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**MOTHERS' REPRESENTATIONS OF THEIR CHILD IN A
MATERNAL MENTAL HEALTH SETTING IN NEW ZEALAND.**

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Abstract

Attachment theory and research indicates that early close relationships impact on later socio-emotional functioning, and mothers' mental representations of their infants are thought to play an important mediating factor. Severe and long standing maternal mental health problems have found to interfere with sensitive caregiving. The present study examined the use of the Working Model of the Child Interview (WMCI) in the clinical setting of the Maternal Mental Health (MMH) system in New Zealand. Eight mothers, all of whom had either severe post-partum depression and/or other mental health issues, were interviewed. Qualitative differences in their narratives pointed to clinically relevant maternal distortions. Less than half of the transcripts were classified as balanced (balanced 37.5%, distorted 25%, disengaged 37.5%). Results supported previous research findings that maternal mental health issues interfered with the mothers' insight into how the child experienced the caregiving environment, placing children at greater risk for developing insecure attachments. Findings indicated that certain excerpts from the WMCI could be used by MMH workers to assess risk and protective factors to the infant-mother dyad and their implications for clinical interventions. The current research offers support for an integrated approach to maternal and infant mental health in a MMH setting.

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Prologue

Attachment theorists suggest that working models of relationship, including working models of caregiving, develop within the context of the family and guide individuals' behaviour over time (Bowlby, 1980; Rutter, 1997). Empirical data support the association between child and adult attachment classifications, as well as caregiving representations and parenting behaviour (Bretherton & Munholland, 1999; Solomon & George, 1999). Less clear is the process through which these associations occur, and how early experiences of care are relevant to later socio-emotional and personality growth. Studies examining the role of maternal representations of their children explain some of the mechanisms thought to be involved in the intergenerational transmission of internal working models (Zeanah, Benoit, Hirshberg, Barton, & Regan, 1994), as they seem to reflect how caregivers and infants experience the dyadic relationship. Insight into caregiving perceptions can alert clinicians to misconceptions and unmet developmental needs of the children.

A number of studies have shown an association between maternal mental health, the quality of caregiving, and risk factors to subsequent infant cognitive and emotional development (Espinosa, Beckwith, Howard, Tyler, & Swanson, 2001; Oates, 1997; Ward, Lee, & Lipper, 2000). A significantly higher level of insecure attachment has been found among infants of depressed mothers compared with mothers from a non-clinical population (Robinson, 2002; Teti, Gelfand, Messinger, & Isabella, 1995), and maternal depression has been linked to qualitative aspects of parenting, since severe and

prolonged depressive symptoms have found to interfere with the mother's ability to interpret and become sensitive to her infant's signals (Murray & Cooper, 1997).

Exact data on the prevalence of post-partum depression (PPD) in New Zealand are unavailable because this disorder often goes undiagnosed, but it is estimated that it affects between 10 and 15 per cent of mothers within the first year after birth (Courtney, 2004). The Maternal Mental Health (MMH) system in New Zealand primarily targets mothers who have either a history of mental illness or severe and prolonged PPD. While interventions are usually directed at the mother's mental health issues, MMH workers rarely assess the parent-infant interactions or mothers' perceptions of themselves as caregivers and how they view their infants and their development. Because an early identification and prevention of risk to infant development can reduce potential negative outcomes associated with aberrant parent-child interactions, it seems critical that MMH workers focus on aspects of individual areas of strengths and weaknesses within the parent-child dyad while providing support for the caregiver (Atwool, 2000; Graham, White, Clarke, & Adams, 2001; Nightingale, 2001).

The research reported in this thesis evolved from my specific interest in the integration of attachment theory into the clinical work with parents and children. It is the first study is the first to examine the use of the Working Model of the Child Interview (WMCI) (Zeanah, Benoit, Barton, & Hirshberg, 1996) with a clinical population in New Zealand. The key aim of my study was to investigate the applicability of the WMCI in a New Zealand MMH setting.

Attachment Theory and Research

Bowlby (1988) proposed that everyone has the innate biological ability to parent, but that personal history and experiences shape the particular form it takes. His theory has promoted the theoretical understanding that early interpersonal experiences are translated into abstract and generalised knowledge structures that individuals use to predict and guide interactive behaviour. An overview of theory, research, and literature regarding attachment is necessary to sufficiently understand how the adult caregiving system evolves, and how parents form representations of their infants and themselves as caregivers.

Representations of Attachment Experiences

Attachment is a reciprocal relationship that develops gradually through stages during the first year and is mediated by the quality of adult-child interactions. While the goal of attachment behaviour in the child is to seek protection and maintain proximity to the attachment figure, the caregiving role is to facilitate the child's development within a safe environment. How parents fulfil this role, as Bowlby suggested, is shaped by their developmental history and their own attachment experiences. Through a history of child-caregiver encounters infants come to expect particular caregiving responses to signs of distress or the need for closeness. This fosters particular patterns of overt interpersonal behaviour, emotions, and perceptions about self and others. By about the age of three, these patterns of dyadic behaviour are internalised to form mental

representations or 'internal working models' (IWMs) of self and relationships (Bowlby, 1980). Over time these models are incorporated into the personality structure of the individual and become resistant to change, since new experiences are accommodated by existing models even if they are inconsistent with these. According to both social-cognitive and attachment theory, cognitive-emotional schemas derive from implicit learning experiences and provide information processing rules - including defensive processes and biases in recall - to organise and regulate how information related to attachment is stored and what is available to consciousness or blocked out (Lay, Waters, Posada, & Ridgeway, 1995; van IJzendoorn, 1995; Weinfield, Sroufe, Egeland, & Carlson, 1999). In this way IWMs mediate intrapersonal aspects of emotional and cognitive development (i.e., access to one's feelings and memories and the appraisal of social situations) as well as interpersonal communication processes throughout life.

Even though differences in attachment are thought to influence subsequent development and later outcomes in terms of personality and the ability to cope with stressful life events, changes in pattern of adaptation always remain possible. In childhood, IWMs may be changed through different and more positive experiences with the caregiver or other important adults, and in adulthood these models can be revised through reflective processes and the formation of new attachments (Bretherton & Munholland, 1999).

In summary, attachment theorists agree that IWMs are derived from early attachment experiences with the primary caregiver(s). Secondly, they consist of mental structures (schemas, rules, and scripts) that are generalised into an organizing perspective of

interactive experiences and affect. Thirdly, IWMs involve defensive processes that influence general and specific memories and the personal narrative of attachment related experiences. Fourthly, even though internal representations are thought to become increasingly stable, change can occur through the influence of new attachment experiences and the development of a self-reflective capacity.

The Caregiving System

According to attachment theory, the infant-caregiver relationship consists of more than mere observable interactions. These relationships also include the subjective experience of infant and caregiver, which, on a representational level, organises the caregiver's behaviour and the infant's attachment strategies. This model therefore predicts continuity and the intergenerational transmission of relationships (if living conditions do not change), as well as the degree of sensitivity and responsiveness with which parents react to infant attachment signals. While the caregiving system is distinct from the attachment system, it is thought to be moderated by the caregiver's own working model of attachment (Bowlby, 1969/1982; Solomon & George, 1999; Main, Kaplan, & Cassidy, 1985). How individuals see themselves as caregivers will depend on core-beliefs about self, and caregiving experiences (even pregnancy itself) can trigger off "old psychological conflicts" (Huth-Bocks, Levendosky, Theran, & Bogat, 2004a, p. 81). Parents' capacity to have insight into their role as caregivers and into their children's personality is thought to depend on differences in information processing (including defensive processes), which in turn is linked with the ability to access and

integrate their own attachment experiences (Main et al., 1985; Zeanah, Benoit, Barton, Regan, Hirshberg, & Lipsitt, 1993). This helps parents to distinguish current caregiving demands from their past experiences. From a clinical perspective, the subjective experience of the relationship is as important in the assessment and treatment of mother and infant dyads as the behavioural component (Stern-Bruschweiler & Stern, 1989).

Research on maternal perceptions show that both mental illness (Wood, Hargreaves, & Marks, 2004) and a stressful environmental context, such as domestic violence and lack of social support (Huth-Bocks et al., 2004a) affect mothers' representations of the child and self as a parent before and after the birth of their child. Mothers who participated in these studies were more likely to reveal distorted or disengaged representations compared to the normative data obtained from non-clinical samples. The findings of these studies further indicate that these representations are associated with risk to infant mental health.

Caregiving representations though, like working models of attachment, need to be viewed as developing since they are open to changes. Interactions with the child constantly challenge caregiving representations, and parental awareness and confidence has been found to develop with experience over time, especially if support from parents or a spouse is available (Goldberg, 2000; Newberger & White, 1990) or intervening change occurs in the quality of parental care (Thompson, 2000).

Measures of Attachment and Caregiving Representations

A structured observation schedule, known as the Strange Situation (SS) test, was devised by Ainsworth (1967) to measure individual differences in infant attachment behaviours in laboratory or other controlled settings. She identified three distinct behavioural patterns of how children (12-18 month of age) use the attachment figure as a 'secure base' from which to gain reassurance when exploring their surroundings and how they cope during separations and at reunion. The three main groups are: secure, insecure-avoidant, and insecure-ambivalent. Later a fourth attachment category was identified by Main and Solomon (1986), the insecure-disorganised/disoriented.

Main and Solomon (1986) created a discourse-centred research instrument called the Adult Attachment Interview (AAI). Its emphasis is on how adults organize and evaluate childhood attachment experiences from their current perspective, and scoring of the AAI focuses on the coherency of discourse. In attachment research a coherent discourse is one that follows Grice's (1975) four maxims of quality (statements are supported), quantity (succinct), relation (relevant to topic), and manner (clarity). The speaker should be able to integrate emotional laden or traumatic experiences into the discourse without the loss of clarity (Main et al., 1985). The four patterns of discourse in the AAI – autonomous, dismissing, preoccupied, and unresolved/disorganised correspond to the four patterns of infant attachment and predict the organisation that an infant will have with the caregiver (Benoit & Parker, 1994; Bretherton & Munholland, 1999).

Table 1

Overview: Measures of Attachment and Caregiving Behaviors/Representations

Strange Situation (SS)	<u>secure</u> active exploration - seek physical contact when distressed; easily comforted on reunion	<u>avoidant</u> adequate exploration; active avoidance of parent on reunion; fails to cry on separation; these children often look independent	<u>resistant/ambivalent</u> preoccupation with caregiver interferes with explorative behaviour; ambivalent (angry/passive) reunion behavior; cannot easily be comforted on reunion	<u>disorganised/disorientated</u> incoherent/chaotic behavior in presence of parent (e.g., freezing with trancelike expression; approaches parent sideways, eyes averted)
Adult Attachment Interview (AAI)	<u>secure/autonomous</u> clear and coherent discourse; offer specific support for descriptions; objective evaluation and integration of attachment experiences	<u>dismissing</u> dismissive of attachment experiences; generalised representations; transcripts tend to be brief	<u>preoccupied</u> not coherent, preoccupation with past experiences; contradicting specific memories; extremely long transcripts	<u>unresolved/disorganised</u> incoherent, irrational and confused narratives; lack of resolution of traumatic events indicated by lapses in reasoning during interview
Working Model of the Child Interview (WMCI)	<u>balanced</u> representations are coherent, include both negative and positive characteristics of infant; open to changing developmental needs; see children as individuals	<u>disengaged</u> downplay child's need for closeness and impact they have as parent on child; do not seem to know child as individual; unelaborated descriptions	<u>distorted</u> unrealistic expectations of child; contradictory descriptions; high emotional tone (negative or positive); confused, overwhelmed by child or other concerns; possible role-reversal	
corresponding caregiving behavior	interact in a responsive and predictable way with child; non-intrusive; adjust caregiving behavior in developmentally appropriate manner	encourage independence; react in strict disciplinary way	over-involved and anxious; insensitive to child's cues and need for autonomy	Inconsistent and frightened or frightening caregiving behavior

Note: Descriptions of SS behavior is summarized from Ainsworth (et al., 1978); Main (et al., 1985, 1986). Descriptions of AAI representations are summarized from George (1996); Main (et al., 1985). Descriptions of WMCI representations are summarized from Benoit (et al., 1997); Oppenheim (et al., 2002); Zeanah (et al., 1995). Caregiving descriptions have been summarized from Belsky (et al., 1995); Solomon (et al., 1996, 1999); Hesse (1999).

A third important assessment device, the Working Model of the Child Interview (WMCI) was designed by Zeanah and colleagues (1996) to assess parents' perceptions and subjective experience of their children and to identify particular problems in the dyadic relationship. The three main classifications proposed are: balanced, disengaged, and distorted. These correspond to the three AAI classifications of secure, dismissing, and preoccupied and the SS classifications of secure, avoidant, and resistant (see Table 1).

Previous studies with the WMCI (Benoit, Zeanah, Parker, Nicholson, & Coolbear, 1997; Zeanah et al., 1994) have found a significant association between WMCI classifications (even before birth) and infant attachment behaviour at one year. These findings are important, since the parents' state of mind with respect to attachment behaviour is thought to direct as well as to perpetuate parenting behaviours (Brisch, 2004; Slade, Belsky, Aber, & Phelps, 1999; Pederson, Gleason, Moran, & Bento, 1998). This raises questions about how parents transmit their mental representations of attachment to their children, and how that affects individual differences in attachment security and later development.

Transmission of Attachment Patterns

Attachment theorists have investigated how early experiences affect social and personality development, and what central features of parenting are influential in this process. For many years maternal sensitivity – a mother's ability to “see things from her

baby's point of view" (Ainsworth, Bell, & Stayton, 1971, p. 114) - has been considered the most important factor in the transmission of attachment. The effect size for the relation between AAI classifications and sensitive responsiveness has found to be only moderate however, mainly because the sensitivity construct cannot be uniformly operationalised (Isabella & Belsky 1991).

Oppenheim and Koren-Karie (2002) used the construct of 'insightfulness' to describes a wide range of maternal behaviour, including the caregiver's ability to interpret the child's actions as goal-directed and to use the infant's perspective and developmental needs as a point of reference in dyadic interactions. This perspective is consistent with that of Fonagy (2003), who describes the capacity for an interpersonal interpretation, which overlaps with the concept of a 'theory of mind', as the key determinant of secure attachment. Main (1991) believed that a mother who could access and openly acknowledge attachment-relevant information and memories was also able to recognise and respond to her child's changing attachment needs. A sensitive parent can support the child in increasing autonomy and set age-appropriate limits (Lieberman, 2004).

Taken together, attachment theory and research outcomes support the notion that a mother's representation of her child is related to own attachment experiences, her caregiving behaviour and to the quality of attachment formed with the child. Attachment is not synonymous with the total relationship between child and caregiver, and while it is likely that early experiences of care become relevant to later socio-emotional development, distal factors including maternal mental health and social support influence the aetiology and maintenance of psychosocial problems.