn.

☐ I understand that I can decline to answer any questions that I am not comfortable with.

☐ I understand that any information obtained will be kept confidential, unless the researcher is concerned for my safety. When concerns are raised these will be discussed with me.

☐ I understand that the interviews will be recorded using audio equipment and that these recordings will be destroyed once the interviews have been transcribed.

☐ I understand that observations will be recorded using video equipment and that these recordings will be destroyed once the data has been analysed.

☐ I agree that research data gathered for the study may be published and if this occurs precautions will be taken to protect my anonymity.

☐ Contact information has been provided should I wish to seek further information from the investigator at any time for purposes of clarification.

Participant's name:

Participant's signature:

Date:

Researcher's name: Chancy Marsh

Researcher's signature:

Date:

You are may keep a copy of this form for your own reference if you so wish, please ask your researcher Chancy Marsh for a copy. The signed original will be kept in a private and secure place according to the protocols outlined for this study

7.9 Appendix I: Non-Disclosure Agreement

<u>Doctorate in Clinical Psychology</u>

<u>University of Hertfordshire</u>

Transcription confidentiality / non-disclosure agreement

This non-disclosure agreement is in reference to the following parties:

Chancy Marsh

And

Transcription service……………………………………………………..

- **The recipient agrees to not divulge any information to a third party with regards to the transcription of video and audio recordings, as recorded by the disclosure. The information shared will therefore remain confidential.**

- **The recipient also agrees to destroy the transcripts as soon as they have been provided to the discloser.**

- **The recipient agrees to return or destroy any copies of the recordings they were able to access provided by the discloser.**

Signed: ……………………………………………………………………………

Name Printed: ………………………………………………………………

Date:…………………………………………………………………………………

7.10 Appendix J: Breaching Confidentiality

Protocol for Breaking Confidentiality

Are there risk issues/disclosures of risk regarding safety of mother or baby?

NO

Maintain client confidentiality, whilst being mindful of safety

YES

Inform client what the concern is regarding and that consultation with another professional is needed

Inform site supervisor of risk to mother or child

The site specific supervisors take the concern to the team meeting and professionals involved in the client's care create appropriate action plan.

Details of this protocol of breaking confidentiality are also explained in the Participant Information Sheet (PIS).

7.11 Appendix K: Debriefing sheet

Debriefing information:

Thank you for your generosity in giving your time to take part in this research project. Hopefully this research will help us better understand mother's experience of living with an eating disorder. This will hopefully expand our thinking in ways we can help provide support for other women who are in a similar situation.

Previous research findings have implied that friends and professionals can provide a useful source of support to mothers living with eating difficulties. However, it is acknowledged that sometimes talking can be hard in practise. There is still a limited understanding about what helps or hinders the relationship between mothers with eating disorders and infants and this is what is being investigated.

The information that you have provided will be kept confidential and the recordings will be destroyed after the interviews have been transcribed and analysed.

If you wish to withdraw your involvement in the research, you can do so at any time.

If participation in this research caused you any distress, please discuss this with a representative from your adult eating disorder service.

However, if you would like further support, please find below the details of some resources and organisations that may be useful:

BEAT:
Beating eating disorders, providing a helpline for adult support
Telephone: 0345 634 1414
Email: help@b-eat.co.uk
Website: www.b-eat.co.uk

Eating Disorders Support:
This is a confidential telephone and email helpline to provide support and advice for eating disorders.
Telephone: 01494 793223
Email: support@eatingdisorderssupport.co.uk
Website: www.eatingdisorderssupport.co.uk

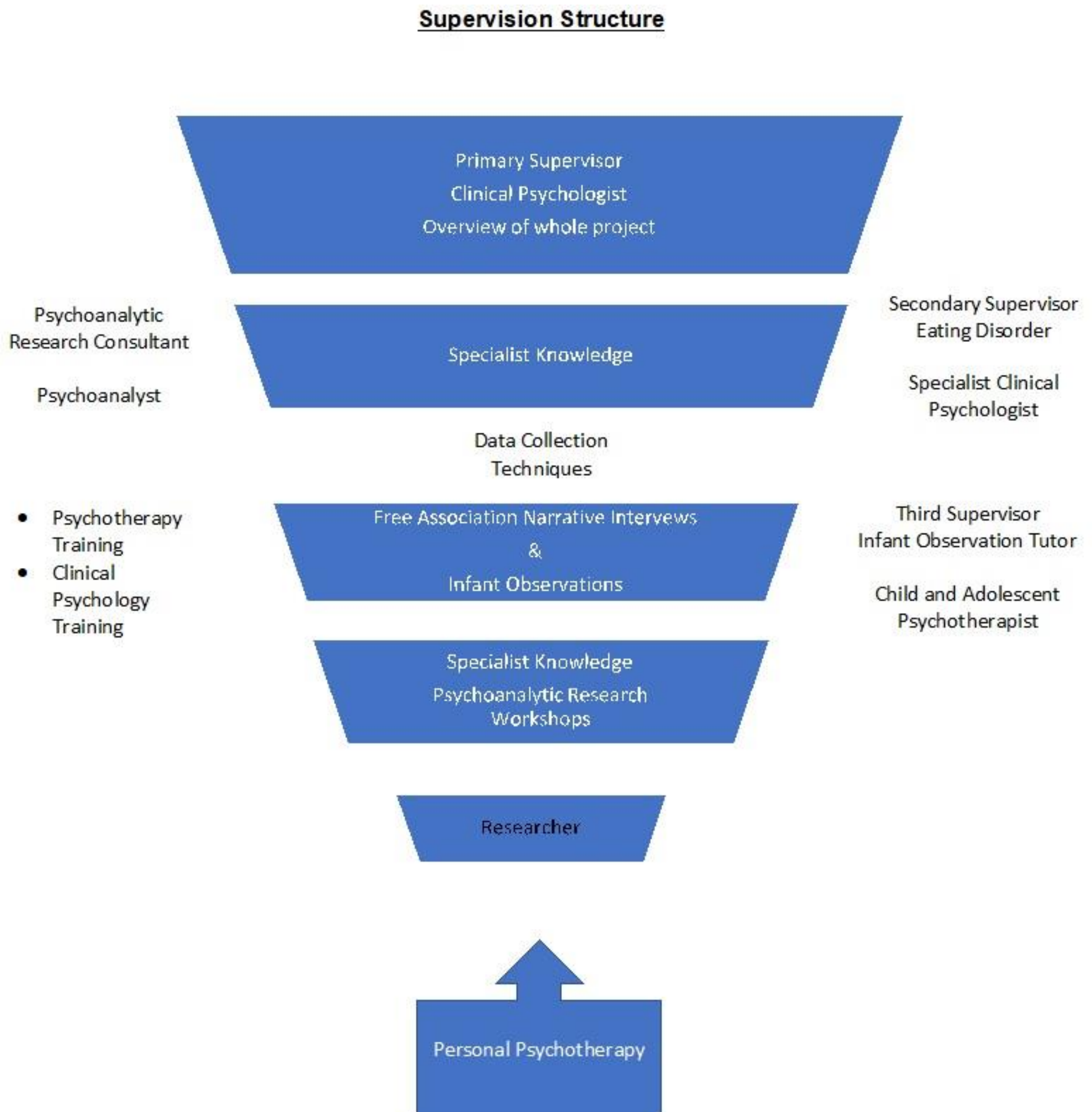
Samaritans:
This is a confidential helpline for anyone experiencing any emotional distress
Freephone: 08457 90 90 90
Website: www.samaritans.org

If you have any further questions, or would be interested in being informed in the outcome of this study, then please contact me by email (c.marsh3@herts.ac.uk)

If you have any complaints about the study, please contact Tejinder Kondel by email (t.kondel@herts.ac.uk)

Thank you again for your participation and support.

7.12 Appendix L: Supervision Structure



7.13 Appendix M: An example of full pen portrait

Brenda and Bobby: A Pen Portrait

Context

Brenda and her family lived on a social housing estate and the home looked lived in and pleasant. Brenda and her husband Bob lived here with 4 of their children, Brenda's eldest daughter (19) from a previous relationship was away at university. Living together in the home were Brenda and Bob, their sons Brian (13) and Ben (11), their daughter Bella (9), and their toddler Bobby (2).

Upon meeting Brenda, it was striking how large she was, Brenda was 40 years old and her physical frame filled the doorway when she came to greet me. Bobby was 2 years old and had a mop of floppy blonde hair that drew you in, and made me want to ruffle. Brenda was warm and inviting and Bobby looked pleasantly cheeky and curious. Brenda's husband was also present and asked if I was the 'psychiatrist' whilst I was on the door step. This immediately gave the visit a formal power and added an air of assessment to the interaction. When in conversation with Brenda I felt warm, and invited fully into her life and family. In the moment, it was very seductive and I became aware of how strong the pull was to like her in the transference. Brenda works in a school and Bobby is cared for by her mother and Bobby's dad bob when Brenda is not available. Bobby himself seemed used to new faces and he was eager to interact in a way that suggested a level of confidence and self-certainty. Despite there being children coming in and out of the living room and her husband in the kitchen in the next room Brenda immediately began to pour her life story over me, including details of her previous relationship with the dad of her eldest daughter. At the time, it felt like a desperate need to share, in reflection it felt more like a consumption of my mind that was overwhelming. Brenda's tone of speech was soft and slow and reminded me of honey. There was a lullaby effect to the quality of her tone and yet it became more and more childlike in its delivery as the interview went on. At point's the words and phrases chosen could have been from a child telling tales on others. Brenda's family of origin consisted of her, her older sister and her mother and father. Brenda's parents divorced when she was 3 or 4-year-old due to her father having affairs with other women since she was approx. 2 years old, when they initially separated. Brenda made a point of saying "so I have no memories of my dad being at home" and this insisted upon a lens of deprivation being placed over her history.

Adolescence

Brenda's mother remarried shortly after the separation and her step father was described as "grumpy, quite Victorian, like children should be seen and not heard" Brenda lived with her mother, new stepfather and sister until she was 14 years old. There was no mention of what life was like for Brenda during these 14 years however Brenda did speak of a guilty feeling that she had of "leaving them". Brenda only remarked on her mother in a present context "my mum has always, like not been good with my weight. Because she is not very helpful at all. No Brenda you don't need a biscuit". Brenda described a hostility between her mother and step-father and her father and step mother, she was encouraged to move in with her father who was described in contrast as "my dad spoiled us" and at 14 she went to live with them. Brenda then went to live with her father and her step mother until she was 17 years old. These three years were described as 'hell' due to Brenda feeling that she was 'emotionally abused' by her "really horrid" stepmother.

Brenda described her father and stepmother as "alcoholics" and there were arguments and constant rivalrous hostility between Brenda and her step mother often ending in Brenda having to apologise to appease her step mother. There were situations described where her stepmother had said "I

wanted to hurt you like you hurt me" indicating a childish battle involving power and abuse of authority. Whilst Brenda was giving these examples she seemed to be shielding her father of any blame, anger or responsibility. He was protected as all "bad" and "evil" had been projected into her stepmother as they fought for his affections. Brenda described learning "that people could do things to you and then you have to forget about it and not cause any more trouble" as after these arguments everyone had to "just forget it ever happened" and carry on. During this time Brenda reported taking drugs and drinking alcohol as she "went off the rails and like used to get in with the wrong crowd. So, I would not remember all of what was going on".

Brenda said that at 17 she left her father's home and found herself in an abusive relationship with the father of her eldest daughter. Brenda described the relationship as intense and that he had 'really known' her and this was something that Brenda during each visit remained emotionally connected too. Brenda commented on her eating patterns during this time and reported not eating at all as she "could not afford it". Brenda said that "I didn't have anyone, but I had my nan, she was the best thing" Brenda was referring to her paternal grandmother who she had always been close to. When she was pregnant at 19, she returned home to live with her mother, stepfather and older sister. Brenda said that she felt she did not fit in as "the black sheep". Brenda returned to her eldest daughter's father and despite being "really really close, we got each other" Brenda said that "he was horrid and it didn't work out".

Brenda described a state on constant confusion over what "actually" happened "you don't know what you said because you say things and then it gets twisted. So, you say something innocently and it gets twisted into some, that you said something awful. So I grew up not certain of my actions, because people always telling me I had a different meaning to what I had. Now I am completely unsure of myself" and spoke of needing external validation and verification "my husband said no you never did that" as she experienced uncertainty over her own feelings and sense of her own behaviour. External sources included her therapists past and present "they say that (laughs) they say that. When I have been to different therapies. I went to CAT therapy and she said something similar. I find it very hard to tolerate situations which I am not certain about, because when I was younger, I was put into really uncontrollable situations that caused a lot of anxiety". Brenda described a lack of attunement from her caregivers growing up and this could be seen in the observations when she was with bobby. The first few minutes of the first observation were excruciatingly uncomfortable to watch. It highlighted how difficult it was for Brenda to emotionally 'be with' bobby as well as being observed. Despite this apparent disconnection, it was Brenda that Bobby sought out when he was distressed. During the interview Brenda spoke about various incidents involving estrangement from her father and stepmother and how at different points contact was made and resulted in conflict. The stories were difficult to follow and appeared disjointed and had a quality to them that were not unlike fairy tales.

Eating disorder

During adolescence, Brenda said that she "didn't eat as I had IBS and would worry about triggering this off" this was the first reference to her relationship with food and also an indication of how distressing these experiences were for Brenda. After Brenda had had her first child she "probably over ate" and this made me think of how Brenda needed more nurturing herself when she became a mother. When Brenda was 32 years old she was the mother to 3 children and had been married to her husband for a few years. Brenda's paternal grandmother passed away, this was a "very difficult time, I couldn't say she had died without crying for 3 years" and Brenda began binge eating "quite

badly, because I hadn't had a safe place". When Brenda was prompted she spoke of this time "I felt incredibly lonely and sad, ehm. I was at home with the kids, so I used to be like in the house and kind of just walked to the cupboard and back. I know it was then that I would eat the food. Like when someone would give us a box of chocolates and I eat them all and then have to go out and buy them to replace them so that no one would know". At this point Brenda described feeling isolated and emotionally deprived of connectedness which would have impacted on her eating behaviour. Brenda spoke about her feelings of hostility towards her husband and I wondered whether this anger was a projection, of her own anger that wasn't able to be expressed to her parents, namely her father. Brenda reported going to family therapy with her daughter and her husband, then went on to say, "the therapist said your dad should have protected you". Brenda continued to detail different instances where she had argued with her father and both her father and step mother "cut me off". Again, the relationships were described as difficult, especially when Brenda had to join a pair "my mum and my sister blamed me. They always said that I was considered the argumentative one, my sister was the one who pleases people and so I was like the bad one". This also indicates a great deal of splitting in Brenda's accounts of her life. Brenda continued to talk about her dad and stepmother and it was remarkable how fragmented and childlike her tone was. These recollections sounded like a school playground 'telling tales' and in the transference, I was positioned to be the authoritarian teacher who was expected to see wrong doing in Brenda's father and stepmother. When Brenda was with Bobby there were 'missteps in the dance' of their interaction when she unprovoked and mindlessly stopped his play so that he had to 'share' his toys.

Brenda shifted to the present and spoke about her binge eating and how that may affect her children, "sometimes when I binge eat, he (bobby) eats it as well. And if I binge eat then I don't want to cook tea and sometimes I am...I wonder if I feed him the correct diet". Although Brenda spoke of consciously being unsure her next comment made me curious as to the unconscious need to keep her children with her and in similar patterns of eating, "I think (eldest son) overeats and he got that from me. And I think (eldest daughter) has gone to uni and lost weight and I feel a bit jealous. I think maybe I fed her too much on purpose. I don't think I did". Almost as if the extra weight is a coat of substance from Brenda that she can clothe her children in. as if in her mind they are replicas of her, without a sense of self, too fragile inside to cope. If they take the coat off whilst being away from her not only is she abandoned by them but they are actively rejecting the very substance of her.

Weaved throughout the interview Brenda spoke about guilt, in relation to what she fed the children, "I feel guilty afterwards" or having her mother look after them whilst she went to therapy "just add that to the list of things I feel shit about" and "that's another thing to feel bad about". It was unsurprising that Brenda would take her medication and sometimes co-codamol so that she would feel sleepy and drowsy as "I just stop thinking". This made me think about her teenage years and the way that Brenda used drink and drugs to numb herself of her feelings and isolation. Brenda despite surrounding herself with children and animals still experiences acute abandonment and rejection which stems from her childhood.

Motherhood

The last 8 years have been difficult for Brenda and during this time was marked by ambivalence "we had four children and I'd hoped that we would have an accident and have another one, although I didn't think I could have any more children" and anxiety "I never enjoyed any pregnancy, because I was worried so much. I had a girl and then we had two boys, then I found out I was having another girl and I didn't believe it. So, I went and had a private scan the next day. And then I was convinced I

won't be having this baby because how could I be so lucky to have that – two girls and two boys, how could I be that lucky. After her I was ill and back in hospital and I cried for a month and said I've got everything I have ever wanted and now I'm going to die". There was also a sense of fantasy and the same fairy-tale telling quality already felt "this was my only chance to get another baby" and "it sounds very awful, I like stole my husband's sperm on occasion, well I just scooped it up". This indicated that this aspect of the relationship between Brenda and her husband was perhaps at times seen as a vehicle to producing babies. Having babies seemed to mean something significant to Brenda and others perhaps did not share this view, "anyway straight away I got pregnant and I told (eldest daughter) I was pregnant. And she just cried and it was like the reverse conversation of like child going 'mum, why have you done that? You're so irresponsible'".

Pregnancy and delivery was difficult for Brenda with Bobby and it was marked by severe and all-consuming anxiety. Brenda became known to the perinatal team. Brenda's pregnancy was dominated by the fear of 'not getting' a baby "every time I went to the toilet I was checking for blood. I just thought I am going to lose him. I paid for quite a few private scans because I had spotting and then I paid for another one. I just didn't think we would have a baby". This level of anxiety was present in previous pregnancies. There was a concern in Brenda's perinatal team that she may develop post-partum psychosis, she had strong beliefs that she would give birth to a doll and they feared that she would not believe that the baby was hers. Hearing about this situation made me think how contagious Brenda's fears were and it was difficult to identify any solitary relationship in which Brenda felt held and contained. After a "Brutal" 2-hour caesarean "because they could not get him out" by a consultant Brenda named "Dr Doom" and a few days in hospital due to these complications Brenda arrived home with Bobby. The crippling anxiety did not subside and like all her other babies was replaced by the fear of them not 'staying' "I used to have like ehm, rituals of like having to put their blankets on them the other way around. So, like they had animals on their blankets and they would have to face away from them. So, if like you put them upside down or the wrong way around, I used to think, but I don't think this anymore, but I used to think evilness, in like the form of my step mum and her spirit would lurk in the darkness and I used to think that they'd be watching, if you didn't show that you looked after the baby properly, the darkness would like take the baby away from you". It is clear how frightening this time was for Brenda, her understanding of these thoughts was "I think it is just used to be like my diary, when I was only allowed to talk to my mum if she (step mother) was listening on the other phone". Brenda's step mother had come to represent the epitome of evil who had the capacity to judge Brenda unworthy and snatch away her baby, as she did with her father.

Brenda arrived home from the hospital with Bobby to a full house with her mother, sister, step-son and her children as well as the crisis team. This made me think about the transference between Brenda and I, the need to look after her and help her. Elements of that could be seen in the way her house was filled with helper's ready to support and care for Brenda. Brenda said that bonding with bobby happened naturally and effortlessly. However, after about 6 weeks she was not feeling good "I knew how hard it was. I hadn't really thought about how hard it was in reality. I was exhausted and the thought of how hard, you know, I have got the weaning, and I have got the that stage and that stage and the sleep deprivation". This made me think about what collecting babies meant to Brenda and how different the reality was to that. This also indicates a real tension between dependency and separation and at the time of the interview Brenda was still breastfeeding Bobby who was 24 months. In addition to this struggle, jealousy was also seen again in a more explicit way when Brenda said, "my husband never helps with the babies at all. Which is fine because I had (eldest daughter) on my own, so when I was pregnant with (second child) I was worried how I would share him with someone, because I just didn't want to. So, the fact that I always just breastfed them

and just done everything in the night and that's like fine". Parallels to this jealousy were seen in the observations with the enforced sharing, Bobby demonstrated his dislike of sharing toys and his mother with his older brother.

The relationship between Brenda and Bobby

Brenda's anxiety was driven by the fear that Bobby wouldn't "stay" and this was still the case when I saw them. Brenda spoke of her "happiest" time when her husband slept in a spare room and the children had "sleepovers" and she was in bed with them all. During these times Brenda felt "I was just surrounded by these guys, which is really nice, just felt safe, warm and tucked up. In fact, she is still in bed with me" (points to second daughter). Brenda described a warm soft womb like feeling that she can feel when she has her children around her and it is unclear if she is providing this to her children or indeed the collection of children are providing this for her. I suspect it is an interplay of both of these functions.

When Brenda was asked about specifically the relationship between her and Bobby she replied, "I think it is good" and gave examples where other people (professionals) had deemed it so. As if her recollection or opinion was not valid or robust. Brenda spoke about stopping breastfeeding him "I know its half him and half me, it's going to be sad. I want him to grow up and obviously being alive and not growing up sad. I just wait for grandchildren now. Yeah, it will be an end of an era" this seemed to indicate that weaning Bobby from the breast was a death for her, babies growing up meant a separation that was profoundly difficult for Brenda. This was confirmed with what came next "it is hard to think that my child bearing days are over. Since it makes me think all that is next is death (laughs). I don't like that I won't have, I don't know, that age is ticking away of your life. You just move towards death".

It seemed difficult for Brenda to stay with the relationship between her and Bobby and instead spoke about a generic feeling of being needed. Weening symbolised a separation and the individualisation of the babies which was too much for Brenda to tolerate so this neediness could be replaced by animals, "I like being needed by them (babies). Definitely. What I do as well then, I don't know whether you noticed but we got a puppy (laughs). We are waiting to get another puppy. I think because I spent a lot of my life feeling not wanted. So, it is the opposite of being needed". Brenda seemed to use babies and animals interchangeably as a way to repair a deep primal wound that still hurt a great deal.

Brenda spoke of replicating a union, a suspended reverie which new mothers and new born babies relish in "when it's just you and the baby, that is really natural, like nothing changes in time. The most natural thing in the world". During the interview and the observations, it appeared that Bobby was a miracle baby that couldn't be anything but 'kind', whereas 'Daddy' could be the safe recipient of projected negative feelings. The function of this kept Brenda and Booby together in a pristine reverie not unlike a pure Mary and Jesus. Although for Brenda once the bubble of symbiotic relationship is burst with the sharp needle point of separation there became an element of anger and disappointment, "I mean the older they get the more corrupt by society the more you move away from that. And then it's hard because you have put so much into it and they outgrow it (laughs)". At this point I could feel Brenda's outrage in the transference, this was confirmed when she said "how dare they, exactly. Like it is hard to think that they will have their own husbands. And like (eldest daughter) going to uni for two days. I mean, I felt suicidal. I was just so what's the point, when they are just going to leave me. And then I got panicked because I think what's she going to

have this adventure and she is not going to take me on it. What if I wanted to go but not allowed to? Was just scary. That made me ill. They are so important to me and in the future, I won't be so important to them. That's scary. That's not cool (laughs)". Brenda views her children's independence and separation as an abandonment that connects her to previous feelings of being left and replaced.

My experience of the interview: Brenda was warm during time together and there was an invitation from her to like her and 'do something'. This was discussed during an infant observation seminar where there was an unconscious pull by Brenda to recruit others to be responsible for something for her. A guilt at thinking about her weight as if it were the researcher's responsibility to carry. Brenda was very engaging during interaction and was exceptionally open during the interview, almost as if she was greedily consuming the space. Brenda spent a lot of time during both contacts 'spilling out' her story in an uncontained way. There was a parental feeling in the transference to care for her, as she needed looking after and repairing. Listening back to the audio of the interview, Brenda had a childlike quality to the way she spoke, both in tone and in the dialogue, she chose. The story that she gave to the interview space was not unlike a fairy tale in the quality and content. Brenda positioned herself as the passive princess with 'evil' and 'horrid' wicked stepmothers and stepfathers.