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# 'The Agony & the Ecstasy: Managing a Chronic Pain Condition Whilst Being a Mother'

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University of Plymouth

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**UNIVERSITY OF  
PLYMOUTH**

**‘The Agony & the Ecstasy: Managing a Chronic Pain Condition  
Whilst Being a Mother’**

by

**Movita Chapman-Moyle**

A thesis submitted to the University of Plymouth  
in partial fulfilment for the posthumous degree of

**DOCTOR OF PHILOSOPHY**

School of Psychology

**October 2021**

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## **DEDICATION**

I dedicate this research to my own beloved mother, Suzette Chapman, who we lost in 2008 due to complications with her chronic pain condition ... and to all our mothers.

## **Acknowledgements**

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## **Author's Declaration**

At no time during the registration for the degree of *Doctor of Philosophy* has the author been registered for any other University award without prior agreement of the Doctoral College Quality Sub-Committee.

Work submitted for this research degree at the University of Plymouth has not formed part of any other degree either at the University of Plymouth or at another establishment.

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# **Attachment Influences the Relationship Between Maternal Persistent Pain and Child Pain Complaints**

**Movita Chapman-Moyle**

## **Abstract**

Persistent pain is a debilitating condition affecting more women than men, and for women in their child-rearing years this means struggling to bring up children whilst contending with an unforgiving pain condition. Existing research in this area has found increased levels of pain complaints in children of mothers with persistent pain, raising the risk of them developing some form of pain in later years.

A primary aim of this research was to investigate ways attachment influences pain development in children of maternal persistent pain sufferers. Additionally, the aim was to investigate how transmission of pain behaviour, including the experience of pain and coping strategies, is influenced by whether mothers suffer with pain with a medically acknowledged aetiology, such as rheumatoid arthritis (RA), compared to more contested aetiology, such as fibromyalgia (FMS). Mothers with children aged between 5-16, were recruited via national pain organisations and via social media, completed standardised questionnaires, five participated in attachment interviews, parenting interviews, and their children engaged in child attachment interviews

All five women described how their pain condition was an emotional and practical challenge, and had childhood histories indicating difficulties in dealing with their lives and pain. In turn, these impacted on their parenting, meaning four of the five cases indicated considerable risks to the future development of their children. Differences in pain aetiology were not related to attachment styles, nor the expression of either maternal or child pain. Four of the five mothers reported providing physical care when their children were in pain

or distress, one, whose pain was relatively well managed, reported providing comfort for her child when ill. Conversely, none of the children reported receiving comfort or nurturing when ill.

Clinical implications include a need not just for individual but also for family based therapies for women with persistent pain and their children.

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## CHAPTER 1 INTRODUCTION

### 1.1 Introduction

The following extract is from a short fiction on maternal chronic pain by the disability researcher and novelist, Dr Tanvir Bush of Bath University<sup>1</sup>.

*'Shhh ... keep still.*

*Breathe in, hold, breathe out.*

*... and just don't bloody move...!*

I squeeze my eyes shut and desperately try to concentrate on my mindful breathing, but I know it's no good. Under my eyelids my eyes are already hot and wet with furious tears. I want to scream *'leave me alone'*, but who would I be screaming at?

My phone beeps and instinctively I tense, sending what feels like shards of glass into my lower back. *No, no, no ... please wait* I beg the pain. *Give me a little more time.* I inhale with a hiss and slowly, carefully, start to slide my body sideways, legs edging over the seat, heading to the floor. I am trying to trick my own body that I am NOT moving. It doesn't work. It never does. As I swing myself into a sitting position, my knuckles and wrists are plunged into boiling oil, my knees feel as if they are being roughly twisted the wrong way round. I become breathless, my heart pounding ... *nonononono I can't do it...* and I wish I could faint. At least then I would be mercifully absent. Pain-free. Unconscious.

I don't faint though and the pain flares and then ebbs slightly, flickering like fire.

I have to get my shoes on. I have to get my bag and the car keys. I have to pick Kitty up from school. *I have to I have to I have to I have to...*

---

<sup>1</sup> Dr Bush is a personal friend and is a disabilities researcher and novelist, who lives with macular degeneration. We met at a researcher development residential set up by our respective universities in 2015. Dr Bush collaboratively wrote this extract specially for the introduction to this thesis

Glass shards in my back so painful my entire leg kicks out and I almost fall backwards. *I can't do this ... I have to do this... I can take another co-codamol in 45 minutes.* I imagine the plop and fizz of the tablet hitting the glass of water. 45 minutes. I can do this. I can get Kitty from school and then it will be time for medication and another short reprieve. I may even be able to put a laundry load on, maybe make supper.

In the hall. I glance at the mirror, feeling like the Little Mermaid walking on knives. I touch up my quivering lips with rose coloured lipstick and pick up my sunglasses. I practice a smile. 45 minutes. Let's go and get Kitty.'

Tanvir Bush – 45 Minutes (2020)

In the quote above we can see how the mother desperately states how she 'has to' pick up her child, Kitty, from school. The demands in the midst of the agony of her pain experience appear overwhelming and relentless. But what about Kitty? Undoubtedly, she is influenced by her mother's desperate experience of pain. Does this lead to Kitty learning that she should not bother her mother with any pain she might experience, or perhaps that she needs to exaggerate her experience so it can be heard above her mother's own pain? This is one of the central questions in this thesis, which emanates from my own experience of being a child similar to Kitty, whose mother was in constant severe pain.

Persistent pain is one of the leading causes of disability worldwide, and as such has the potential to become all-encompassing and debilitating for the sufferer. Statistically, more women appear to suffer with persistent pain than men (IASP, 2018), for example, with the persistent pain condition fibromyalgia syndrome (FMS), 80-90% more women are diagnosed than men (NIAMS, 2004). One explanation for this has been posited by the International Association for the Study of Pain (IASP), who suggest that women experience pain in more adverse ways to men, for example, women tend to have more recurrent, more severe and longer lasting pain than men (IASP, 2018). This becomes more of a problem when women

living with persistent pain are in their child-rearing years and bear the lion's share of the caring and domestic duties. Juggling work, and domestic and maternal roles, whilst managing persistent pain can be extremely challenging (Backman, del Fabro Smith, Smith, Montie, & Suto, 2007), and, because persistent pain does not occur in a vacuum, potentially the ramifications can reverberate through family units, putting children at risk of negative outcomes (Dura & Beck, 1988; Jamison & Walker, 1992; Evans & de Souza, 2008)

For example, research suggests that children of mothers with persistent pain tend to have more pain complaints, poorer general health, more behavioural problems, higher levels of depression and anxiety, and lower family functioning outcomes compared to children whose mothers have no pain (Higgins, Birnie, Chambers, Wilson, Caes, Clark, Linch, Stinson, & Campbell-Yeo, 2015; Evans, Keenan, & Shipton, 2007; Jamison & Walker, 1992; Schulte & Petermann, 2011; Sherman, Bruehl, Smith, & Walker, 2013). Furthermore, with contested pain conditions such as FMS, the additional uncertainty surrounding the causes and treatment for the condition, can heighten distress (Steiner, Bigatti, Hernandez, Lydon-Lam, & Johnston, 2010). Contested pain refers to pain conditions with uncertain aetiology, unclear treatment, and disputed medical and cultural definitions (Gorman & Gorman, 2019). For example, FMS, chronic fatigue syndrome, irritable bowel, or chronic Lyme disease. These conditions are thought of as 'contested' because some, including clinicians and scientists, dispute their existence. Patients with contested conditions are often told the symptoms they experience are 'in their head', or they are overreacting, which tends to lead some to reject psychological explanations for their pain. However, the pain they experience is the root cause, the aetiology, that is disputed.

FMS is a relatively common pain condition which manifests as widespread musculoskeletal pain, fatigue, multiple tender points, and is often accompanied by an array of other symptoms, such as sleep disturbance, cognitive and memory impairment ('fibro fog'),

irritable bowel, headaches, restless leg syndrome, as well as a variety of other symptoms. There are no biological markers for FMS, meaning it becomes a diagnosis of exclusion, potentially increasing the stress of the sufferer, but clinicians believe intense emotional, physical, or psychological stress can trigger the development of the condition (NIAMS, 2004). Due to the contested nature of FMS, sufferers often feel their pain is not taken seriously by family, partners, health clinicians, and employers, increasing their distress, and often leading to a rejection of non-biomedical explanations for their pain.

Rheumatoid arthritis (RA), on the other hand, is an incurable autoimmune pain condition with clear biological markers, causing intense pain, swelling, and stiffness in the joints, most commonly the hands, knees, and feet, but not confined to these areas. Intensity of symptoms can fluctuate through ‘flare-ups’ and ‘remissions’, and it is the swelling during flare-ups that can damage the joints, sometimes leading to deformation of the hands and feet. These can sometimes be ‘corrected’ through surgery, but usually medication is taken to slow the effects of the damage. Complications of RA include inflammation of the lungs, heart, and eyes, carpal tunnel syndrome, and a higher risk of heart attack, stroke, and gastrointestinal perforation. With RA, 25% more women are diagnosed than men (Laivoranta-Nyman, Luukkainen, Hakala, Hannonen, Möttönen, Yli-Kerttula, Ilonen, Toivanena, 2001), compared to the 80/90% with FMS (NIAMS, 2004).

Research studies indicate that children of mothers with persistent pain conditions tend to have more pain complaints (Higgins et al., 2015; Hoftun et al., 2013) than those of pain free mothers, which potentially appears indicative of some form of transmission effect between parent and child. However, the cognitive and affective mechanisms underlying the transmission of pain between parent and child are currently unclear. One of the primary aims of the research in this thesis was to investigate whether and how attachment may influence pain development in children of maternal persistent pain sufferers. Attachment Theory was

chosen in this thesis because it focusses on understanding how care and comfort is sought when in danger, and pain is a very important indicator of danger. In particular, the aim was to investigate how the transmission of pain behaviour, including the experience of pain and coping strategies, is influenced by whether the mothers suffer with chronic pain with a medically acknowledged physiological aetiology, such as RA, compared to more equivocal etiology, such as FMS. Further, how these conditions are in turn influenced by the different self-protective attachment strategies that the mothers have developed.

## **1.2 Definition of terms**

Certain words are used interchangeably in the body of this thesis, due in part to changes in terminology over time. For example, earlier research uses the term ‘chronic pain’ and later research tends to use the term ‘persistent pain’. Both of these generally mean the long term experience of pain, however it has been suggested that ‘persistent’ might be a more helpful nomenclature, because ‘chronic’ may imply pain is progressive or unchangeable. Therefore, the term used in this research will be ‘persistent pain’, except when discussing previous research where the term ‘chronic’ has been used. Additionally, the terms ‘medically unexplained pain’, ‘functional pain’, or ‘somatisation’ or ‘somatised pain’, all referring to pain of no obvious organic origin or clear aetiology, in some areas of this thesis is used interchangeably with the term ‘contested pain’, meaning pain with an uncertain aetiology, unclear treatment, and disputed medical and cultural definitions.

## **1.3 Order of chapters**

This thesis is organised into 9 further chapters, which will serve as a broad map of how this research was operationalised. Chapter 2 begins with the consideration of the need for an alternative understanding for persistent pain, and the development of a new conceptual

framework to assist with this, incorporating modern pain models, attachment theory, and social constructionism. Chapter 3 evaluates the current research and theory through a review of the literature in the area of maternal persistent pain and identifies any gaps in the research. Chapter 4 is an exploratory qualitative investigation into how mothers with two different pain conditions, RA and FMS, experience their pain while maintaining their maternal roles, using threads from four open forum parenting networking sites. Chapter 5 discusses the methodology of this research and outlines the study's main aims and research question. Chapter 6 considers the recruitment process and associated problems, and describes the next study, which involves the use of two questionnaires; the Parenting Stress Index (PSI-4-SF), and the parent version of the Varni-Thompson Paediatric Pain Questionnaire (PPQ). In chapter 7 five mothers participate in Adult Attachment Interviews (AAIs) where they discuss their childhood experiences, which were analysed to assess their attachment categorisations. Chapter 8 is an investigation of the five participant mothers experiences of parenting their own children through the use of the Parent Development Interview (PDI), the data from which were analysed using the Meaning of the Child (MotC) analytical framework, which allows a sophisticated examination of dispositional representations, or systems of beliefs and attitudes the parent has towards their child and their relationship. Chapter 9 assesses the Child Attachment Interviews (CAI) of four of the five children from the mothers involved in this research, where they discuss their experiences of being in their families, and their attachment patterns are reviewed. Chapter 10 brings this thesis to a conclusion with a consideration of the findings, the major clinical implications, and future research and interventions.

The next chapter will begin the journey into the search for a greater understanding of the familial effects of maternal pain by redefining how we understand persistent pain.

## **CHAPTER 2                    CONCEPTUAL FRAMEWORK**

### **2.1     Introduction**

This chapter will introduce and outline a new framework for understanding persistent pain, and is structured in a very specific and important way. Firstly, in section two, a basic description and explanation will be given, outlining the three individual concepts/theories that are to be combined in this new framework; pain, attachment, and social construction. This initial section is very important, because it is imperative one understands the key features of the individual concepts before attempting to assimilate them to form a framework. Section three will discuss how these concepts are related and integrated to form the new framework. Finally, section four will conclude with a summary of the whole chapter.

### **2.2     An Outline of the Framework**

The framework used in this thesis is tripartite in its composition, in that it combines three individual concepts/theories to underpin the research in this thesis. It brings together the 3 individual concepts on which the whole research project hangs; that of persistent pain and the modern theories that attempt to explain it, attachment theory, and social construction. The first of these to be outlined will be that of pain theories, the discussion will then move onto an explanation of attachment theory and its importance for this research, and finally will discuss the key features of the social constructionist paradigm.

### **2.3     Overview of the Theories**

#### ***2.3.1 Theories of pain***

The International Association for the Study of Pain (IASP) define pain as ‘An aversive sensory and emotional experience typically caused by, or resembling that caused by,

actual or potential tissue injury' (IASP, 2019). Pain has been part of the human existence for as long as humankind has been on earth, and from the dawn of time comprehensive explanations for the physiological basis of pain perception have been sought. From the 17<sup>th</sup> century pain theories began to form what we recognise today as more modern ideas concerning pain perception. In this section I shall concentrate on the wider Cartesian model, biomedical model, and the biopsychosocial model of pain.

**2.3.1.i. The Cartesian Model of Pain.** Cartesian Dualism was first postulated by Renee Descartes (1596-1650) and is the basis for the western modern medical model we use today. Prior to Cartesian Dualism the belief was that humans were spiritual beings, and the body and soul were one. Illness was attributed to incorporeal influences and could only be healed by repentance to God through the guidance of the church. Pain was believed to be evidence of God's presence, an understanding of being damned, or as a test from God (Eeman, 2014). Self-inflicted pain was used as a penance for the sins of martyrs, preferring to receive the pain of punishment in this life, rather than in the fiery hell of the next (Morris, 1991).

In opposition to this, Descartes argued that the body and mind (or soul) were separate; the body operating like a machine, whilst the mind remained ethereal. This then allowed the body to be investigated by the natural sciences; however, the mind (or soul) was still not considered open to the same kind of examination, as its metaphysical nature excluded it from physical laws (Eeman, 2014). In this model, the body was seen as machine-like, having working components that when breakdown result in ill health and pain. This mind-body dualism meant examination of the mind, the nature of consciousness, and how they relate to and influence the body ultimately became known as the Mind-Body Problem.

**2.3.1.ii The Biomedical Model of Pain.** The biomedical model of pain takes on elements of Cartesian Dualism and applies it to western modern medicine. As such, the mind

and body are considered separate and distinct. The body is regarded in terms of physical processes, which are seen as objective and measurable, and are prioritised over mental processes, which are thought of as subjective and immeasurable (Gatchel & Kishino, 2008).

This model assumes pain belongs to discoverable pathologies, with predictably identifiable features, and disease pathways (Eeman, 2014). The elevation of the body over the mind can be seen as reductionist (Mehta, 2011), in that its only interest is in specific disease criteria, and effectively dismisses and separates psychological, behavioural, and social/environmental factors involved with persistent pain. The patient's lived experience is of little importance to the clinician and takes on an entirely depersonalised criterion of particular pain conditions.

Therefore, for the biomedical model of pain, if there are no observable physical causes, such as damage, inflammation etc., clearly operating as the pain stimuli, then the pain cannot be real. The clinician concludes the pain has a psychological aetiology, which has the effect of dismissing the patient's pain (Eeman, 2014). The gaps created between the observable/objective elements of a pain condition, and the subjective/unobservable lived experience of a pain patient makes the biomedical model of pain untenable and creates frustrations in clinician and patient alike.

The reductionist mind-body dualism can be seen to be organised around individualised body part specialisations, such as cardiology, gynaecology, and gastroenterology. These are treated separately, often with little discussion between departments and services, and as such is far from holistic. Because of this separate organ-based approach much can be missed, and many fall between the gaps. Within the biomedical model, dualism is perhaps most blatant in the division of psychiatry and neurology.

Examples of theories that fit the biomedical model are Specificity Theory and Intensity Theory. In essence, Specificity Theory, which was first developed by Von Frey in

1894, states each sensory system, such as sight, touch and pain, has its own specialised receptor within the peripheral nervous system, known as a nociceptor. These lead to individual sensory centres within the brain, and each of these individualised nociceptors are sensitive to one particular type of stimulus (Dubnar et al., 1978). So, when a particular nociceptor is activated by a specific kind of sensory stimulus, such as damage to the skin, for example, signals are sent along the individual pathways, or nerve fibres, to the target centres within the brain. The target centre then processes the information to produce the experience of pain. The assumption then is that a pain specific pathway can be identified and intercepted to ease pain.

For Intensity Theory there are no distinct pathways for specific sensory stimuli. Instead, sensory impulses build up; the more there are, the more intense the stimuli are encoded. Therefore, low levels of synaptic impulses are encoded as innocuous stimuli, and therefore not painful, whilst higher levels of synaptic impulses are encoded as nocuous stimuli, therefore painful. As such, any sensory modality can be perceived a painful when sufficient intensity is reached. Neither of these theories take into account the patient as a sentient being; pain happens *to* them, it is described purely in physiological terms with no acknowledgement of the lived experience of such pain, and no account of contributory psychological, behavioural, or environmental factors.

**2.3.1.iii. The Biopsychosocial model of Pain.** Due to limitations and criticisms levelled at the biomedical model for pain, shifts in thought came around the middle of the 20<sup>th</sup> century (Bendelow, 2013), and with it a change in how the aetiology and maintenance of pain was viewed. Individual psychological and social factors were now understood to interact with biological factors, bridging the gap between the physiology, psychology, and sociology of pain.

This approach provides an explanation of how and why individual's experiences variability in pain. Engel (1977) argued that the psychosocial 'layers' of illness related stress, illness behaviour, and 'the sick role' complicate illness progression. Engel argued that illness developed through the interaction of not only biological factors, but also of psychological and social factors (Engel,1977). For example, an individual may have a genetic predisposition for a particular pain condition, however, psychological factors such as severe anxiety, and social factors such as an unsupportive partner, and lower socioeconomic status, may layer upon the predisposition, triggering and exacerbating the condition. Loeser (1982) furthered this idea by saying there are four elements to pain; nociception, pain, suffering, and pain behaviour. Nociception is the physiological and biological parts involved with sensory input, such as synapses, receptors, and fibres. Pain relates to the individual subjective experience of adverse sensory stimuli, as we all experience pain differently, for example, what might be referred to as different pain thresholds. The anxiety, fear, and depression often experienced by persistent pain patients can be understood in terms of suffering, and it is this element that brings in the psychological component, with pain behaviour being the behavioural reaction to finding oneself in pain, such as restricting movement, which conversely can delay recovery, and unconsciously exaggerating one's symptoms in an effort to elicit care from others (McWilliams and Holmberg, 2010). The increased burden this can put on others, such as family members, or work colleagues, however unintended, can cause financial, social, and psychological reverberations.<sup>2</sup>

Examples of theories which fit within the biopsychosocial model are Melzack and Wall's Gate Control Theory (Melzack and Wall, 1965), Melzak's Neuromatrix Theory (Melzack, 1990), and Central Sensitisation. The Gate Control Theory was one of, if not the first theory of pain to introduce the significance of psychosocial factors affecting pain

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<sup>2</sup> This is discussed in greater detail in Chapter 3 - Literature review

perception. The 'gate' refers to a group of cells, called the substantia gelatinosa. This group of cells run the entire length of the dorsal horn, which is one of the columns making up the spinal cord. According to the gate control theory, the substantia gelatinosa performs a gate-like function, controlling the intensity and quantity of impulses coming in from the peripheral nervous system, to the central nervous system. The higher the number, and greater the intensity of the impulses coming in opens the gate, causing the central nervous system to tell the brain the body is perceiving pain. Descending signals from the brain to the substantia gelatinosa close the gate, which diminishes pain perception. Psychological factors can affect the descending signals from the brain, for example anxiety, fear, depression, or feelings of vulnerability can act to open the gate, whereas taking analgesia or a placebo, or comfort from family can act to close it, thereby diminishing or perpetuating the perception of pain.

Whilst this theory was very influential, and significantly changed the pain paradigm, it did not account for more baffling pain conditions, such as phantom limb pain, where a patient still feels pain in an amputated limb (Melzack, 1990). The neuromatrix theory of pain argues that, in contrast to the biomedical model and all previous pain theories, pain is produced in the central nervous system. Rather than tissue damage being the source of pain, Melzack (1990) argued that the peripheral nervous system merely reports physical or environmental stimuli to the central nervous system, and that multiple areas within the brain work together to generate pain perception. According to Melzack (1990), the brain holds a map of the body, which he named the neuromatrix, because the 'map' is spread over a number of different areas. When the brain sends impulses to an area on the map that is no longer physically there, for example in attempting to move an amputated foot, and receives no reply, the brain sends stronger and stronger impulses to the area, and it is these intense impulses that cause phantom limb pain.

Given that the matrix comprises many areas of the brain, including the hippocampus, amygdala, hypothalamus, somatosensory cortex, motor cortex, and prefrontal cortex, among others, each of these areas contributes to the experience of pain, the emotional, cognitive, sensory, and behavioural features (McAllister, 2017). The neuromatrix theory of pain explains not only the biological/physical aspects of pain perception, but also the social context of the occurrence of pain and how it influences perception and intensity, and the affective aspects of its perception and intensity. Melzack (1990) also argued that an unintended glitch in the neuromatrix could explain the placebo effect and medically unexplained pain. This biopsychosocial theory bridges many gaps between observable/objective elements of a pain condition, and the subjective/unobservable pain experience, as well as providing credible answers to the question of functional, somatoform pain, which is ambiguous, non-specific, often debilitating pain with no biomedical markers and unknown aetiology. Functional somatic pain conditions are exemplified in conditions such as Persistent Fatigue Syndrome (CFS), visceral pain in irritable bowel syndrome (IBS), and the musculoskeletal pain in fibromyalgia (FMS). Despite having no observable organic aetiology, the pain felt by patients with functional pain conditions is very real. The neuromatrix theory attempts to explain the psychological and social factors involved in the generation and treatment of functional pain syndromes (McAllister, 2017).

Central sensitisation is a newer pain theories and stands on the shoulders of the Gate Theory and the Nueromatrix Theory. Central sensitisation occurs when the nervous system becomes over-activated, in a process called 'wind up'. It gets stuck in a state of persistent high reactivity, which has the effect of lowering the threshold for pain and persevering the pain experience (McAllister, 2017). Symptoms of central sensitisation are allodynia, pain caused by a stimulus that would not usually cause pain, and hyperalgesia, an extremely

heightened sensitivity to pain. This is due to the nervous system being in a state of persistent high reactivity, prompting the brain to ‘over-react’, producing amplified pain.

This heightened sensitivity can also affect other senses beyond that of touch. Patients can also experience sensitivity to light, sounds, and odours (McAllister, 2017). Central sensitisation is also associated with cognitive deficits and poor memory retention, as well as increased stress and anxiety due to an over reactive nervous system (McAllister, 2017). This is because there are changes at the dorsal horn of the spinal cord, causing increased neural activity, a reduction in the threshold for activation by peripheral stimulation, meaning a lighter touch will cause higher levels of pain, and increased suprathreshold stimulation, which refers to a stimulus large enough to produce a neuronal response, meaning a smaller stimulus is likely to produce a painful response (Schwartzman, Grothusen, Kiefer, & Rohr, 2001).

Psychophysiological factors, such as intense protracted stress, may be involved in the development of central sensitisation. The nervous system being flooded with cortisol for long periods of time, for instance, can have the effect of lowering the immune system (McAllister, 2017). It is as if stress primes the nervous system for the development of central sensitisation. So, a history of unresolved anxiety, trauma, and depression can be predictive of persistent pain in later life (Talbot et al, 2009; Hauser et al, 2013).

### **2.3.2 Attachment Theory**

<sup>3</sup>Attachment Theory is a psychological construct, which can be described as an emotional bond between two people, either sibling relationships, parent-child relationships, or romantic relationships, for example. It is an integrative theory that was developed to offer an explanation of how we respond to danger by seeking support and protection from parents

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<sup>3</sup> This will be explored further in Chapter 4- Exploratory Study

and other protective figures. One of the earliest dangers for an infant is pain, and how pain and attachment are integrated will be discussed in greater detail in the next section. When an attachment relationship is unchallenged it is experienced as a source of security (Bowlby, 1980). However, threat to the relationship, whether in the form of inappropriate responses from one's attachment figure, or whether they are unresponsive in some way, gives rise to anxiety and feelings of insecurity (Bowlby, 1980). It is this attachment insecurity that generates self-protective mental, emotional, and behavioural strategies (Farnfield, Hautamäki, Nørbech, and Sahhar, 2010).

Attachment theory, therefore, is essentially a theory of danger and the strategies used to protect one's self from this danger through eliciting protection from a primary caregiver. The various strategies people employ to gain security and comfort are well known; for example, interpersonal regulation by soothing, physical comfort, cognitive and affective reassurance.

John Bowlby first developed Attachment Theory after WWII (1969/1982; 1973, 1980) as a result of his own psychiatric work with delinquent boys and children separated from their mothers. He believed that maternal love was central to secure attachment, and, as a result, social competence. He believed forming an attachment in infancy to a primary caregiver, usually the mother, is a fundamental and biologically based inevitability, and works primarily to afford vulnerable infants protection during their early years (Bowlby, 1969). According to Bowlby, when a child feels threatened or in pain they will engage in various forms of behaviour to obtain and maintain proximity to their parent, using the parent as a 'Secure Base' from which they go out and explore the world, returning to the secure base when scared, in need of comfort or protection. The way parents respond to the child's bids for protection, care, or comfort when in pain, is key to shaping and developing the child's attachment system, and future attachment related behaviours. He believed a physically or

emotionally unavailable parent is likely to set the child on the path for psychological disorders in the future, in addition to skewing their strategies for dealing with pain and illness. Bowlby stated children develop an Internal Working Model (IWM) that guides how they view themselves, their attachment figures, and their relationship with their attachment figures.

Bowlby's attachment theory was empirically used by Ainsworth (1967) in two naturalistic observation studies. Firstly, when she observed Ugandan mothers and their children, she noted that whilst there were important differences in how children behaved when separated from their mothers, it was during reunion that differences in child behaviour were most evident. From these observational studies she identified three different attachment types: secure, insecure, and absent. Secondly, whilst working in Baltimore, USA, observing the behaviour of babies and their mothers in their homes. It was at this time she developed a method for assessing infant attachment; the Strange Situation Test. From this work she refined her attachment types by removing the absent classification and subdividing the insecure classification in two; Type A – Insecure, anxious avoidant, this is where children had mothers who disliked or disapproved of their baby's negative affect, including for some displays of pain, meaning the child tended not to seek proximity on reunion; Type B – Secure children had mothers who were warm and appropriately protective, and the child sought proximity on reunion; Type C – insecure anxious ambivalent children had mothers who were unpredictable in their response to their child's bids for care, meaning the child was indecisive in their desire for proximity on reunion, seeming to both want it, but not want it at the same time. This model formed the ABC model of attachment. The model was later modified by Main and Solomon (1986), adding a fourth classification (Type D) for children whose behaviour did not fit into A, B or C categories, or could not be classified.

The Dynamic Maturational Model of attachment (DMM) (Crittenden, 2006) offers an alternative conceptualisation of attachment to the recognised ABC+D model, proposed by Bowlby and Ainsworth. Instead of the IWM, the DMM conceptualises attachment in terms of the development of dispositional representations guiding how we see ourselves and our potential attachment figures. The DMM describes dispositional representations as the ways in which information is processed to generate meaningful representations of our world, past and present, and how behaviour is then organised in accordance with these representations (Crittenden, 2002). Individuals will generate multiple dispositional representations from all their attachment interactions. For example, when one's mother is brought to mind, certain mental representations of what the word 'mother' means for them will be generated from an array of personal interactions, disposing them to act in a particular way. Dispositional representations not only guide one's behaviour, but it also provides an expectation of the outcome of that behaviour, and the transactional behaviour of others as a result (McKinsey Crittenden, 2017).

In addition, the DMM differentiates the disorganised patterns of attachment described in the ABC+D model of attachment, as a complex mixture of basic attachment strategies, which are not disorganised at all, but are in fact extremely organised functional self-protective strategies. It is these more extreme and complex patterns that are typically involved in dealing with highly stressful or dangerous circumstances.

Therefore, the research in this project will be considered within an over-riding framework of attachment theory and its elaboration in the Dynamic Maturational Model (DMM) of attachment and adaption (Crittenden, 2006) (see fig. 1 below).

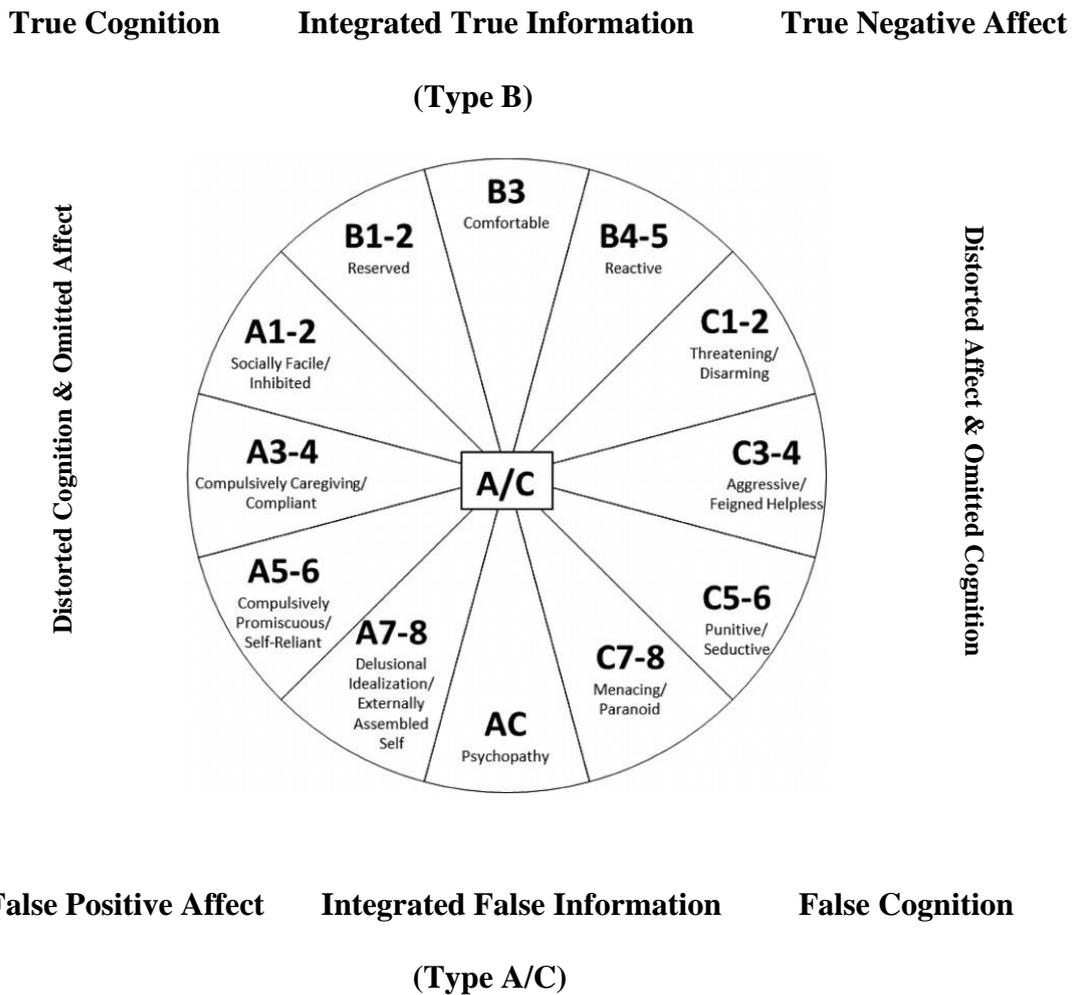


Figure 1: Dynamic Maturational Model (DMM) of self-protective strategies

**2.3.2i. Differences Between the ABC+D Model and the DMM of Attachment.** The DMM is particularly useful in differentiating some of the more complex and difficult attachment behaviours. Whilst the Ainsworth ABC+D model provides useful understandings in the differentiation of avoidant/dismissive or preoccupied/ambivalent attachment behaviours, the DMM is arguably more flexible in differentiating so called ‘disorganised’ attachment behaviours (Shah and Strathearn, 2014). As mentioned briefly above, Ainsworth’s ABC model of attachment was extended by Main and Solomon (1986), through introducing a fourth attachment category (Type D). This fourth categorisation indicates ‘disorganised’

attachment behaviours in severely maltreated children, who subsequently show no strategic attachment style. Ainsworth's model was later further elaborated upon by Crittenden (2006), who developed the Dynamic Maturational Model (DMM) of attachment. Both revisions agree that attachment behaviours are developed during childhood, and enduringly reflect childhood experiences, and whilst they both explain secure and relatively insecure attachment behaviours in useful ways, they differ on several key points. Main and Solomon's revision suggests that fear has a disorganising effect on attachment behaviour, whilst the DMM argues that fear works as a highly organising factor, producing attempts at self-protective strategies (Shah and Strathearn, 2014). In effect, the DMM offers a systemic perspective; that the relational attachment setting is 'disorganised', complex and unsafe. The attachment strategies that the individual subsequently develops are attempts to manage this context, and may appear 'disorganised'. However, these are, in fact, attempts to survive a 'disorganised' context. Furthermore, the DMM suggests increasing exclusion or distortion of either cognitive or affective information and memories, the more complex an individual's attachment strategies become (Crittenden and Ainsworth, 1989).

These are particularly useful ways of explaining attachment-based pain behaviour, principally in so called medically unexplained pain and somatising disorders.

**2.3.2 ii. The Dynamic Maturational Model of Attachment (DMM) – Behavioural Strategies.** Essentially, the DMM describes attachment behaviour as organised self-protective strategies, which may vary in severity or complexity depending on the perceived level of threat, or feelings of vulnerability and pain. It aims to explain how development of behavioural and mental strategies occur during childhood, and ultimately serve to maximise comforting responses and minimise possible threatening responses from attachment figures. The DMM describes these self-protective strategies as being 'organised' and 'strategic', because the individual uses them in predictable ways, and each behavioural strategy is

specific in its function (Crittenden, 2006). According to the DMM, there are 5 developmental stages, infancy; preschool; school age; adolescence; and adulthood. As the child matures, more attachment strategies become available. Infants up to around 15 months are able to use strategies A1-2, B1-4, and C1-2. Preschool and school age children are additionally able to make use of strategies A3-4, and C3-6. Adolescents add A5-6, whilst all the attachment patterns are available to adults. Notably, children in disorganised environments may often attempt to use strategies developmentally beyond them. For example, school age children using Type A4 (compulsive compliant) strategies may attempt self-reliant strategies (Type A6), however because this is developmentally beyond them, they will not be able to use the strategy effectively (Farnfield and Stokowy, 2014).

**Type B.** Type B strategies are characterised by clear and open bids for attention, care and comfort, where the attachment figure responds in predictable and appropriately sensitive ways. Individuals are able to integrate all sources of available information, such as cognition and affect, to guide their own behaviour, and predict the behaviour of others. Such balanced attachment strategies reflect experiences of safe environments, where the individual feels protected and comforted by their attachment figures.

**Type A.** Individuals using Type A strategies tend to rely more on cognitive information and memories to guide behaviour, minimising, or distorting available affective information. Type A attachment strategies are characterised by the suppressing of negative affect in individuals using A1-2 strategies, and is replaced with false positive affect by those using more complex A3-8 strategies (Farnfield et al., 2010). This occurs in situations where open bids for attention, care, or comfort produces a predictable negative response from the attachment figure; such as, failure to respond to what is seen as unnecessary displays of emotion, withdrawal from the individual, or frank displeasure, anger, or punishment. The

individual's internal script becomes 'do the right thing', which engenders a need to please others with no regard to their own feelings or desires.

**Type C.** Type C strategies are characterised by an increasing over-reliance on affective information and memories to guide and predict behaviour, and the exclusion, or distortion of available cognitive information. Type C strategies involve disregarding of cognition in those using C1-2 strategies, which becomes increasingly falsified in individuals using C3-8 strategies (Farnfield et al., 2010). This functions to provoke a caregiving response from inconsistently preoccupied, inattentive, or neglectful attachment figures. The attachment figure's unpredictability may include intermittent withdrawal or neglect, or erratic outbursts of anger. The individual's internal script becomes 'stay true to your feelings; do not negotiate or compromise in any way that favours the other'. Individuals using Type C strategies do not feel held in mind by attachment figures, causing them to exaggerate, inhibit, and alternate between displays of fear, anger, and desire for comfort, according to which strategy is most adaptive at the time.

**Memory systems.** There are 8 memory systems around which dispositional representations and attachment behaviours are organised, and these can be further organised in five different ways; somatic, cognitive or affective, implicit (pre-verbal) or explicit (verbal). These ways of organising information are directly linked to the attachment strategies one uses (Crittenden, 2016).

<b>Representational Memory Systems</b>			
	<b>Somatic</b>	<b>Cognitive</b>	<b>Affect</b>
<b>Implicit</b>	Organic States	Procedural Memory	Imaged Memory
<b>Explicit</b>	Body Talk	Semantic Memory	Connotative Language
	Episodic Memory (source memory)		
	Working Memory (reflective integration)		

*Table 1: Organisation of representational memory systems*

Somatic information indicates disruptions in homeostasis, including feeling hungry, tired, discomfort (such as feeling cold or too hot), or pain, and are the earliest DRs to develop. In fact, attachment relationships can shape the way in which pain is signalled (Kozłowska, 2009). Somatic information can be represented either implicitly via organic (physiological) states, such as IBS or stress headaches, or explicitly, represented by ‘body talk’, openly discussing or unconsciously escalating pain signals.

Implicit memory systems develop from early childhood and include procedural and imaged memory. Procedural memory is cognitively based and involves knowing how to do things without thinking about it, such as driving, riding a bike, and writing. In attachment terms, this involves learning how our attachment figure is likely to respond when we make bids for care, attention, protection, or love.

Imaged memory involves sensory information, such as the smell of cut grass, the image of our mother’s face when she smiled, the sound of our father singing, or the taste of

certain sweets from our childhood. Smell and sound can be particularly powerful in evoking memories.

Explicit memory systems develop when we are a little older and involves semantic memory, and connotative language. Semantic memory relates to language acquisition and refers to the internalisation of verbal narratives and discourse. For example, family scripts around pain/illness behaviour, or knowing how to behave at school. This can also involve internalising the observations of others about our own behaviours, for example, 'I am a difficult person, because I argue every time my partner texts other women'.

Episodic memory can be described in ways that relate to our generalised ideas about what memory is, in that it stores memories of episodes from our past. Episodic memory integrates both cognitive and affective information about the episodes that occurred in our past. A subset of episodic memory is source memory. This relates to our awareness of where the memories originate from, such as we remember it happening, or we remember the episode because it was repeatedly retold to us when extended family got together. It also relates to the ability to distinguish what we know to be true about an event, and what we were told about the event, such as, our parents telling us the dog went to live on a farm, when we know the dog actually died and was buried in the back garden.

Lastly, working memory is the space where we inspect information from other memory systems. This is an active process where we can integrate information from the past, memories and what we knew as a child, with information from the present, what we have subsequently learned. For example, the memory and knowledge from childhood that one's father was always short tempered, with the adult realisation that he worked long hours for little pay, ran a household, whilst looking after a sick wife and several small, near feral children. This integration ability, in time, allows one to develop new dispositional representations (Farnfield and Stokowy, 2014).

### ***2.3.3 Social Constructionism***

Social constructionism originated in opposition to the postmodernist view of the nature of reality. Based in sociology, social constructionism is concerned with group processes, such as those relating to race, gender, class and sexuality, for example. Contrary to the deductive, top-down research processes of quantitative, postmodern research paradigms, social constructionism highlights the social production of reality, focusing on everyday co-created lived experience and truth. Beginning with and building on observed patterns in behaviour and group narrative, these observations draw attention to the patterns of daily life within specific social groups, the truths they generate, their meaning making processes, and building of joint realities.

Berger and Luckmann (1991) proposed that reality is socially created, negotiated, defined, and modified, yet this reality is based in the subjective experience of everyday life. It is how the world is understood by those within social groups, rather than through an objective, scientific reality of the natural world. Therefore, according to social constructionism, the known and the act of knowing is concerned with trying to make sense of what it is to be human, described as ‘meaning making’, via lived experience, as opposed to hard scientific knowledge, in that it is individuals, or groups of individuals, who define this reality. Accordingly, at any one time there can be multiple truths, multiple realities, multiple knowing. For example, we see these multiple truths everyday via news outlets. Politicians argue their versions of truth and reality based on their own lives, upbringing, beliefs, and experiences, meaning these truths are both relative and subjective, and can often be conflicting, therefore can often conflict with the truths of those holding other political ideologies.

Weick (1993) argues that with social constructionism comes a shift in viewing truth, knowledge, and therefore reality, as a static product waiting to be discovered, to thinking of

truth as a process in that it becomes a dynamic, flexible process that fluctuates between social groups, through differences in lived experiences.

So, while there is an acceptance of an objective reality, social constructionism, however, is concerned with how knowledge is co-constructed and understood.

**2.3.3i. Social Constructionism vs Social Constructivism.** There are different branches of the social construction movement, which can basically be condensed to that of social constructionism and that of social constructivism. Whilst they are often used interchangeably (Howell, 2012), there is a subtle difference. Social constructivism argues individuals construct and make meaning of their worlds, while social constructionism regards meaning to be co-constructed through social/group improvisation and consensus. They have more than one shared stance, however, such as both stressing the influence of language as conveying shared meanings, both focussing on power, and who holds the power to promote and maintain certain versions of ‘truth’, and perhaps most importantly, that reality is not entirely objective, but is established and defined through social interaction; meaning community and self are inextricably entwined. The branch used in this thesis is that of social constructionism, where meaning and reality is co-constructed through social collaboration, nevertheless, it is acknowledged here that knowledge, truth, and reality begins with individual experience.

**2.3.3ii. Ontology and Epistemology.** The ontological assumptions of social constructionism are, due to the changeable nature of groups and individuals, that reality is viewed as relative. Therefore, social construction is understood as ‘relative realism’ or as having a ‘relative ontology’ (Howell, 2012). The epistemological assumptions of social constructionism are that research findings are created through negotiation and subjective constructions, meaning findings are co-constructed by both the researcher and the researched; they are intrinsically linked, and both are influenced by historical and cultural values.

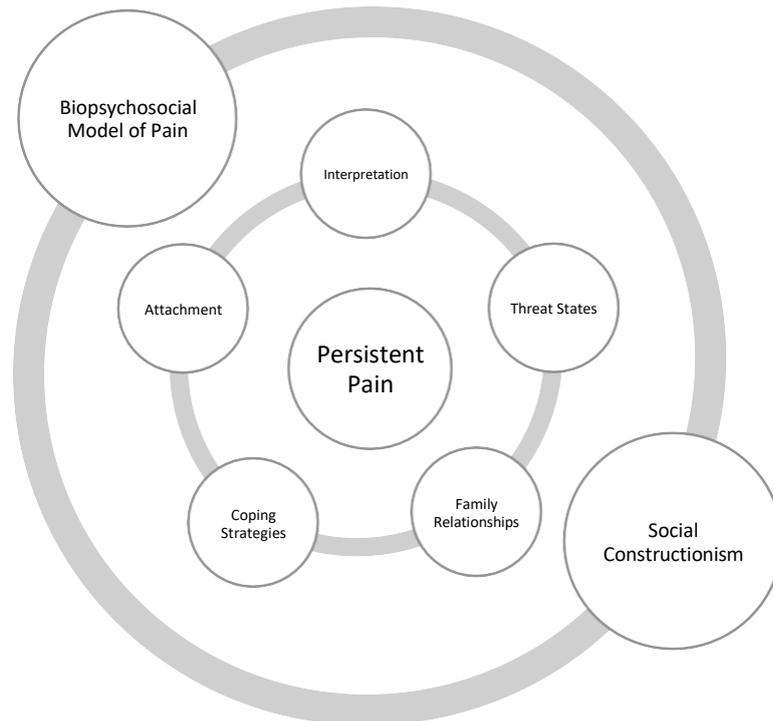
## 2.4 The Attachment Integrated Model of Persistent Pain

This new conceptual framework for persistent pain comprises elements that interrelate and interact within the three main concepts of the biopsychosocial model of pain, attachment theory, and social construction. These elements include interpretation, threat states, family relationships, and coping strategies. These are all influenced by and influence the individual, their environment and relationships, and each other, creating a dynamic, ever changing status quo, whilst being controlled and influenced by the wider contextual concepts of social constructionism and the biopsychosocial understanding of pain, the intersectionality of which will be discussed below.

The wider social context, in turn, affects and informs on a more intimate and individual level. Individually, **Threat states** are about the affective and cognitive **interpretation** of what threat is, how danger (externally felt) and fear (internally felt) are appraised by the individual. These are in turn linked to **attachment** strategies, with dismissive strategies using cognitive interpretations, and preoccupied strategies using affective interpretations, and how the interpretation is linked to motivating an action as a response. There is no order, necessarily, it could be that an emotional interpretation occurs first, and a cognitive rationalisation happens once the threat subsides, or vice versa, depending on one's **attachment** strategies. These threat states could come from pain, trauma, unresolved loss, fear of being judged, not being believed, or even one's own child.

**Coping strategies** relate to how individuals attempt to regulate threat states or respond to a stressor. How they cope with the pain, challenges with relationships, challenges from the wider context i.e. the discourses that locate them as being neurotic, their pain being in their heads, or as them not meeting what it means to be a good mother. This, of course, all feeds into and interacts with **threat states** and **interpretation**. Additionally, as has been

explained above, **family relationships** are inextricably linked with the shaping of **attachment** and the implementation of attachment strategies. Therefore, the very nature of the way these elements and the concepts are interlinked and interact can be seen to be systemic (fig. 3) and will be explained in further detail in the last few sections of this chapter.



*Figure 2: The Attachment Integrated Model of Persistent Pain*

**2.4.1.i. Attachment and Pain.** Arguably one of the most interesting features in the consideration of attachment and pain, is that while pain is central to attachment theory, attachment is not considered central to mainstream pain models. Similarly, attachment is a fundamental component of the parent-child relationship, yet has been employed relatively infrequently in relation to research or the theoretical consideration of persistent pain. Attachment is relevant, because it is fundamentally a theory of how danger and distress is managed in families, and specifically how comfort is sought and provided. This concept is central to the study of pain in families, because it may provide some insight into what cues

are attended to by the parent, or what strategies the child needs to employ in order to get their needs met. Parents frequently remark that they experience the pain of their child as sharply, or even more acutely than their own pain, and the inability to soothe one's child's pain can be an extremely distressing experience for a parent.

Pain is one of the earliest signals of danger that infants feel; hunger, cold, soreness, illness, etc. It is evident then, that pain is one of the primary mechanisms through which the body signals the danger of illness. Headaches, aches, unpleasant coughs and sensations are the body's natural way to alert us and our carers that we may be in danger, and need care and protection. Children learn that relief from pain is provided by their parent, or attachment figure, and as the child develops, these figures also give meaning to the various sensations and pains that the child experiences, and in turn the strategies children develop for managing their pain and distress. Out of this provision of safety and relief of pain and distress, the child and parent develop a relationship. Attachment theory therefore suggests that danger (and pain as a protective mechanism) and relationships are inter-woven.

So, included in how we learn to seek care and support from others is how we learn to respond to pain; our own pain, and pain in others. In some families there is a stoic position of dismissing pain and illness, being tough, not making a fuss, and not being a 'cry baby'. This is represented by Type A patterns, where an individual has learnt to unconsciously dismiss their own pain, and emphasise and focus on the pain of others instead. In some cases, this could manifest in dismissing the pain of others because one's dispositional representations inform us that fussing about pain is unacceptable, possibly reviving memories of feelings of danger that crying in pain evoke. Such parents might have suggested that the child should not be such a 'cry baby', becoming angry if the child continues to cry.

***The Role of Medication – Type A.*** The role of medication as one of the major pain interventions can be interpreted and used in different ways for different strategies. For

example, parents using Type A strategies, having learned to inhibit affect, particularly anger and possibly the expression of pain or requests for comfort, may use medication as a way of giving some practical care for their child, but this also keeps pain at a distance by not letting it get too close or getting too organised by it. Giving medication to their child reassures them they are doing something, but allows them to withdraw emotionally, thus distancing themselves from the child's pain and any emotional arousal triggered by it.

In other families, displays of distress and anxiety associated with pain and illness are allowed, whereby a very low threshold of acceptability of pain means that medication and analgesics are used widely. These behaviours are represented by Type C patterns, where an individual can unconsciously exaggerate pain for themselves and dismiss pain of others. The Meaning of the Child analysis<sup>4</sup> (MotC), devised by Dr Benedict Gray, suggests these parents are focussing on their own needs and controlling the child in an attempt to force them to be what they need them to be, e.g. not being irritating or making demands. At the very extreme, individuals who are moving towards extreme A/C patterns, can even enjoy the pain of others. Parents in these families often become consumed with their own experience of the child's pain, making it more about them than the child. They become overly distressed and upset, causing the child more distress, so the child's sense of pain necessarily becomes exaggerated, in order to be acknowledged by their parents, rather than attenuated. These parents are often overwhelmed by their child's needs and may inflict pain on them when they need comfort and care, become extremely distressed and frozen with the child, or alternate between ignoring and becoming overwhelmed.

***The Role of Medication – Type C.*** Parents using Type C strategies have learned to exaggerate affect and anger, and are organised by their own upset. So, if their child is in pain they may find it an irritation, or would feel anxious, which becomes the focus rather than the

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<sup>4</sup> The Meaning of the Child analysis will be discussed in greater detail in Chapter 5 - Methodology

child's pain, so the thing that comes first is their own feelings about their child's pain and distress. When talking about it these parents tend to use 'me' and 'I language, such as 'I was terrified of what would happen to him' or 'I couldn't sleep for worrying about him', so it becomes more about what is happening for them, than what is happening for the child. So, in a way, medication is used in order for them to not feel so bad. For those parents using a more balanced Type B patterns medication is used in a less reactive or distancing way, and more as what is best for the child.

So, when it comes to persistent pain, and especially contested pain, such as Fibromyalgia, this may challenge the basic attachment strategies, such that neither purely avoidance (Type A attachment behaviours), nor purely preoccupation (Type C attachment behaviours) is adequate to manage the condition. Additionally, in these mothers their persistent pain, and for some their early childhood experiences, constitute some traumatic states so that their strategies are compromised. Evidence supports this by suggesting characteristics found in individuals displaying preoccupied attachment strategies often struggle to cope with their pain (Ciechanowski, Sullivan, Jensen, Romano, & Summers, 2003). Thus, as noted above, pain catastrophising (unconsciously exaggerating symptoms) appears influenced by attachment (Vervoot, Goobert, and Crombez, 2010). Kozłowska (2009) argues attachment relationships shape how pain signals are expressed; inhibiting pain signals being indicative of avoidant attachment strategies; exaggerating pain being representative of preoccupied attachment strategies. From previous research, the implication is that patients whose pain condition has a biomedical aetiology, due to the relatively secure understanding of the condition's progression, may have more available resources to work harder in maintaining feelings of security within attachment bonds (Steiner, Bigatti, Hernandez, Lydon-Lam, & Johnston, 2010; Kozłowska, 2009). Thus, displaying comparatively reserved attachment strategies relative to those with pain of no obvious

organic origin, such as Fibromyalgia (FMS), Persistent Fatigue Syndrome (CFS), or Myalgic Encephalomyelitis (ME) (Ciechanowski et al., 2003).

For example, based on the understanding of the above mentioned research it may be that persistent pain sufferers with a biomedical, organic aetiology to their condition display a comparatively more stoic, pain-dismissive form of coping, whilst pain sufferers with a more undefined aetiology may well use a more anxious, aroused, preoccupied coping pattern<sup>5</sup>. Arguably, both these patterns, typically described as ‘insecure’, in fact make sense as coping strategies. The DMM emphasises the phrase ‘insecure’, as a blanket term, may not be comprehensive enough, since these are adaptive strategies (Farnfield et al., 2010). Given that the pain is intractable, attempting to dismiss and deny its importance, as ostensibly appears with stoic, pain dismissive patterns, can be seen as a functional strategy. For example, Kozłowska (2009) suggests patients unconsciously inhibiting the severity of their pain, or related affective distress, are generally liked by medical staff, due to their uncomplaining nature and easiness to treat. The praise received for being a ‘good patient’ in some way satisfies the patient’s care needs, thus reinforcing this attachment strategy. We see this as a dominant discourse in our society, such as the brave amputee who stoically battles against the odds to run from Lands’ End to John O’Groats virtually without drinking, eating, or sleeping. It is the idea of courage in adversity which often has the ‘dark side’ of encouraging stoicism and not adapting to bodily change.

Likewise, for pain sufferers with pain conditions with few biomedical markers, such as FMS, the uncertainty regarding their illness’s cause and progression (Steiner *et al.*, 2010), and consequently the oft perceived ambivalent reactions of medical staff, friends, family, etc., unconsciously escalating one’s level of affect in order for the pain to be taken seriously (Vervoot *et al.*, 2010), may also be identified as functional (Vervoot *et al.*, 2010). For

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<sup>5</sup> This is a theme that is reviewed in the exploratory study discussed in Chapter 4

instance, through unconscious escalation, one's need for care, comfort, or assistance from one's attachment figure is then perceived as more likely to be fulfilled. Whichever strategy is implemented, however, it ultimately means the pain sufferers are working hard to employ defensive processes. As a result, it may be these pain sufferers have few cognitive and affective resources left to attend to the needs of others.

**2.4.1.ii. Pain and Social Construction.** Attachment Theory explains how our dispositional representations, beliefs, emotions, and actions regarding pain are influenced by family traditions across the generations. But our conceptualisations or representations are also influenced by the wider culture in which we live, and as such society reifies the biomedical understandings of the body in such a way that if there is no diagnosis or a biomedical evidence, the pain does not exist. Pain, when formulated in a purely biomedical way, appears as a biological limitation and a bodily malfunction and is viewed as a purely medical problem. Within this narrow medical discourse pain is considered to be a product of abnormal physiology (Hughes and Patterson, 2006). However, pain is more than this; it is only through jointly accepted language that meaning and understanding is given to such bodily sensations (Morris, 1991). It is via locally co-constructed consensus that meaning can be conferred. In this way, pain ceases to be merely a biomedical fact, but also a discursive construct. For example, one individual cannot share the exact pain experience of another, however, meaning and knowledge can be conveyed through commonly accepted and socially constructed systems of discourse.

Whilst persistent pain conditions may exist as a biomedical definition, such as what it is to live with persistent pain, are also co-created within local interactions, such as with groups who share comparative, yet individual pain experience, and construct a unified way of knowing. Additionally, further understandings of these pain groups, and the individuals within, are constructed by family members and wider cultural systems, such as medical

professionals, politicians, and the media, creating dual, and often conflicting truths.

Therefore, truth is seen as both subjective and relative (Howell, 2012). To fully understand this, researchers often apply a dialectical method, which by taking apart the whole into its constituent parts, analysing the contradictory components, such as the reality constructed by pain groups, and the conflicting realities constructed by family, medical professionals, politicians, and the media, and redefining the whole, arrive at a more comprehensive understanding.

We can see how pain has been socially constructed within our own society, and the extent to which medications have been used historically to control pain. For example, pain and how we experience and manage it are arguably a vital and economically substantial cultural process. The sale of analgesics is a major industry, with Big Pharma selling vast quantities of medications worldwide, actively promoting the extensive use of medications, such as Calpol to soothe infants. Social constructionism is interested in these processes, and their historical development, since medications have a substantial history.

For example, amongst the vast array of products for sale in the Victorian era was laudanum (containing morphine and codeine) to ease the pain associated with dysentery, chlorodyne (the principal ingredients being chloroform, morphine, cannabis and laudanum) for coughs and colds, and a tincture containing opium infused with camphor for asthma, opium pills were coated in varnish for the working class, silver for the rich, and gold for the very rich (Anderson, 2005), as a class distinction always needed to be maintained. Bottles of Ayer's Cherry Pectoral prescribed for children's coughs and colds was actually a mixture of alcohol and opium, guaranteed to quieten the most fractious child. Gripe Water for teething babies contained between 3.6% and 8% alcohol, and whilst it certainly eased their pain enough for them to sleep, it was perhaps not particularly good for their long-term health.

Coca leaf, from which cocaine is derived, was advertised as a nerve and muscle tonic, to “appease hunger and thirst”, and to relieve sickness and pain (Anderson, 2005).

An emphasis on the immediacy and ease of pain relief continues today with extensive analgesia advertisements between light-hearted daytime television shows, and where doctors prescribe higher and higher doses of analgesia for intractable pain conditions, even when it is known they become ineffective with long-term use. This reliance on, and medication being the first port of call for the relief of pain was further highlighted at the beginning of the recent Coronavirus pandemic, where paracetamol was one of the first things to run out in the supermarkets.

It is important to note that the theories and concepts that make up this framework are garnered from predominantly white, western-based understandings, and that people from other ethnicities, other cultures, and other minorities may have different experiences and explanations for pain. This is evident by the racial bias that exists in modern western medicine, for example, medical training textbooks illustrate the appearance of rashes on the skin, but the textbook photo illustrations are more often of white skin (Louie & Wilkes, 2018; Massie, Cho, Kneib, Sousa, Morrison, & Friedrich, 2020). However, rashes, such as the meningitis rash, can look very different on non-white skin, and can therefore be missed or misdiagnosed (Prichep, 2019). Racial bias has also been found in medical pain assessment, meaning black people, particularly black women, are more likely to have their pain dismissed by medical staff than their white counterparts (Hoffman, Trawalter, Axt, & Oliver, 2016; Sabin, 2020), meaning a black woman would have a very different pain experience than a white man. Different cultures may also have alternative explanations for pain, for example in some areas of the world persistent pain may be explained by curses, bad behaviour in a previous life, or the sins of the parents, etc.

For example, my mother was mixed race, Iberian and Indian, and was born and brought up in Sangre Grande in Trinidad. Her family were Muslim, and it is this Caribbean-styled Islamic upbringing that primed her for her eventual explanation for her pain. On her arrival in England she immediately dropped Islam and looked for alternative high-control religions. She met and married my father, a thoroughly Caucasian man, and together they became Jehovah's Witnesses. My mother's explanation for her intense and often debilitating pain became one seen through the lens of her adopted religion; her pain was Satan trying to tempt her into sinning against Jehovah. When her religion stopped her from accepting blood transfusions, meaning she could not have a vital knee-replacement operation, it was Satan using the doctors to tempt her into committing a sin, when flare-ups caused her to miss Jehovah's Witness meetings, putting her in danger of becoming weak in her faith, it was Satan putting obstacles in her way, as her joints disintegrated it was Satan targeting Jehovah's faithful people. However, remissions were explained as Jehovah blessing her for her faithfulness. At other times the explanations would shift and would become that Jehovah had 'allowed' her to develop RA, because her adventurous spirit would never have allowed her to stay in one place long enough to learn 'The Truth'<sup>6</sup>. The narrative was never a medical one, it was always a spiritual one, and it was the doctors who lacked that vital understanding due to their reliance on the science of Satan's world.

Acknowledging that social groups other than our own, other than the mainstream cultural majority, produce different explanations, have different experiences of pain, different coping strategies and frameworks, different narratives and beliefs, will widen our understanding of the underlying mechanisms in people's pain experience.

**2.4.1.iii. Attachment and Social Constructionism.** Attachment theory is often viewed as classifying people as either dismissive, secure, or preoccupied, which then assumes

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<sup>6</sup> Jehovah's Witnesses refer to their religion colloquially as 'The Truth'

attachment classifications are fixed entities that embody the person. Viewing these as objective, fixed classifications lends itself to a more positivist approach, and can also be described as being reductive, in that it is reducing human behaviour to a few limited boxes (Dallos, 2006).

However, by considering attachment behaviour as representative of prior experience, and using those representations to guide behaviour, and to predict that of others, more flexibility is introduced. The individual can be seen as attempting to make sense of their experiences, or to construct meaning of their subjective experience, and when this act is engaged in with attachment figures it becomes a co-construction, a joint reality, and a locally constructed truth.

Of course, when using either dismissive or preoccupied strategies, certain types of information are distorted or repressed (Farnfield and Stokowy, 2014). Considered from an observer's point of view, they would do so both in terms of their own meaning making processes and their own attachment patterns, so that dual truths emerge (Dallos, 2006). This view of attachment patterns and meaning making then lends itself to a social constructionist approach.

Additionally, what constitutes a good mother can be seen to be socially constructed. The pressure on recent mums to be content in their new domesticity, in control, and to suddenly spring back to the pre-birth weight, is immense. These images of ideal motherhood are often reinforced in the media, with reports of organised, laidback celebrity mothers, and on social media displaying photograph after photograph of happy families delighting in each other, in a rose tinted, problem-free world. Those struggling to bond with their new baby, especially first-time mothers, those not coping with the night feeds and lack of sleep, those confused by the constant crying of their baby, those not coping with the sudden and unexpected shock of identity change, and those with post-natal depression, do not fit the

socially constructed ideal of what a good mother is, or that of the ideal parent-child relationship. Somehow new mothers are meant to have a natural maternal instinct that magically bestows them with an instant knowledge of motherhood, a cool capability and unflappability, comforting hands that immediately sooth a crying baby, and an eternally contented child. The quiet guilt felt by women not fitting the predesigned maternal mould often goes undiscussed, leading to feelings of failure and discontent.

When it comes to how a parent reacts to their child's pain complaints, the link between attachment and social construction becomes very important, and signals what will be central to this thesis. For example, the parental reaction may become part of either insecure pattern. Therefore, for parents displaying Type A dismissing patterns, part of their strategy may be to remove/distance themselves and their feelings from their child's distress, including the social ubiquity of giving them painkilling medication. For Type C preoccupying patterns, part of their strategy may be to relieve their own anxiety and cover up their irritation with their child by, again, giving medication, and resolve their internal conflict of not being the socially ideal parent and being exasperated with their child. In contrast, parents displaying Type B balanced patterns are likely to try to delay giving painkillers, and be able to offer their child comfort and relief from the pain, without becoming overwhelmed by their own distress at their child's suffering. They give their child pain medication, but see their child's experience and are able to separate this from their own needs, and can balance the two.

## **2.5. Conclusion**

This chapter started by outlining the conceptual framework underpinning the research in this thesis. It then outlined the three individual concepts and theories incorporated within, explaining in detail the key features of each. The theories of pain discussed how the Cartesian model of pain and the biomedical model see pain as the body gone wrong, and needing

medical professionals to fix it, but the biopsychosocial model of pain approached the subject from a slightly different angle, eschewing dualism and embracing monism and a holistic approach. Both the Cartesian and biomedical models fit well with acute pain, but they have trouble explaining persistent pain. The biopsychosocial model, however, is better equipped to explain persistent pain because of its rejection of dualism. By seeing the body and mind, as well as outside forces within the individual's environment as interconnected, each affecting the other, persistent pain makes more sense. Attachment theory was discussed in terms of the ABC+D model and the DMM, comparisons were made, and the DMM's flexible and detailed explanation of more complex attachment strategies were deemed more useful when it came to analysing and explaining the research findings within this thesis. Social constructionism was discussed as being the most useful paradigm for the research methodology, due to its ontological and epistemological assumptions.

The third section looked at how each of these concepts and theories hang together to form a coherent and cohesive framework to underpin the research and how it could be used to guide as well as explain the research findings. How attachment and pain intersected, and how each were central concepts to the other, and how that might manifest in behaviour was set out. The social construction of pain and persistent pain conditions was then considered, before moving on to an exploration into the history of how pain medication has been socially constructed. Lastly, an examination of attachment as social construction was outlined.

The next chapter will look at the existing research in the area of the familial effects of maternal persistent pain, and the extent to which attachment and family systems has been considered.

## **CHAPTER 3                    REVIEW OF LITERATURE REVIEW PERTAINING TO PERSISTENT PAIN IN OTHERS AND THE EFFECT ON THEIR CHILDREN**

### **3.1     Introduction**

The review of the literature utilised a systematic research strategy by accessing a range of data bases. It also attempted a more general review by following the work of key figures in the field in looking at relevant documents and included drawing on media presentations. It is acknowledged that research data bases privilege quantitative research so that some qualitative work that has been undertaken may not have reached publication in peer – review journals. A further complication is that journals privilege positive results. So that statistically inconclusive studies tend to be omitted sometimes leading to a distorted picture. There is also a potential wider bias in that conditions, such as fibromyalgia have experienced a drift towards medical vs psychological explanations and these in turn drive research and also what is accepted in journals for publication.

Now that a conceptual framework has been developed, incorporating and explaining how pain theories, attachment, and social constructionist principals can help understand persistent pain, and persistent pain behaviour, it seems expedient to look at the existing research on the transgenerational effect of persistent pain.

Adult persistent pain conditions can prove extremely distressing for the sufferer, consequently increasing the significant negative effects for other family members (Dura & Beck, 1988; Jamison & Walker, 1992). Moreover, when the pain causation is medically unclear, as in so called ‘medically unexplained’ pain, such as FMS, then the additional uncertainty surrounding the causes and treatment for the condition, may heighten familial distress (Steiner, Bigatti, Hernandez, Lydon-Lam, & Johnston, 2010).

#### ***3.1.1 Parental Persistent Pain and The Impact on Children***

Research in this area has recognised that parental persistent pain conditions are

associated with worse psychosocial and physical health outcomes in offspring. Further, the acknowledgment of associations between parental persistent pain and child reports of pain have gradually increased (Evans, Keenan, & Shipton, 2007; Jamison & Walker, 1992; Schulte & Petermann, 2011; Sherman, Bruehl, Smith, & Walker, 2013). Although often reported as one of many familial effects of parental persistent pain, there has been little research focusing specifically on the associations between children's experience of pain and persistent pain in their parents. Evans and de Souza (2008) argued the most 'profound ramifications' of living with a mother suffering with chronic pain are to the child's own health. Evans and de Souza (2008) found an association between child somatising pain, manifesting in headaches, abdominal, or limb pain, and maternal chronic pain seemed apparent. Additionally, they found some evidence of children mirroring their mothers' pain. This sense of adversity is echoed by Jamison and Walker (1992), who suggested mere exposure to parental chronic pain, may be sufficient to increase the likelihood in developing child pain.

The literature concerning these issues has grown, and there is a need for practitioners and sufferers to bring findings together. A review, conducted by Higgins *et al.* (2015), also concluded children of parents with chronic pain tend to experience symptoms of pain, poorer general health, psychological, and family functioning outcomes, compared to children of parents with no pain. The growing body of literature in this area suggests a transgenerational association involving mothers with persistent pain and increased child pain. However, further research is required to explore the major contributing factors and underlying mechanisms regarding the intergenerational transmission of persistent pain.

### **3.2 Aims of the Review**

The aim of this literature evaluation is two-fold; 1 - to examine what has already been found to contribute to the transgenerational effect of persistent pain; and 2 - to then evaluate these findings using an attachment explanatory framework. Attachment is a fundamental

component of the parent-child relationship, but has been employed relatively infrequently in relation to research or theoretical consideration of this area. As argued in the previous chapter, attachment theory is relevant, because it is fundamentally a theory of how danger and distress is managed in families, and specifically how comfort is provided. This concept is central to the study of pain in families, because it may provide some insight into what cues are attended to by the parent, or what ‘buttons’ the child needs to press in order to get their needs met. The main findings from the review will be considered within an over-riding framework of attachment theory and its elaboration in the Dynamic Maturational Model (DMM) of attachment and adaption (Crittenden, 2006)<sup>7</sup>

### **3.3 Review Structure**

The review is arranged into two main sections; 1) Parental persistent pain (meaning either parent with a persistent pain condition); and 2) maternal persistent pain. These sections are then further arranged into six sub-sections; 1) the impact of persistent pain on the family; 2) the impact of persistent pain on the parent; 3) partner role strain; 4) the impact of persistent pain on the child; 5) moderation by gender and 6) attachment. Implications for further research will then be discussed.

#### ***3.3.1 Search Strategy and Key Papers.***

Searches were made on the databases PsycINFO, PsycArticles, and PubMed, as well as Google Scholar, searching between the dates of 1988 to 2017. A series of search words were used in the following search order, and were as follows; ‘Parents’ and ‘Chronic Pain’; ‘Mothers’ and ‘Chronic Pain’; ‘Families’ and ‘Chronic Pain’; ‘Children’ and ‘Chronic Pain’; ‘Families’ and ‘Chronic Pain’ and ‘Pain Behaviour’; ‘Children’ and ‘Pain Behaviour’; ‘Attachment’ and ‘Families’ and ‘Chronic Pain’; ‘Attachment’ and ‘Pain Behaviour’; ‘Intergenerational Transmission’ and ‘Pain Behaviour’; ‘Transgenerational Effect’ and ‘Pain Behaviour’; ‘Familial effect of chronic pain’; ‘Intergenerational Transmission’ and ‘Chronic

Pain'; 'Transgenerational Effect' and 'Chronic Pain'; 'Parental Health Anxiety'; 'Parental Health Anxiety' and 'Pain Behaviour'; 'Attachment' and 'Parental Health Anxiety'.

Initially 113 studies were found, five of which were literature reviews. The abstracts of the remaining studies were read, and studies were excluded if they did not fit with the nature of this review. The remaining studies were examined in greater detail and were excluded if they did not meet the inclusion criteria. Thus, studies were discarded if they did not explicitly examine: a) the familial effects of maternal/parental persistent pain, b) the physical health of children of mothers/parents with persistent pain, c) the experiences of mothers with persistent pain, d) familial factors influencing the intergenerational transmission of persistent pain, e) the role of attachment in persistent pain, f) the relationship between maternal/ persistent chronic pain and child pain; and g) familial factors influencing child functional pain. The reference sections of the remaining studies were searched for additional papers. A Google Scholar cited reference search was then conducted on all the retained papers. 17 studies finally met the inclusion criteria and were included in this review.

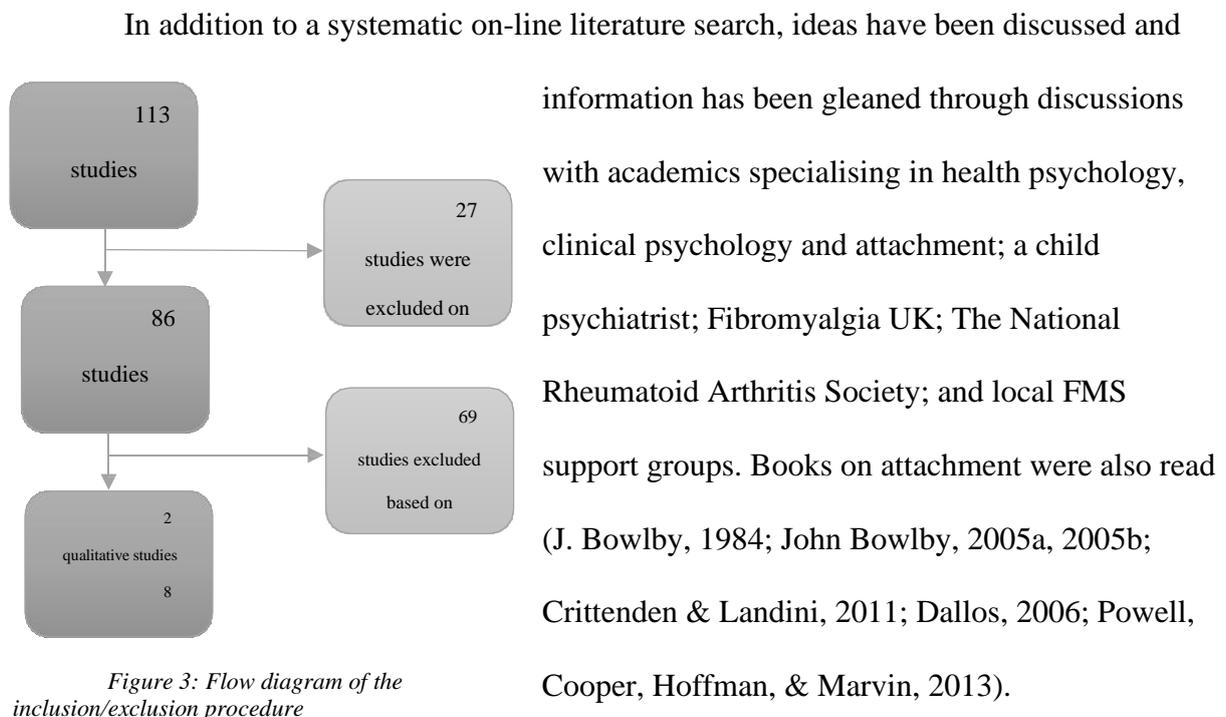


Figure 3: Flow diagram of the inclusion/exclusion procedure

### 3.4 Findings

#### 3.4.1 Description of the Studies.

Of the 17 studies included in this review, two studies were purely qualitative (Backman, del Fabro Smith, Smith, Montie, & Suto, 2007; Evans & de Souza, 2008), eight were quantitative (Dura & Beck, 1988; Evans *et al.*, 2007; Hoftun, Romundstad, & Rygg, 2013; Jamison & Walker, 1992; Jones, Silman, & Macfarlane, 2004; Marshall, Jones, Ramchandani, Stein, & Bass, 2007; Ramchandani, Murray, Romano, Vlachos, & Stein, 2011; Ratnamohan & Kozłowska, 2017), two were focus articles (Goubert, Vlaeyen, Crombez, & Craig, 2011; Kozłowska, 2009), five were reviews, three of which were predominantly quantitative (Schulte & Petermann, 2011; Umberger, 2013; Sinclair, Meredith, Strong, & Feeney, 2016), one was mixed methods (Higgins *et al.*, 2015) whilst one did not specify (Evans *et al.*, 2008).

The smallest study sample included 12 mothers and their families, the largest included 7,373 participants, 2003 of which were parents and 5,370 were their offspring, although data for this study was gathered from a nationwide health survey and then gleaned for persistent pain information. Child ages ranged from 0-30 years, with the majority of studies investigating primary school aged children, ranging 6-12 years. Four studies specifically examined maternal pain, 10 discussed parental pain, although six of these explicitly mentioned maternal pain. Pain conditions included rheumatoid arthritis, lupus, polycystic ovaries, migraine, repetitive strain injury, and ankylosing spondylitis. Non-specific pain included persistent head and neck pain, spinal pain, back pain, abdominal pain, chest pain and widespread pain. Studies were conducted in British Columbia (n=1), the USA (n=2), England (n=3), New Zealand (n=2), and Norway (n=1). Both qualitative studies used semi-structured interviews, although there was no evidence of reflexive procedures; no mention of reflexive journals, biases or how researchers shaped findings from either study. Of the quantitative

studies most used a cross-sectional design with comparison groups (no illness control group n=2, other chronic illness control group n=1, both control groups n=2, no comparison groups n=1), one study used a nationwide survey. Child outcome measures were completed by the children themselves in four studies, by the parent only in one study, both parent and child in three of the studies, with one study collecting additional teacher report.

### ***3.4.2 Quality Assessment***

The qualitative studies and reviews were assessed using the Critical Appraisal Skills Programme tools (CASP 2014). The CASP tools are a set of checklists to assist researchers to assess clinical health research for reliability and validity, clinical relevance, and methodological quality. These each comprise a set of 10 questions designed to prompt systematic assessment. Specific appraisal checklists were used; the CASP qualitative checklist (2014) and the CASP systematic review checklist (2014).

After closely applying the checklists, neither qualitative studies, nor any of the three reviews were excluded from this review and were found to be of middling to high quality based on the CASP (2014) criteria. Although both quantitative studies lacked a reflexive component, and one of the reviews lacked a methods section, based on the CASP (2014) criteria they were suitable for inclusion in this review.

A table outlining the findings and critical evaluation of all the research papers in this review can be found in Appendix 1.

### ***3.4.3 Themes***

From examining the 17 studies included in this review five main themes were found, with the first main theme having three sub-themes, and the second theme having five sub-themes. These are outlined in the table below (Table 3).

Main themes	Sub-themes
1. Parental persistent pain	<ul style="list-style-type: none"> <li>• The impact of parental persistent pain on family functioning</li> <li>• The impact of parental persistent pain on parenting</li> <li>• The impact of parental persistent pain on parenting</li> </ul>
2. Maternal persistent pain	<ul style="list-style-type: none"> <li>• The impact of maternal persistent pain on family functioning</li> <li>• The impact of maternal persistent pain on mothers and motherly duties</li> <li>• Partner role strain</li> <li>• The impact of maternal persistent pain on children's psychosocial wellbeing and physical health</li> </ul>
3. Increased risk of child pain reports and somatising symptoms	
4. Moderation through gender	
5. Attachment	

Table 2: Table of themes

### 3.4.3.i. Parental Persistent Pain.

**3.4.3.i.a. The Impact of Parental Persistent Pain on Family Functioning.** Higher levels of family dysfunction, poorer family environments, less perceived support, cohesiveness, and expressiveness, with more depression and anxiety were found in families with persistent pain, than families with other chronic illnesses, or families with no illness (Evans *et al.*, 2008; Jamison & Walker, 1992; Schulte & Petermann, 2011; Umberger, 2013; Higgins *et al.*, 20015; Ratnamohan & Kozłowska, 2017).

Umberger (2013) conducted a review of the literature on children of parents with chronic pain. She noted that not only was the suffering parent affected by chronic pain; both parents were unable to fulfil their usual roles. This negatively affected family functioning, as well as the parents' relationship with the child. Chronic pain was noted to cause friction between parents, siblings or parents and children. One study in Umberger's (2013) review found the quality of parent child relationships significantly mediated the effects of chronic pain on child externalising, which has been described as aggression and social difficulties.

Evans *et al.* (2008), reviewed the literature on pain associations between parent and child, and acknowledged the important role of family in socialising a child's display and function of pain behaviour. However, at no point was the quality of the parent-child

relationship explicitly cited as even a possible moderator to the development of medically unexplained pain (MUP) in children. This seems a fundamental omission and will be examined further in the discussion section of this review.

**3.4.3.i.b. *The Impact of Parental Persistent Pain on Parenting.*** There is little specifically mentioned about how persistent pain affects general parenting, but the studies reviewed found parents to have higher levels of dysphoria and pain related emotional distress. For example, one study investigating illness behaviour in children of parents with persistent pain reported higher levels of stress, psychological disorders and somatising preoccupation in parents where one had a persistent pain condition, as well as significantly more parental functional disability and pain behaviour, as well as higher levels of emotional distress (Jamison & Walker, 1992). Yet, another described parents with chronic non-cancer pain as having slightly higher levels of depression than non-pain parent groups (Umberger, 2013). While Sinclair et al (2016) noted parenting distress was associated with lower child functioning.

Jamison and Walker (1992) noted poor familial support and marital problems maintained 'pain complaints' in chronic pain patients, however, discussion tended to centre on prevalence rather than mediating and moderating factors. The term 'pain complaints' used here infers catastrophising or externalising on the part of the chronic pain patient.

**3.4.3.i.c. *The Impact of Parental Persistent Pain on Child Psychosocial Wellbeing and Physical Health.*** Children of parents with persistent pain were found to have higher levels of depression, social problems, and health problems. In fact, increased health anxiety in persistent pain patients was found to be associated with unexplained pain in children (Jamison & Walker, 1992; Marshall *et al.*, 2007; Ramchandani *et al.*, 2011; Higgins et al, 2015; Sinclair et al, 2016; Ratnamohan & Kozłowska, 2017).

Higher correlations between parent and child pain were found in children from persistent pain parent groups than in controls (Evans *et al.*, 2008; Jamison & Walker, 1992; Umberger, 2013). Persistent pain patients who sought more pain treatment and were more

emotionally externalising about their pain were found to have children who were more likely to report higher levels of pain and lower health status (Evans *et al.*, 2008; Umberger, 2013). In addition to this, parental catastrophising about child pain, explained as comprising of ‘rumination, magnification, and helplessness’, was suggested as a significant predictor of child pain (Evans *et al.*, 2008; Sinclair *et al.*, 2016). One study in Umberger’s review found 1/3 of children had identical pain to the mother, and half identical pain to the father (Umberger, 2013). However, whilst the reasons for why some children develop mirror pain and some do not, or what the contributory factors to this effect might be, was not considered at all, it will be considered later in this review.

One study in Evans *et al.* (2008) review investigated adult offspring and parent recollections of parental persistent pain. Reportedly, accuracy was not important, but the level of recollection of parental pain was that which predicted child chronic pain in adulthood. Evans *et al.* (2008) explained this as the result of social learning, and although they did also acknowledge that not all children from families with chronic pain go on to develop chronic pain themselves, they did not speculate on why this might be. This will, however, be considered in the discussion section of this review.

Children in the studies examined for the current review were more vulnerable to internalising behaviours, which was described as depression and anxiety; and externalising behaviours, which was described as aggression and social difficulties (Evans *et al.*, 2008; Jamison & Walker, 1992; Schulte & Petermann, 2011; Umberger, 2013; Higgins *et al.*, 2015). These were argued to be triggered by parental inability to care for their offspring, and projected age inappropriate expectations (Umberger, 2013). 75% found children from families with parental chronic pain reported to have significantly higher levels of depression and the same for anxiety. Unsurprisingly, one study found adolescents with both parents suffering from chronic pain were at over twice the risk of anxiety and depression than those of pain free parents (Umberger, 2013). Paradoxically, Hoftun *et al.* (2013), who conducted a study investigating pain associations between adolescents and parents, using data from a

Norwegian national health survey, found fewer offspring pain reports when parents had dysphoria, but the likelihood of child pain increased when both parents reported chronic pain. Other studies argued that parents with comorbid mental health problems increased the likelihood of child psychological maladjustment, and was explained through speculated genetic vulnerability (Umberger, 2013). Only one study mentioned investigating child coping; specifically, child catastrophising as a coping strategy, and was reported as predicting the relationship between parental chronic pain and the level of child pain (Umberger, 2013).

Nevertheless, not all studies found an association between parental pain and child pain reports (Jones *et al.*, 2004). However, this study, which used 39 schools from which to gather a sample of 1,326 children and parents, suffered from significant methodological flaws, such as a limited child age range (13-15 years), and use of a population-based sample rather than a clinical sample. In fact, all parental data were pooled, all child data were pooled, and then compared, meaning it was not possible to analyse the specific pain association between each dyadic or triadic family unit. Jones *et al.* (2004) reported that of the 1,326 children involved in the study, 323 had no corresponding data from either parent, yet it appears the data from this group of children was still included in the analysis. It could be argued that the inclusion of such data might skew the findings. In addition to this, there were no clear pain definitions, and no clear measurement for pain intensity or duration.

### **3.4.3.ii. Maternal Persistent Pain.**

**3.4.3.ii.a. *The Impact of Maternal Persistent Pain on Family Functioning.*** Studies found significantly poorer perceived family environments, and higher levels of depression and anxiety in families living with maternal persistent pain (Dura & Beck, 1988; Evans & de Souza, 2008; Evans *et al.*, 2007; Evans *et al.*, 2008; Marshall *et al.*, 2007; Ramchandani *et al.*, 2011; Schulte & Petermann, 2011), described as dysfunctional and negative family climates by Schulte & Petermann (2011). These included having more angry, critical and

aggressive mothers than controls, who adopted intrusive parenting styles (Schulte & Petermann, 2011; Umberger, 2013).

Family environments were perceived to be significantly less cohesive and more controlling, with more conflict and less expressiveness by mothers suffering with chronic pain (Dura & Beck, 1988). This was reflected by the qualitative studies, revealing a more personal account of family functioning. For example, in a study examining maternal experiences of everyday life with chronic pain, many mothers mentioned the negative impact their illness had on their families, such as, perceptions of not being ‘normal’, and regret at the unavoidable focus on illness (Backman *et al.* 2007). The authors noted these perceptions were not shared by all participants, despite similarities in abilities and restrictions to mothering. However, the reasons for this difference in experience was not explained or speculated upon further.

Evans *et al.* (2007) conducted a quantitative study into the mental and physical health of the children of mothers with chronic pain. They explained the effect of chronic pain on family functioning by arguing that the stress of pain is embedded in a social context, meaning families often reward and prolong pain behaviour of both the mother and the child. Consequently, the pain sufferer inevitably affects the family by creating stress and pressure through the unavoidable increase in care demands, and the inability to fully participate in the maternal caregiving role, creating a destructive, circular, familial behaviour pattern (Evans *et al.*, 2007).

Whilst comparing family functioning between families with a mother with chronic pain, a mother with diabetes, and mothers with no illness, Dura and Beck (1988) argued level of disability, rather than type of condition, determines familial and maternal depression levels, and family functioning.

However, some families were found to be more cohesive due to rallying round the mother with pain (Backman *et al.* 2007). This occurrence in some families but not others was explained by the mother's resilience and attitude to mothering tasks. However, why some mothers appeared more resilient and positive than others was not explained or even questioned in this study, other than to assert the main factor was the family's response to the mother's way of doing tasks. Although not explicitly stated, this could indicate familial support may well facilitate maternal resilience and positivity.

**3.4.3.ii.b. *The Impact of Maternal Persistent Pain on Mothers and Motherly Duties.***

The qualitative literature discussed strategies used by mothers to fulfil their maternal role, giving an intensely personal and emotive 'inside' reflection of the quantitative findings. Backman *et al.* (2007) reported that mothers coped by reassigning tasks to partners, grandparents or children, and the occasionally resultant 'me time' was seen by some as essential to becoming a healthy and better mother. Evans and de Souza's (2008) qualitative study, which claimed to focus on the positives of maternal chronic pain, described how mothers found attitude to be key in finding the strength to cope with chronic pain, and reported developing positive coping strategies by focusing on what they could do, rather than what they could not. Pain was either seen by mothers as negative and stressful, or less negative and a challenge, and through exploring different strategies and enabling factors they revealed positives in spite of, and because of chronic pain. Mothers reported a significant factor in successful coping was that of familial support (Evans & de Souza, 2008), although its moderating effect on maternal coping, or child outcomes, was not investigated by any studies in this review. It was further reported by Evans and de Souza (2008) that mothers sometimes coped with maternal duties by using their pain to coerce children to comply, with some reporting using their pain as a form of discipline, blaming the child for making their pain worse.

Mothers found pain related fatigue an additional difficulty to manage, and further obstructed their ability to 'mother' to their perceived ideal level. Rest was reported to be difficult to manage with children, as they need constant attention. Mothers were left feeling guilty at their inability to do 'normal' things with their children (Backman *et al.* 2007). Mostly, mothers found pain impaired their parenting ability, leaving no resources to facilitate parenting. This left most acutely aware of the sacrifices their children were forced to make, leaving them with a profound sense of guilt, not just at the inability to mother their children physically, but also emotionally (Evans & de Souza, 2008). This was reflected in findings from the quantitative studies, which widely reported significantly higher levels of depression, and anxiety in mothers from chronic pain groups, than mothers in control groups, and that these mothers generally had higher dysphoric scores than fathers (Dura & Beck, 1988; Evans *et al.*, 2007; Evans *et al.*, 2008; Ramchandani *et al.*, 2011; Schulte & Petermann, 2011).

However, it was noted that these women were still able to find positives in such a difficult situation, and still managed to take care of their children despite constant and intractable pain (Backman *et al.*, 2007; Evans & de Souza, 2008). Whilst most reported pain related parenting difficulties, some reported extra time spent with their children and heightened awareness of positive interactions (Evans & de Souza, 2008). However, it was reported that interactions between mothers and their children were always shrouded with guilt and despair for what they perceived as inadequate mothering (Backman *et al.*, 2007; Evans and de Souza, 2008).

**3.4.3.ii.c. Partner Role Strain.** There is a thin thread relating to partner role strain running through the studies on maternal persistent pain, although not often explicit. In studies specifically examining the partners of persistent pain patients, lower health levels, higher levels of depression, loneliness and subjective stress, as well as higher levels of role strain were reported (Steiner *et al.*, 2010). This was reflected by other studies in this review;

maternal tasks and duties were often reassigned to partners, meaning neither parent were able to fulfil their parental roles sufficiently, and partners from pain groups had significantly higher depression and anxiety scores than control groups (Backman *et al.*, 2007; Dura and Beck, 1988; Umberger, 2014). However, as previously discussed by Backman *et al.* (2007), not all families found this a damaging experience. Why this might be, or how increased partner role strain impacts on the child and their pain signalling, was not considered by any of the studies in this review.

**3.4.3.ii.d. The Impact of Maternal Persistent Pain on Children's Psychosocial Wellbeing and Physical Health.** Children from families with persistent pain are found to be most adversely affected in comparison to either healthy controls, or other chronic illness groups. They are often less physically healthy and less well-adjusted than children from the other control groups (Dura & Beck, 1988; Evans *et al.*, 2007; Evans *et al.*, 2008; Ramchandani *et al.*, 2011; Schulte & Petermann, 2011; Umberger, 2013).

Children with mothers suffering with persistent pain were found to have significantly higher levels of anxiety and depression, aggression and delinquency, and insecure attachment, with significantly lower social skills and more health problems (Dura & Beck, 1988; Evans & de Souza, 2008; Evans *et al.*, 2007; Evans *et al.*, 2008; Ramchandani *et al.*, 2011; Schulte & Petermann, 2011; Umberger, 2013). Teachers reported decreased social skills and increased pain complaints in this group of children than for any other group. Mothers with persistent pain also reported lower levels of psychosocial adjustment and physical health in their children (Evans *et al.*, 2007).

However, positives were reported. For example, Evans and de Souza (2008) stated some mothers felt their children were growing up with a heightened sense of compassion and consideration due to the necessary caring role they had to adopt, and a level of premature independence having a mother with chronic pain provoked. Evans and de Souza (2008) took

this assessment at face value, and did not investigate any further, however, this point will be considered further in the discussion section.

Nevertheless, children of mothers with chronic pain were also discovered to suffer in other ways; mothers were often unable to hug or pick up their small children (Evans & de Souza, 2008). Children felt they were missing out on certain things due to their mothers' pain conditions. They reported being often quite angry about having to forego outings, treats, and particularly attention (Evans & de Souza, 2008). One child lamented relinquishing their childhood due to picking up the slack in household chores. The child reported being unable to discuss this due to her mother crying each time the subject was brought up (Evans & de Souza, 2008). Again, the far-reaching effects on the child was not considered any further, but will be examined in greater detail in the discussion section.

Whilst some children were reported to be the only source of support for mothers, with quite young children reported as becoming both carer and emotional support (Evans & de Souza, 2008), many mothers were not able to explicitly reflect on the impact of this had on their child. This could, of course have been a weakness in the study, rather than a parental one. However, mothers implicitly reflected on how their children's emotional health was affected by maternal pain, possibly more so during flare-ups. At these times, children reportedly became clingy, anxious and sad, often backed up by child reports. Children also reported hiding their anxiety regarding their mother's health. These concerns were often grossly magnified through their child-like perspective, morphing into terror-filled, horrifying anxieties (Evans & de Souza, 2008).

**3.4.3.iii. Increased Risk of Child Pain Reports and Somatising Symptoms.** The existence of pain in children of mothers with persistent pain has been explained by social learning and reinforcement (Dura & Beck, 1988; Evans & de Souza, 2008; Evans *et al.*, 2007; Evans *et al.*, 2008; Goubert *et al.*, 2011; Hoftun *et al.*, 2013; Schulte & Petermann,

2011; Umberger, 2013). Goubert *et al.* (2011), in their focus article considering the cognitive and affective mechanisms underlying observational learning of pain behaviour, define observational learning as changes in behaviour acquired through constant exposure to environmental regularities and, in the context of parental chronic pain, being exposed to repeated implicit pain-related behavioural cues, especially from a significant attachment figure. Kozłowska (2009) supports this from an attachment perspective, arguing an individual's repeated interactions with their attachment figure likely hones the ways in which they signal their subjective pain experience.

Studies in Schulte and Petermann's (2011) review of the literature on familial risk factors for child somatisation, found maternal psychological distress and family conflict predicts functional disability in children with recurrent somatised pain (Schulte & Petermann, 2011). This was supported by lab studies, where maternal anxiety and depression predicted higher levels of recurrent abdominal pain and headaches in their children. Additionally, maternal anxiety sensitivity (defined as a tendency to interpret anxiety-related physiology (eg, rapid heartbeat) as dangerous) was found to predict child anxiety sensitivity, which then predicted lab induced acute pain intensity (Evans *et al.*, 2008). Observational learning was given as explanations for this effect. However, in this particular study the effect appeared to be more salient for girls than boys, but this is not a robust finding (Evans *et al.*, 2007; Umberger, 2013). Whilst it could be argued that a same sex role model was an underlying factor here, there is also a strong case to be made for attachment relationships as a more useful, and consistent explanation, and this argument will be furthered in the discussion section. In addition to this, since Goubert *et al.* (2011) defines observational learning as repeated implicit behavioural cues, it might be argued that the implicit behavioural cues modelled during a relatively short lab study would not be sufficient to incur behavioural

change in the child. This lends further weight to the notion that other factors, such as attachment, may well be salient.

Further to this, levels of solicitous parenting (comfort giving) were found to be linked to increased functional disability (Evans *et al.*, 2008; Sinclar et al, 2016). The original study seemed to imply that less parental reaction during children's painful medical procedures resulted in lower levels of child distress. Evans *et al.* (2008) explained this using social learning theory, however, they did not go on to explain any underlying mechanisms in any great detail. It could be argued this effect may have its root in attachment strategies, and will be considered further later in the review.

Children mirroring parental pain, additional child pain, or somatising symptoms were reported throughout all the studies, and was a recurrent theme (Dura & Beck, 1988; Evans & de Souza, 2008; Evans *et al.*, 2007; Evans *et al.*, 2008; Schulte & Petermann, 2011; Umberger, 2013). For example, Evans and de Souza (2008), in their qualitative study, where the aim was to give a voice to both mothers with chronic pain and their children, reported the high occurrence of child somatised pain, manifesting in headaches, abdominal or limb pain. Many children developed mirror pain to their mothers'. A significant fact reported by Evans and de Souza (2008) was that 69% of mothers in their study reported having a close family member with a similar pain condition, often the mother, sometimes going back several generations.

**3.4.3.iv. Moderation of Effect Through Gender.** Findings for moderation of pain behaviour through gender were inconsistent (Evans *et al.*, 2007; Evans *et al.*, 2008; Hoftun *et al.*, 2013; Umberger, 2013). Umberger (2013) reported very mixed findings, going so far to pronounce there was no agreement at all. The only studies reporting findings similar to others, were those reporting no gender differences at all.

**3.4.3.v. Attachment.** Attachment as a consideration could only be found in three studies (Evans *et al.*, 2007; Schulte & Petermann, 2011; Ratnamohan & Kozłowska, 2017), although one of these examined children and adolescents with persistent pain, not the effect of parental pain or parental attachment strategies, which, considering attachment relationships are a fundamental component of family life, might be considered a conspicuous omission.

Evans *et al.* (2007) found parental chronic pain was linked to insecure attachment in children, and that parents with chronic pain were often necessarily inconsistent in their caregiving, leading to withdrawal or clinginess on the part of the child. The often-accompanying maternal hospitalisations and withdrawal, due to their pain conditions, lead to compromised development of attachment relationships. This is supported by the attachment literature (Crittenden, 2006; Kozłowska, 2009), demonstrated by Evans *et al.* (2007) in finding higher levels of insecure attachment in children from chronic pain groups, than those in the well groups.

These findings were reflected by Shulte and Petermann (2011), who reviewed a study where attachment and child somatisation were assessed. Shulte and Petermann (2011) reported that 43% of children with somatisation and conversion disorders were found to have avoidant attachment styles, 43% with ambivalent styles and the remaining with a mixture of attachment styles. However, this somewhat over-simplified the reporting of the complex attachment strategies used by the children assessed in the original study (Kozłowska & Williams, 2009).

Ratnamohan & Kozłowska (2017) looked at attachment from a slightly different angle; that attachment patterns in children with chronic functional pain. These children were found to have higher levels of unresolved loss and trauma, suggesting long-term stress and disruption of attachment relationships. Ratnamohan & Kozłowska (2017) argued that it was the quality of attachment relationships which contributed to developing and maintaining child

chronic functional pain. This finding appears to fit in with the parental chronic pain literature reported in this review. However, parental attachment strategies were not considered.

### **3.5 Discussion**

As revealed from the studies in this review there are a range of unique challenges faced by mothers with intractable pain conditions, by their partners, as well as their children. The consensus is that families where one or both parents suffers with persistent pain are adversely affected, with greater levels of dysphoria, poorer family environments, and greater partner role strain. It seems clear that children in this group are at greater risk of increased pain complaints, in addition to depression, anxiety, behavioural problems, and attachment issues. Almost all the studies in this review cited social learning of illness behaviour as explanations for increased risk of developing pain in children of parents with persistent pain. Bandura's social learning theory suggests there has to be some form of identification with the parent, or other figure functioning as a model, in order for the child to adopt observed behaviours (Bandura, 1961). Goubert et al (2011) expanded on this by reasoning identification with a model would necessitate an element of empathy. They defined empathy as covert cognitive and affective responses to another's pain rendered as overt behaviour. However, none of the studies in this review explained how these underlying cognitive and affective mechanisms actually facilitate social learning. (Goubert *et al.*, 2011; Kozłowska, 2009).

Certain behaviours were identified by the studies in this review, yet were not considered in any depth. For example, Dura and Beck (1988) argued that it was level of maternal disability which affected family dysphoria and functioning. Whilst Backman *et al.* (2007) noted that not all observed families were negatively impacted by maternal chronic pain. Backman *et al.* (2007) explained this by the familial response to how well mothers

adapted to their maternal duties. These explanations for levels of negative family impact may well be two sides of the same coin. However, it may be more likely, in addition to level of disability and ease of maternal adaptation, to be type of pain condition, level of perceived familial support, as well as both parent and child attachment strategies that all contribute to levels of family functioning, coping ability, and levels of anxiety and depression in the sufferer, spouse and child, alike. However, in order to provide a more definitive answer, this is an area which warrants further research.

It is clear from the findings in this review there is consensus that family functioning is severely affected by parental persistent pain. The relationship between parents is particularly vulnerable where one has to pick up the caregiving and domestic role of the ill parent, causing bad feeling, resentment, and exhaustion. Sibling relationships were noted to be affected, and in particular the parent-child relationship, leading to detrimental outcomes for children. Whilst this was noted in the majority of the studies (Evans *et al.*, 2008; Jamison & Walker, 1992; Schulte & Petermann, 2011; Umberger, 2013; Higgins *et al.*, 20015; Ratnamohan & Kozłowska, 2017), only one explicitly investigated the quality of the parent-child relationship as a possible influencing factor to the development of medically unexplained pain (MUP) in children (Ratnamohan & Kozłowska, 2017). Whilst Ratnamohan & Kozłowska (2017) did not study children of parents with chronic pain conditions, they did find it was the quality of the parent-child attachment relationship that contributes to the development and maintenance of chronic functional pain in children. However, it would stand to reason that persistent pain parent-child attachment relationships would be further negatively impacted, and is worthy of future study.

The studies in this review found children of parents with persistent pain to have higher levels of depression and anxiety, social difficulties, and MUP. The studies described these as internalising behaviours (depression and anxiety, and mental health issues) and

externalising behaviours (social difficulties and aggression). The reasons for the differences for internalising and externalising behaviours in children may be subtle, but the literature did note parents with increased health anxiety, more emotional externalising about their own pain, and catastrophising about child pain, compared with emotional unavailability, and higher levels of depression and comorbid mental health issues (Jamison & Walker, 1992; Marshall *et al.*, 2007; Ramchandani *et al.*, 2011; Higgins *et al.*, 2015; Sinclair *et al.*, 2016; Ratnamohan & Kozłowska, 2017). It may be these differences in coping and/or responses to their own pain conditions that determine whether a child displays internalising or externalising behaviours, both of which were linked to higher levels of MUP. Isolating the underlying cognitive and affective mechanisms within the parent-child relationship, and those systemic within a family functioning environment, could establish which parental coping and pain responses are likely to lead to more child internalising or externalising behaviours.

The common theme throughout the research in this review appears to be that some fair better living with parental persistent pain than others (Umberger, 2013; Evans *et al.* 2008; Backman *et al.* 2007), and while tentative explanations were sometimes given, this was not an question investigated in any great depth. Despite the lack of research, these areas are central to the study of pain. As is well known, pain is usually the body's way of signalling illness or damage to the sufferer. The expression of pain also serves as a vital signal to the individual's attachment figures, such as their family, children, and friends that they are suffering, may be in danger and in need of help. Attachment theory has not been used as a way of understanding the existing research into the transmission effect of parental persistent pain. By viewing these findings through an attachment lens a greater understanding of the familial effect of parental persistent pain may be arrived at, which the next section will attempt to do.

### ***3.5.1 The Findings: An Attachment Explanation Using the Dynamic Maturational Model (DMM)***

A child who continually sees their parent in pain, may also see them as needing help. This can reverse the relationship, such that the child may feel confused about how to express their own needs and pain; for example, whether to suppress their own needs or expression of pain, or exaggerate them in order to be attended to. This phenomenon was reported in several studies (Evans & de Souza, 2008; Sinclair et al, 2016; Higgins *et al.*, 2015) Kozłowska (2009) argues that parental responses to attachment requests serve to shape pain signalling behaviour in children. As such, the DMM offers a useful approach in explaining the risks of the development of compulsive caring strategies (Type A3), or subsequent self-reliant strategies (Type A6), for example.

Whilst considering maternal coping, Evans and de Souza (2008) described how some mothers often use coercion to force their children to comply with their wishes, sometimes using their pain as a form of discipline by blaming the child for making their pain worse. As a result, the children in this study reported 'being good' as soon as their mother became angry or coercive, so from the mothers' point of view this seems to be an effective strategy. However, viewed through the lens of attachment theory, from the child's perspective, the psychological ramifications of this could be far-reaching. Kozłowska (2009) provides a useful way of understanding child pain signalling behaviour, by the application of DMM, demonstrating how repeated interactions with an attachment figure shapes a child's pain signalling behaviour. Here Kozłowska (2009) describes a parent using anger, for example, as a form of selective punishment, is likely to result in the child employing a compulsively compliant attachment strategy. This is identified as being one of the Type A subtype strategies (Type A4). This strategy is seen to be functional in that compliancy protects the child from parental anger, thus maintaining parental approval and proximity. Additionally,

the child experiences a problematic bind in the form of: 'I resent my parent's anger, and feel angry myself, but feel I should *not* have these negative feelings, because she is ill and in pain'. However, there is the danger that the child's strategy of compliancy will become maladaptive in later life, and with later attachment figures (Kozłowska, 2009; Crittenden, 2006).

Evans and de Souza (2008) identified a rare positive behavioural outcome for the children of mothers with persistent pain; a heightened sense of compassion and consideration, due to the necessary caring role they had to adopt, and a premature sense of independence. This can be seen somewhat less benignly when viewed as an example of a compulsive caring strategy (Type A3), to either defuse an angry parent (i.e. coercive parenting strategies sometimes adopted by the mothers), or as a possible means to gaining some emotional closeness to the parent (Crittenden, 2006; Kozłowska, 2009). Again, whilst this is not necessarily harmful in itself, it is likely to become so if this strategy is taken into adulthood. For example, leading an adult to continually suppress their own needs in relationships, and possibly risk being in exploitative or even abusive relationships. Therefore, what is being seen here as positive, may actually be a potentially harmful attachment strategy, especially if the adult has little insight into this childhood process.

As mentioned, children were also reported to be more independent than children of well mothers, due to being forced to entertain themselves during pain flare-ups. Both mothers and children saw this as a positive, however, occasionally the children added a caveat; that premature independence could sometimes be 'a bit lonely' (Evans & de Souza, 2008). From an attachment perspective, the premature independence, and the parental approval of this coupled with certain caregiving behaviours, lends the child to the development of Type A attachment strategies (Crittenden, 2006; Kozłowska, 2009). This is where the child inhibits negative affect, to greater or lesser degrees, to gain parental approval by being 'good', thus

minimising the likelihood of parental withdrawal and anger, and maximising the likelihood of parental availability. The downside to this strategy is children do not learn to identify or manage negative affect (Kozłowska, 2009). In addition to this, this premature independence could be perceived from the child's perspective as a form of neglect (Crittenden, 2006; Kozłowska, 2009).

Children also reported being unable to discuss their displeasure at the increase of chores, maternal unavailability, and at having to miss out on certain activities, due to mothers becoming distressed when the subject was brought up (Evans & de Souza, 2008), creating more internal binds. Again, the far-reaching effect on the child was not considered further. Arguably, this could be seen as evidence of parents discouraging certain types of negative affect in the child, which, Kozłowska (2009) maintains, may put them at higher risk of developing somatoform disorders in the future. She explains, whilst certain types of negative affect are actively discouraged, for a sub-set of children, signalling pain to their parent is not. This suggestion is supported by the literature, which reveals parents with chronic pain are often hyper-attentive to their child's pain, whilst being unavailable at other times (Jamison & Walker, 1992; Evans & de Souza, 2008; Evans *et al.*, 2007; Marshall *et al.*, 2009; Ramchandani *et al.*, 2010; Shulte & Petermann, 2011; Goubert *et al.*, 2011; Umberger, 2014; Sinclair *et al.*, 2016), driving pain signalling as the vocabulary of attachment requests. This behaviour has been identified as using 'catastrophising' as a coping strategy in children, and has been found to predict the relationship between parental chronic pain and the level of child pain (Umberger, 2013). Kozłowska (2009) goes on to explain, a sub-set of these children are at risk of learning to channel their negative affect through pain signalling and having their attachment needs met through the subsequent parental attention.

As a demonstration of this affect, Evans *et al.* (2008) found the level of recollection of parental pain predicted the development of persistent pain in adulthood. However, again, the

causal cognitive and affective mechanisms underlying this occurrence were not speculated on. An attachment explanatory framework explains how witnessing parental persistent pain as a child, for some, may involve a protective strategy of muting the level of negative affect experienced (Type A strategies), resulting in channelling the resultant distress through their own pain. Whilst those who appear to focus on, or be preoccupied by, the parental persistent pain they witnessed, may use Type C attachment strategies. Type C strategies develop when the child is unable to predict whether their needs will be met by their attachment figure, and therefore learn to unconsciously exaggerate negative affect, such as pain, in an attempt to coerce a caregiving response from an inconsistent, preoccupied, or unpredictable parent (Crittenden, 2006; Kozłowska, 2009, Ratnamohan & Kozłowska, 2017). Kozłowska (2009) calls this unconscious exaggeration ‘implicit deception’.

Attachment may also go some way to explaining why some children in families with persistent pain do *not* go on to develop pain in adulthood. Crittenden (2006) argues that children in Type B attachment relationships are able to clearly and openly request comfort, protection, love or attention from their attachment figures, in the assured knowledge of having those needs met appropriately. Kozłowska (2009) explains, some parents are able to ‘teach’ their children how to recognise and regulate unpleasant bodily sensations, including pain, so that when children reach adulthood they are competent at signalling and managing pain appropriately (Kozłowska, 2009; Crittenden, 2006; Crittenden & Landini, 2011). However, persistent pain is likely to skew attachment strategies towards A or C. For example, parents may find it difficult to respond to their child’s attachment needs if continually distracted by their own pain, effectively forcing the child to unconsciously look for more ‘complex’ ways to getting their needs met. Additionally, a very young child may find their mother’s ‘pained face’ quite aversive and frightening, leading them to develop strategies to reduce the chances of reoccurrence. So, it would seem that both parent and child may have to

use Type B attachment strategies to negate the intergenerational transmission of persistent pain, implying that mothers with persistent pain would be certain of receiving familial support when clearly and openly requested.

Further to this, in a review of the literature on parent-child pain relationships, Evans *et al.* (2008) argued that parental solicitousness was linked to child functional disability. Here solicitousness refers to the comfort offered by the parent. Evans *et al.* (2008) suggested that less parental reaction during medical procedures served to minimise children's distress. Seen through an attachment perspective, an alternative explanation is a muted parental response during medical procedures 'teaches' the child that their attachment requests will not be attended to. Therefore, this encourages the child to inhibit their expression of distress, rather than lowering the actual level of distress felt. The assumption here is that child functional disability is a conduit for distress. Consequently, it may be that less parental solicitousness (or comfort) inhibits the display of distress, and therefore, functional disability; because, from the child's point of view, displaying distress is not permitted (Kozłowska, 2009). This effect appeared to be more salient for girls than boys.

However, gender as a moderator was an extremely mixed finding, with varying explanations given. These explanations mainly centred on socially constructed gender roles, i.e., girls are typically expected to take on a carer role with their families, and especially regarding an ill mother (a Type A strategy). However, there was no clear consensus in these explanations. This leads to the notion that gender may actually be a distractor; it could be argued that the differences found in these studies may actually be attachment related, rather than gender related. It is not uncommon for different gender related parent-child relationships to exist within families. That is to say, a child may have a different attachment relationship with their mother, than they do with their father. It is, therefore, possible to assume that children might implicitly use different gender-related attachment strategies with their parents,

manifesting in differing gender pain signalling (Kozłowska, 2009). It may also be that these confused gender findings were compounded by a difference in the methods and methodologies used within the studies (Higgins *et al.*, 2015).

Further, reports of low child outcomes; described as higher reports of pain, higher levels of depression and anxiety, low social functioning, were rated as ‘insecure’, implying the only other attachment rating is ‘secure’ (Evans *et al.*, 2007). Whilst there was a nod toward child withdrawal or clinginess in relation to this, there was no deeper analysis of complex attachment behaviours associated with these classifications, nor were the minutiae of parental behaviour from which they develop considered or discussed in anyway (Crittenden, 2006; Kozłowska, 2009). It is reasonable to assume that children living in a dysphoric environment, with often necessarily preoccupied parents, are likely to be unavoidably insecure. However, rather than suggesting an inefficiency in the ABC+D model of attachment used in this study, which does in fact differentiate sub-types of attachment in useful and predictive ways, it suggests an oversimplification of insecure attachments, possibly due to researcher inexperience and likely misconceptions of attachment theory.

### ***3.5.2 Gaps in the Research***

Whilst there were two studies briefly touching on attachment, and demonstrating that the children who develop mirror or additional pain to their parents often have insecure attachments (Evans *et al.*, 2007; Schulte & Petermann, 2011), there are no studies found which specifically investigate this in any kind of depth. What is missing, therefore, is research into the extent to which attachment influences the development of mirror or additional pain in children of parents with persistent pain.

What has also yet to be looked at is whether attachment itself, the attachment strategies of parents and child, alter the extent to which child pain behaviours develop. It is suggested here that the Dynamic Maturation Model (DMM) of attachment offers an

interesting approach when used in conjunction with biopsychosocial explanations of pain. The DMM provides useful differentiations on affective and cognitive functioning, as well as information processing at representational levels; procedural, sensory, semantic, episodic and integrative. For example, shedding light on how different types of information at these levels may be repressed, distorted or excluded (Crittenden, 2006; Kozłowska, 2009; Farnfield *et al.*, 2010).

Neither were studies found comparing sufferers from separate persistent pain conditions, with completely differing aetiologies. The different aetiologies underlying pain conditions are likely to engender disparate attachment processes, and focusing on these may be useful in emphasising the diverse ways in which child pain behaviour manifests itself. In order to further our knowledge on the mechanisms underlying the transgenerational effect of persistent pain, more research investigating both parent and child attachment strategies is essential. In addition to this, research comparing different persistent pain conditions, with a focus on the influence of the transgenerational effect of persistent pain, is also evidently required.

However, it is apparent that before these areas can be researched thoroughly, it might be expedient to explore whether there are aetiological differences of pain expression, and what these might be. Additionally, due to the scarcity of qualitative studies, to investigate the way mothers manage persistent pain conditions alongside their maternal roles, and to examine their subjective experience. The following chapter discusses the exploratory study which aimed to do just this.

## CHAPTER 4            EXPLORATORY STUDY

### 4.1.Introduction

As shown in the previous chapter, many women who suffer with persistent pain conditions, such as RA and FMS, are mothers, and the research reveals the extensive negative familial effects of maternal persistent pain, such as significantly poorer family environments, higher levels of depression, anxiety, and dysfunctional and negative family climates, than those with no maternal pain, or with other maternal persistent illnesses (Dura & Beck, 1988; Evans & de Souza, 2008; Evans *et al.*, 2007; Evans *et al.*, 2008; Marshall *et al.*, 2007; Ramchandani *et al.*, 2011; Schulte & Petermann, 2011). Nevertheless, as noted in the previous chapter, there is a scarcity of qualitative studies investigating how mothers manage persistent pain conditions while maintaining their maternal roles. This makes it difficult to assess subjective experience, what collective problems they might encounter, what their main issues are, which would then make it difficult to tailor research or interventions to counter these.

Yet, qualitative research studies investigating the ‘lived experience’ and meaning making processes of participants with RA or FMS, seem to imply differing pain aetiologies may engender diverging coping styles, complicating the picture further. For instance, McMahon, Murray, Sanderson, & Daiches (2012) describe disoriented FMS participants, who explain their pain in terms of loss; loss of former selves, loss of former lives, loss of former hopes and dreams. They paint a picture of lives interrupted and never fully restarted, women preoccupied and immobilised in a world of pain. McMahon *et al.* (2012) note what they call a lack of ‘forward progression’ in their participants. This is partially supported by other study findings (Sallinen, Kukkurainen, Peltokallio, Mikkelsen, & Anderberg, 2012; Sim & Madden, 2008; Söderberg, Lundman, & Norberg, 1999; & Hellström, Bullington,

Karlsson, Lindqvist, & Mattsson, 1999). These studies suggest the development of a preoccupied style of coping, which features pain as dominating all aspects of a person's life, creating a vicious cycle, whereby continual concern with the pain restricts their ability to focus on many aspects of their lives. This coping style is also associated with variables such as severe life stresses, conflict, and abuse, as well as an inability to accept the changes FMS has brought to their lives. It appears those with this preoccupied style of coping have higher levels of pain and distress, but the least amount of social support, and coherence, which was defined as the ability to understand, manage, and make meaning of their circumstances (Sallinen *et al.*, 2012). These studies found that coping ability was positively correlated with coherence and social support, and negatively correlated with levels of pain. Coping ability was also correlated with framing FMS within a biomedical model, which in turn functions to legitimise and validate their pain, and instigate social support (Sallinen *et al.*, 2012; Sim & Madden, 2008; Söderberg *et al.*, 1999; & Hellström *et al.*, 1999). Studies indicated an almost universal and vehement rejection of psychological explanations for FMS by participants. This was because a mental health explanation implies the pain and associated symptoms are 'only in their head'. The suggestion, then is for these participants, narratives have become ordered and organised around biomedical explanations, but they are not able to include psychological and relational influences on their condition.

In contrast, the narratives of participants with RA did not feature the fight for legitimacy and validation, but instead emphasised reflections on social embarrassment due to physical deformities caused by RA (Backman, Del Fabro Smith, Smith, Montie & Sutro, 2007; Hwang, Kim, & Jung, 2004; Fair, 2003). However, along with their pain women with RA, similarly to those reported in the FMS studies, reported suffering with concurrent emotional suffering, anger, and depression. The way the women in these studies seemed to cope was through being proactive, such that if practitioners and clinicians held different

beliefs regarding their RA they either changed practitioners, stopped taking the meds they were prescribed, or quit conventional medicine (Fair, 2003). Both Backman *et al.* (2007) and Hwang *et al.* (2004) described adaption of approach or adjusting of expectations, in the form of searching for positives in their situation, or focusing on or setting of goals. Goal setting seems to ensure they would not be defeated by such a devastating condition. The difference between the women in the FMS studies and the women in the RA studies seems to be the ability to pull some vestige of positivity out of a desperate and all-consuming situation.

Steiner *et al.*, (2010) explains further how varying coping abilities observed among persistent pain patients is influenced by the character of the pain condition. They suggest increased levels of stress and anxiety often accompany conditions without a clear medical aetiology, such as FMS, due to the unpredictable nature of the illness progression. Other studies conclude that much of the reported anxiety stems from the condition's disputed aetiology, which can frequently generate social distrust and vilification (Söderberg *et al.*, 1999; Hellström *et al.*, 1998). However, accusations of exaggerating symptoms, or even hypochondria, are not limited to hailing from outsiders. FMS patients often find themselves having to justify the extent of their pain to clinicians and close family members, due to the absence of visible signs, unlike RA, for instance, which has visible biological markers. The ensuing insecurity this creates may influence the sufferer's underlying coping styles. Hence, the fervent embracing of the biomedical model often reported in FMS patients.

However, there is a conflict between the biomedical model and the lived experience of FMS patients; as revealed in Chapter 2, the biomedical model adopts Cartesian dualism in which the mind and are body separate. The Cartesian model of pain, therefore, assumes medically ambiguous pain to be a failure of the individual, conversely, though, clinicians and patients alike often talk about the relationship between trauma and fibromyalgia, which has also generated much research (Weissbecker, Floyd, Dedert, Salmon, & Sephton, 2006;

Raphael, Janal, & Nayak 2004; Imbierowicz, & Egle, 2003; Toussaint, Whipple & Vincent, 2017). This may explain the ambiguity that is characterised by FMS.

Many women suffering with RA and FMS are mothers; however, there is a scarcity of qualitative studies investigating how these women manage their pain while maintaining their maternal roles. Therefore, the purpose of this qualitative study was to bridge this gap in understanding by exploring how mothers suffering from two aetiologically distinct persistent pain conditions (RA and FMS) discussed their illness and motherhood.

#### ***4.1.2.Aims of the Current Study***

The study aimed to explore and compare how mothers with either RA or FMS described their experiences in threads from parenting forum posts.

1. To provide an enriched understanding of motherhood and persistent pain through the experiences of those who live it
2. To investigate the differing ways in which mothers suffering from RA and FMS might discuss their illness and motherhood
3. To explore if and how discourse made reference to experiences of seeking and providing care in their families

The underlying research position underpinning this study is based in a social constructionist framework. This contains the ontological assumption that while the reality of medical conditions may exist, their meanings are co-created within local interactions, such as within groups who share comparative, yet individual experience, and construct a unified understanding. Additionally, further understandings of the groups and the individuals within are constructed by family members and wider cultural influences, such as professional

services and media, creating dual truths. Therefore, truth is seen as both subjective and relative (Howell, 2013). As such, the purpose of this study is not to produce an objective account of the lives of the women on the forums, but to construct a coherent and informed narrative of their lived experience. In contemporary society an important area of influence on the construction of meanings is the Internet, and in particular social media platforms, such as on-line support forums.

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## **4.2 Method**

### ***4.2.1 Study Design***

Open forum parenting network sites were chosen, in which the women had developed pain support sub-groups, where they discussed a variety of issues relating to their relative persistent pain condition, its impact on their lives, motherhood, and support. The sites included both American based and British based sites, although users are not restricted to these national boundaries. Sites with analogous pain support groups to control user demographic during data-collection were used.

### ***4.2.3. Participants***

A purposive sample was employed, such that inclusion criteria comprised mothers suffering from either RA or FMS, having one or more children. Care was taken to ensure no participants were under the age of 18. Although not always clear, data were excluded where participant age was doubtful.

Posts from family members, or friends of pain sufferers were excluded, as were posts from individuals explicitly stating they were suffering from similar conditions (such as Chronic Fatigue Syndrome, or polyarthritis). However, if no mention of their condition was made, it was assumed they had either RA or FMS, depending on which forum they had posted to. The advantage of this form of data gathering, contrary to the criticism levelled at many qualitative studies, is a potentially large sample size; this study included upward of 350 members per forum.

Precedents for this kind of online support forum study are found in Attard and Coulson's study of online support group discussion forums for Parkinson's disease (2012), Steinfelt *et al.*'s study of the role of online forums in the expression of racism (2010), Holtz and Wagner's study of racist discourse on extreme right-wing online discussion forums (2009), Thompson, Bacon & Auburn's study of dyslexic identities in online forum postings (2015) and Davey *et al.*'s study of online drug forum communities (2012), to name a few. However, the rationale for using this method of data collection is the potential to gather extremely rich narrative data, which would be difficult to gather in any other way, and the potential to access a more heterogeneous group. This not only applies in terms of sociodemographic characteristics, but also in diversity of experience. It also facilitates access to 'real-time' data, which, again, would be almost impossible to gather employing an alternative method. In addition to this, data gathered this way has the advantage of being entirely naturalistic, i.e., it is where discourses around the conditions are ventured, tested, and explored by the forum members.

#### **4.2.4. *vEthical Considerations***

Gathering data from publicly accessed (i.e. non-passworded) forums, comprising non-active threads of several hundred members means a 'passive', unobtrusive observational approach was used, not affecting group processes (Attard and Coulson, 2012), therefore

falling into the category of public observation. The publicly accessed data that was analysed comprised threads posted between 2008-2010, meaning not all who posted to them were still members at the time of data gathering. However, consideration was given to whether or not some individuals would still subscribe to the opinions and views expressed at the time of writing, especially for some of the more pain induced emotive comments, and this is explicitly acknowledged here.

According to The British Psychological Society (BPS) guidelines (2013), Internet Mediated Research (IMR) may not require consent where individuals are unlikely to expect privacy. Therefore, the distinction between what constitutes a 'public' and 'private' domain needs to be made, in other words whether the participants have a realistic expectation of privacy, or not. In assessing the extent to which data gathered from the forums that were accessed could be judged public or private, the issue of forum access becomes key. Forums not requiring any form of subscription, permission, registration or passwords in order to view threads or posts were selected. All data is open to public observation and none of the forums have written statements preventing material being used for research. Therefore, it was concluded the data gathered for use in the current study was in the public domain, and users were unlikely to have an expectation of privacy. However, it was felt there was an issue of respect for the women participating, and whilst it might have proved impossible to contact every single contributing member, it was potentially possible to contact the forum moderators to request permission to use these non-live threads. Several efforts were therefore made to contact forum moderators, but due to the fast moving nature of social media platforms, none of the named forum moderators were any longer members of the forums themselves, and it was not apparent whether new moderators had been appointed. Therefore, the BPS 2013 IMR guidelines regarding consent and expected privacy were adhered to.

Participant anonymity was maintained by eliminating all personally identifiable information, including any mention of names, places and usernames. Pseudonyms were used at all times. However, it may be possible for the determined to trace data to the original source from the study's illustrative theme quotes, and although it is usual for an individual's personal identity to be protected through the use of usernames, some users have profile photos, or can be personally identified in some other way. However, by slightly altering the text within the quotes by correcting spelling, grammar, syntax, and 'text speak', for example, effectively makes them untraceable through a search engine, but preserves the spirit of the quote, as well as participant anonymity, thus enhancing verifiability and scientific value. For additional anonymity and to limit traceability, networking sites used to gather data have not been named.

In addition, The BPS's guidelines for IMR (2013) were strictly adhered to. On these grounds, ethical approval was sought and granted from Plymouth University's School of Psychology ethics committee.

#### ***4.2.5 Data Collection and Analysis***

Threads were collected, containing one or more replies, taking care to match dates between corresponding pain condition sub-groups on each site. Where it was not possible to match exact dates, nearest dates were matched. Closely following the guidelines for conducting rigorous thematic analysis set out by Braun and Clarke (2006), QSR NVivo 10 software was used to prepare the resulting data corpus for analysis, and merged narratives to make two separate pain categories; RA and FMS.

The data within each data set were read and reread prior to generating initial codes, the over-arching themes were initially derived by highlighting commonly discussed subjects. These subjects, with similar features pertaining to the research question, were then grouped together to form relevant codes, which resulted in 25 initial FMS codes, and 21 initial RA

codes. Extracts not relating to the research questions were excluded from analysis. The data collated into initial codes was reviewed, before collapsing some codes into others to form potential themes, and/or sub-themes, or discarding codes that did not work. At this point, having 8 FMS potential themes and 8 potential RA themes, all collated data extracts were reviewed again to ensure each theme worked, generating a thematic map (Braun and Clarke, 2006). Themes were then ‘refined and defined’ ensuring they represented the extracts within, and given descriptive names taken from extracts exemplifying the spirit of each theme.

It was at this point that themes were reanalysed. Meaning the research is, therefore, inductive and data driven, rather than assumption driven.

### 4.3.Results/Findings

Talk revolved around four broad themes that were expressed in different contexts, patterns, and subjects depending on pain condition (see Table 3).

<b>Four over-arching themes</b>	
1. Pain condition; 2. Coping; 3. Family life; & 4. Support	
<b>RA</b>	<b>FMS</b>
1. Pain condition Side effects from meds; flare-ups/remission; treatments	1. Pain condition Comorbid conditions; flare-ups/remission; questioning the root cause of FMS; symptoms
2. Coping Acceptance; Endurance (concise pain language);	2. Coping Communal coping (hyperbolic pain language); battle for validation and vindication
3. Family life Familial support (or lack thereof); difficulties in caring ‘properly’ for the family;	3. Family life Familial support (or lack thereof); children as carers; being unable to care for their children;
4. Support Strong intragroup support;	4. Support Lack of intragroup support; positive result of support

Table 3: Over-arching themes; how talk revolved around different aspects of four broad themes depending on pain condition

The findings will be discussed in terms of four over-arching themes that contained the different super-ordinate themes for each group of women.

#### 4.3.1.Pain Condition

Discussion about their condition mainly revolved around medication and its side effects, fear of taking medication during pregnancy and the harm this may do to the baby. This was a very real fear for many of the women

**RA. Side Effects from Meds.** RA patients take a cocktail of medication, including steroids, anti-inflammatories and pain killers. Although these help with the symptoms of the condition, they have serious side effects, which interfere with the women's day to day functioning. This became even more of an issue during pregnancy; the dilemma being 'to take meds, or not to take meds'.

'I have just found out I am pregnant. Since conception I have taken a total of 55mg of methotrexate and have just had a difficult conversation with my Rheumatologist, who said there is a 1 in 4 chance of foetal defects, & the fact I am over 40 makes this a very high risk. He agrees that this might be lessened by the fact I have not been on methotrexate very long, and the foetus has not had a lot of exposure, but since I didn't stop taking it for 3 months before conception, potentially the risk to the foetus is very high.'

Speculation on how they might cope should the worst occur was common.

'My only big concern for a baby with birth defects is the amount of attention it will need. I have one child who is two years old, and another who is ten months old. So it is going to be really difficult with RA, two tiny ones and one that will need EXTRA care.'

'I was advised that if I ever got pregnant, I should seriously think about an abortion ... although I could never do that.'

Other side effects from the medication were also discussed.

'I'm back on methotrexate after nearly two years break. I'm at the nausea stage, while my body is getting reacclimatised to it. I'm so not looking forward to constantly feeling sick because of my immune system shutting down.'

The extent to which these side effects affect the women's lives are apparent.

'It's like a horrifying cycle – You're in pain & can't function like you need to, you feel emotional & stressed because of it, you take medication to make you feel better, the medication creates further problems, & there you are; in pain & stressed again.'

**Treatments.** A vast array of aggressive treatments, including high dose meds, become routine for the women, which they appear to willingly accept in return for any relief they afforded from the rigors of RA.

‘I have had 13 steroid injections in various joints during the last five months.’

‘I’ve tried sulfasalazine, but found that I reacted badly to it, so unfortunately it is no good for me. However, I have been having hydrotherapy, which is so wonderful; it really helps with getting me moving. How I wish I could have it every day! The physiotherapists were brilliant, & they allowed me to have many more sessions than the normal 8 sessions you should get. Unfortunately it is finished now; they just have so many more people to fit in.’

**Flare-Ups/Remissions.** Flare-ups and remissions are part and parcel of persistent pain conditions; feared and embraced, dreaded and longed for, loathed and loved. The women in the RA forums discussed and compared flare-up and remission triggers; these generally being the weather, food and pregnancy hormones. Whatever the trigger, it becomes obvious flare-ups impact on all areas of the women’s lives, making daily functioning more and more difficult. The emotional toll flare-ups take was also evident.

‘Summer was fabulous. I hardly had any problems. Now that the weather is shifting, I’ve been flaring up like crazy. We are at the beginning of the school year now, which isn’t helping one bit! My feet hurt, my hands hurt, I have a hard time sleeping, and that makes it harder to get up every day.’

‘All I can do sometimes is to scream out loud ‘Stupid arthritis, I hate you, just get the hell out of my body’’

Some women discussed how the right mix of drugs induced a longed for remission. The difference this made to their lives, as well as the lives of their families, was blatantly evident.

‘Once on the right cocktail of drugs I felt almost normal again. I could easily care for my son & run after him (he was a toddler then). Although I was not feeling the way I did before being diagnosed with RA (& still aren’t), however, I feel 1000 times better than I did during the flare.’

‘I started taking sulphasalazine, hydroxychloroquine, on top of all the steroids, anti-inflammatory and pain-killers. I was still pretty bad a few months later, so started taking methotrexate as well ... Now being able to

run down the beach barefoot after my son, run up the stairs and throw him in the air, and being able to take him swimming are worth all the pills, blood tests and endless hours hanging around in doctor's waiting rooms.'

What seems apparent is posting on the RA forums rarely needed to qualify their symptoms, i.e. they were taken as given, and there was also an expectation they would eventually go into remission. This is in direct contrast to the postings of mothers on the FMS forums, where qualification of symptoms was a common occurrence.

**FMS. Comorbid Conditions.** Mothers with FMS discussed their condition in slightly different ways to mothers with RA. Co-morbid conditions accompanying their FMS appeared a common theme. In the face of overwhelming illness, unsurprisingly, reports of depression and anxiety were common.

'I have lots of stomach issues including gastroesophageal reflux disease; I had a stomach bleed that needed surgery a few years ago & nearly died a couple of years later because of it. I've also got irritable bowel syndrome and gluten intolerance; I'm to be tested for Celiac disease. I have joint pain that the codeine is unable to touch in my shoulders, my skin feels like it is on fire if someone even touches me, especially my upper thighs & arms, & lower back, several urinary tract infections a year. I've been diagnosed with persistent lower back pain & degenerative disc disease. I am so fatigued all the time. I also have temporomandibular joint pain. I have depression and severe anxiety. There are other smaller things, but can't think of them right now, because I'm just so brain dead! It is like I just can't think straight anymore. My memory is going downhill fast.'

Not everyone described a vast array of conditions, but, when reported, illustrates how varied and debilitating the condition can be. What seemed significantly different from RA discussions was the lack of narrative around FMS symptoms. FMS mothers were not just talking about the pain they experienced, it was if they were actively trying to define the boundaries of the condition and feeling overwhelmed by its multiple system impacts.

‘I have had FMS for two years now, and persistent fatigue syndrome for one year. I also suffer from heart problems, asthma, thyroid problems and depression.’

***Flare-Ups/Remission.*** Pregnancy hormones were generally discussed as being the trigger for flare-ups and remission for the FMS mothers. Like with RA mothers, pregnancy promised the relief of remission, whilst flare-ups were likely to be experienced post-partum.

‘My FMS pain went away after about the second month of my last pregnancy. I had more exhaustion than ever before. Most days I couldn’t even get out of bed, but no FMS pain. After the baby was born though, around the 5th day, all the pain returned worse than ever.’

‘The FMS pain is just creeping back now my baby is 8 months old. I get it bad in my forearms, legs and, well, almost everywhere!’

Unfortunately, not all found the sanctuary of remission within pregnancy.

‘During this pregnancy my FMS has really flared-up badly, every day seems like a bad day’

***Questioning the root cause of FMS.*** The disputed aetiology of FMS led some women to fervently embrace biomedical explanations for their pain, rather than countenance suggestions of being mental health induced. Accepted explanations tended to lie within a biomedical model, and by doing so they were reaching for a construction of the illness that made sense to them, and legitimised it (Sallinen *et al.*, 2012; Sim & Madden, 2008; Söderberg *et al.*, 1999; & Hellström *et al.*, 1999).

‘My chiropractor explained that the spinal fluid that comes down from the base of the skull is inhibited when our jaw is out of alignment. This makes a lot of sense, because doctors refer people with fibromyalgia to Neurologists, and say that FMS pain is from nerves at the base of the skull being trapped, and then sending the wrong messages to the brain’

‘FMS is just a set of random symptoms, having been given a name by medics. There is an enormously high chance that FMS symptoms are due to food intolerances, which result in a physiological imbalance’

However, some offered alternative accounts of events they believe pushed their bodies beyond what it could bear; burn-out, and car accidents, to name a few.

Some, however, revealed a darker, more disturbing origin to their FMS pain (Toussaint *et al.*, 2017). Here, the legitimacy was not in question, but the desperate unfairness of it.

‘I often find myself getting angry & distressed about the fact that not only did I go through all that pain & trauma as a child, but I’ve also now got a life-long pain condition that seems to be directly linked to what happened as a child, despite trying so hard to put it behind me. On top of this I have other physical issues that I have to live with on a daily basis because of the child abuse I suffered.’

**Symptoms.** Across all forums, for the FMS group there appeared to be a theme of ‘the enormity of the symptoms’ and a related theme of ‘isolation with the symptoms’. These were often denoted by the use of hyperbolic language and very rarely responding to, or commenting on, each other’s symptoms.

‘I constantly live in such horrible pain ... along with this persistent tiredness, I find that I can sleep for hours and wake up still feeling totally exhausted’

‘My main symptoms are various aches, irregular heart beat/palpitations, stabbing & shooting pains, fatigue, cramps in my hands, feet, legs, & shoulders, spasms, have on off breathlessness, anxiety, sometimes panic attacks, low mood, PMT, amazing intolerances, & now I’ve got ovarian cysts’

‘I have pains anywhere and everywhere, endometriosis, pins and needles, irritable bowel syndrome, recurrent thrush and cystitis, headaches, random itchiness, restless legs syndrome, cold hives, memory problems, lots of intolerances and allergies, tinnitus, sleep problems, recurrent miscarriage and still birth (somewhere I read that FMS can cause that I think), and X-rays at hospital have also shown I have slight scoliosis, flat back syndrome and collapsed vertebrae in the lumbar spine’

### 4.3.2 Coping

Methods of coping varied in subtle, yet significant ways, between the pain groups, with seemingly varying levels of success. RA mothers seemed to find succour through bearing these difficulties with fortitude, whilst FMS mothers seemed to need the forums as an outlet for the accompanying overwhelming emotion.

**RA. Acceptance.** There seemed to be a difficult period of adjustment between diagnosis and acceptance; accepting new limitations, the new person, new coping strategies.

‘I have just been diagnosed with RA and I am having a tough time coping with a flare up. I just can't accept this is going to be my life now’

‘My level of 'normal' now isn't the same kind of 'normal' as it used to be ... It took a long time for me to accept that I wasn't the strong person I used to be, though’

**Endurance (Concise Pain Language).** Despite being in intense pain at times, mothers with RA tended to be economical when describing their pain, using the most concise language.

‘I broke my ankle a couple of years ago, and I'm having a tough time with it today. It keeps seizing up and I have to limp around until it loosens up again. It's so frustrating!’

‘I am feeling a bit sorry for myself today. I'm tired, sore and a tad swollen’

‘After my first pregnancy and how well I was beforehand, I'm finding being like this now as a bit of a tough sharp shock. I'm starting to adjust a bit more recently, lots of acceptance and recognising what my limitations are’

**FMS. Communal Coping (Hyperbolic Pain Language).** In contrast, members of the FMS groups often used more hyperbolic language to convey the extent of the pain they often found themselves enduring.

‘I constantly live in such horrible pain. Pain that runs deep into my bones and feels as if I continually have knives stabbing me, or it feels like someone is trying to scrape out the inside of my bones!!’

‘I feel like my skeleton is made of lead’

‘The flare up brought on by this pregnancy feels like actual death’

**Battle for Validation and Vindication.** One of the most common difficulties impacting on FMS group members was the constant battle for their condition to be recognised by family, friends, and medical practitioners, their pain to be believed, and for them to be understood.

‘It’s so frustrating when people don’t understand. I’ve even had doctors tell me that the pain is all in my head’

‘Half the reason FMS is so difficult to cope with, is because people refuse to validate our feelings’

‘I plucked up courage to tell my mother I have FMS, and she didn't believe me. I'm pretty sure she just thinks I'm a druggie’

### **4.3.3 Family Life**

Family support was discussed in similar ways by both groups of mothers, with similar issues, worries, and concerns arising.

**RA. Familial Support (or Lack Thereof).** There was the familiar lament of family and partners not fully ‘getting’ the extent of RA’s impact on the mothers.

‘... there are times that I feel my husband just does not get how I feel. I know he tries, but he just doesn't get it ...’

‘... a few years after diagnosis, I met my husband. We’re very lucky to still be together, to be honest, due to his typically unsympathetic and cynical nature. Before he saw my first really bad flare up he really did think it was all in my head’

‘... my family does not seem to accept my condition at all. They think I should be the same as I was before. So, they have a go at me about sleeping during the day, but that's what helps me cope ...’

**Difficulties in Caring ‘Properly’ for the Family.** A particular point of distress was not being able to ‘mother’ in the ways they wished to.

‘... when you are a mother, and you just want to be able to pick up your child, yet you can't because it hurts, or your baby has to wait for breakfast, because you are unable to move ...’

‘What I am finding the hardest at the moment, is when my 2 year old wants to be held and carried more than I am able to’

**FMS. Familial Support (or Lack Thereof).** As with RA forum members, FMS mothers also found a lack of full understanding from their partners and families

‘... my partner really doesn't understand, and so I do not get much help with the children’

'My husband says he wants to leave me, because FMS has changed me from an independent, happy person, to a depressed, 'lazy', and bitter mother, who is also a horrible wife, because I can't tend to my husband like he thinks I should'

***Children as Carers.*** During painful flare-ups, offspring are often required to act as the care-givers, which became a great source of anguish to FMS mothers

'Sometimes I sit and cry, and my son cuddles me. It's so not fair he does so much for me, and has to see me like this ...He's scared to leave me sometimes, to go to school, but I make him go by telling him he's better off at school with his friends ...'

'My pre-teen has seen me at my worst, like when the pain gets so bad; all I can do is cry. There are times when he even has to help me to go to the bathroom'

'I hate that during this flare up my children have to be my carers, again. I'm supposed to be their carer, because they've both got special needs'

***Being Unable to Care for Their Children.*** On top of finding themselves in the position of cared-for, instead of care-giver, FMS mothers often lamented their perceived inability to always fulfil their children's needs.

'... when my husband's not around the kids get so worked up, especially my oldest. It's tough for them to watch me in pain, especially when I'm the one who's supposed to take care of them'

'My older children know I'm not well, and I can't always play with them. Yet it still breaks my heart when they want me to do something for them, & I just can't'

'... sometimes my children miss out, and always I feel awful about it'

#### ***4.3.4 Support***

Intragroup support was evidenced in both groups, but to very different extents. This may be a reflection of the difference in emotional resources available to mothers.

**RA. Strong Intragroup Support.** There was a strong culture of intragroup support shown by members within the RA groups. Support and advice was routinely asked for and always given.

‘Has anyone taken Methotrexate and became pregnant while on it? Did you have a healthy baby? I am so worried about mine having birth defects’

‘...I have a laid back rheumatologist, who told me when I got pregnant, as long as I was on sufficient amounts of folic acid it shouldn't be a problem’

‘I have no advice to offer or anything to add, but I wanted to send you & your baby hugs and good thoughts’

‘Hi, I am also in the same position as you at the moment. How are you? I am remembering you in my prayers. Please let me know how you and the baby are getting on’

**FMS. Lack of Intragroup Support.** There were many instances of mothers asking for support or advice, but receiving no reply, which either resulted in further, more emotional requests, or an end to that member's participation in the group. However, this was different for mothers who appeared to be speaking from a position where they felt they had family support (see Observations of the postings section below).

**Positive Result of Support.** However, where FMS mothers were able to provide intragroup support, they seemed to have a firm foundation of support themselves

‘I am very fortunate to have family and friends who understand ... I hope things start to get better for you, nothing is worth ending things for. You can always send me a private message at any time, maybe I can be a source of encouragement for you’

‘During flare ups I really have to hand it to my husband for everything he does for me. On those days I'm the weak one, and he becomes the strong one. If you need to talk, or need encouragement you must message me’

‘I'm so sorry you have to go through this alone. When I have really bad flare ups it's nice that my husband can deflect my kids ... I hope having some others to talk to helps at least’

#### **4.3.5 Observations of the Postings**

A striking observation was that there were many unanswered posts from distraught FMS group members. Time after time, across all four forums, FMS mothers begged for support from their peers, raged against the unfairness of their pain, lamented the futility of their roles, and railed against the lack of understanding from family, friends, and doctors. Across all four forums, these posts went unanswered. As seen above, similar calls for support were witnessed in the RA forums, but these invariably led to supportive responses. Even where practical assistance was impossible, or when there was no useful advice to give, a verbal embrace was proffered, emotional support was provided, and this was always gratefully received.

#### **4.4 Discussion**

##### ***4.4.2 Research Questions Answered***

The aims of the study were to provide an enriched understanding of motherhood and persistent pain through the experiences of those who live with it, and to investigate the differing ways in which mothers suffering from RA and FMS might discuss their illness and motherhood. Also, to explore if and how discourse made reference to experiences of seeking and providing care in their families.

The postings on the forums provided evocative material about the nature of the experience and relationship with pain for the women. It also indicated some striking differences in their experiences, one key difference being the continual search for acceptance and validation for the FMS group. The women talked about the impact of pain on various aspects of their lives, their sense of themselves, and on their relationships. A particular focus was on their experience of and ability to act as mothers to their children. Both groups talked about difficulties in managing their maternal roles, guilt at young children having to feed themselves, not being able to pick them up or play with them, or taking children for days out.

FMS mothers had the additional guilt and anguish of having their children care for them, both physically and sometimes emotionally.

From the threads analysed it appears that mothers from both groups were aware their condition impacted on their children, however, higher levels of emotional or preoccupied coping tended to cloud this reflective function a little. For example, those displaying lower levels of emotional coping seemed more concerned with how their condition would affect their child long term, whilst those displaying higher levels of emotional coping expressed regret, there was little reflection on the emotional or psychological impact this was having on the child. Each pain condition appeared to predict differences in perceived familial support; both groups reported a lack of understanding from partners, however, this was found more frequently in FMS forums, as were more harsh or cruel comments from both immediate and wider family, and more emotive reactions as a result. Furthermore, condition related differences in perceived family support appeared to moderate capacity to attend to their children's needs. Their pain appeared to challenge their ability to be reflexive about themselves and their children. Preoccupation with their own pain did at times leave mums with few resources to attend to their child. Where child distress was reported, some preoccupied mothers experienced difficulties in ability to sooth their child. There was some evidence of this situation being resolved through the child developing unexplained pain conditions, meaning they were home to keep an eye on mum, be close to her, or gaining her attention by activating maternal health anxieties. This suggests mother's reactions, through maternal health anxiety and/or child distress regarding their mother's pain, may shape children's expression of pain, and unconsciously channel emotion through pain. However, these mothers recounted an extreme lack of social support, appeared intensely distressed, and displayed an externalising method of coping.

#### ***4.4.3 Support of Previous Studies***

The findings in this exploratory study support previous research where higher levels of perceived familial support appeared to lead to better cohesion, meaning coping with, understanding, and making sense of their conditions (Sallinen *et al.*, 2012; Sim and Madden, 2008; Söderberg *et al.*, 1999; and Hellström *et al.*, 1999). Perceived familial support in turn appeared to influence how much support could then be offered to other sufferers. Conversely, lack of perceived familial support provoked preoccupied and emotional coping, emphasis on reiterating symptoms, and seemingly higher levels of dysphoria. Perceived levels of support also appeared to influence coping styles, with RA mothers tending to display more stoic and enduring coping styles, whilst FMS mothers tended to evidence more anxious coping styles. It would appear that previous research is supported here, indicating less perceived familial and social support in FMS mothers, than for RA mothers (Steiner *et al.*, 2010).

#### ***4.4.4 New Findings***

One of the most striking observations was linked to intragroup support. RA mothers regularly sought and received cognitive and affective support from one another. One explanation might be the importance of a mutually caring and supportive environment, but in addition, it might also be interpreted as a form of maintenance. For example, being unable to provide physical care, the RA mothers were willing and able to offer care, and emotional and practical advice, in the absolute knowledge that it would be received in kind when sought at a later date. Additionally, supporting others may give meaning to one's own illness experience; for example, husbands and other family members did not always 'get' what they were going through, so the understanding, advice, and comfort offered to other RA sufferers sanctions the one supporting to give as they would hope to receive.

In contrast, the FMS forums appeared to be more a medium to vent and seek, rather than receive or offer help. On the surface they seem a final attempt to find understanding and assistance. However, viewing behaviour as functional opens another perspective. Horton-

Salway (2001) regards illness discourse as performative, especially for illnesses with conflicting medical aetiological theories. She argues the potential accusations of malingering or psychological vulnerability can be countered through vigorous demonstration and justification of their own illness, therefore, it could be argued, members are subsequently unable to use the forums to perform supportive and caring roles for each other, but are instead used to express how demonstrable their symptoms are. This was emphasised by the many non-answered posts, as mentioned above.

Furthermore, threads indicated linguistic differences in pain descriptions in the two pain groups. Mothers in RA forums used succinct and reserved language when describing their pain. In one instance, a mother with RA used deeply emotional and emphatic language in reference to her pain. It later became apparent this mother had no familial support whatsoever, leading to high levels of stress, anxiety, and, in turn, amplification of pain. FMS mothers used hyperbolic, emphatic vernacular in expressing their pain. It is proposed the difference in verbalisation of pain experiences is directly linked to coping styles and perceived levels of social support.

One notable new finding relating to RA is how clinical/medical staff often report RA is well managed with drugs; the forums, however, paint a slightly different picture. These indicated intense, unmanageable pain, flare ups, joint swelling and damage, and enervating side effects from medications. The impact this had on the women's lives was devastating, and for some, the forums were the greatest sanctuary of understanding, support, and advice. Additionally, the women in the RA forums appeared to be able to find shared humour in their difficulties, something that was not evident in the FMS forums, where there are negative/catastrophic formulations of the symptoms 'every day bad', 'everywhere', 'worse than ever' as opposed to RA forums, where there is some concept of better times, i.e. RA 'better than worse', FMS 'worse and worse'. The use of humour here could be seen as an

important marker of resilience, but also of dismissing attachment patterns, in displaying false positive affect, such as laughter at one's own pain.

Previous research concluded coping success was linked to meaning-making (Backman *et al.*, 2007). However, this study suggests there is a relationship between ability to make meaning of illness, and both perceived familial and clinical support. The implication is the extent of familial support may be indicative of underlying attachment strategies, which then prove facilitative in providing intragroup support.

The women's postings and differences between the two groups can also be considered in terms of an emotional-regulation and attachment theory framework (Crittenden, 2006; Kozłowska, 2009; Farnfield, Hautamäki, Nørbech, and Sahhar, 2010). The postings indicated differences in that some women appeared to exaggerate the pain, focused on themselves, and employed highly emotive language, which is characteristic of hyper-activating (pre-occupied) attachment orientations. In contrast, some engaged in de-activating (dismissing) processes of minimising their pain, focusing on others, and using matter-of-fact non-emotive language. For example, the RA group themes suggest a comparatively more stoic, pain-dismissive form of coping, whilst the FMS group displayed a more anxious, aroused, pre-occupied coping pattern. Given that the pain is intractable, attempting to dismiss and deny its importance, as ostensibly appears with RA patterns, can be seen as a functional strategy. For example, Kozłowska (2009) suggests patients unconsciously inhibiting the severity of their pain, or related affective distress, are generally liked by medical staff, due to their uncomplaining nature and easiness to treat. The praise received for being a 'good patient' in some way satisfies the patient's care needs, thus reinforcing this attachment strategy.

Likewise, for FMS sufferers, the uncertainty regarding the illness's cause and progression (Steiner *et al.*, 2010), and consequently the oft perceived ambivalent reactions of medical staff, friends, family, etc., unconsciously escalating one's level of affect in order for

the pain to be taken seriously, may also be identified as functional (Vervoot *et al.*, 2010). Whichever strategy is implemented; however, it ultimately means the women are working hard to employ defensive processes. As a result, it may be these mothers have few cognitive and affective resources left to attend to the needs of others. Consequently, some children may later inhibit affect and express emotion through somatisation (Kozłowska, 2009; Lux and Kozłowska, 2017), as indicated by some FMS forum posts.

Ideas of what constitute being a good mother and how their condition limits that, appeared to be the same despite condition, leading to added pressure on mothers, and self-imposed guilt. Attachment interventions may relieve levels of self-imposed guilt in mothers, and recognition of maternal challenges in the rest of the family. Consequently, the research in the rest of this project will focus on investigating attachment patterns underlying instances of development of somatic symptoms in the children of these mothers, and consider whether mother and child attachment strategies influence acceptance of maternal limitations and its consequences. The following chapter will outline the methodology used to implement this.

## **CHAPTER 5            METHODOLOGY**

### **5.1    Introduction**

The research study initially started with a qualitative focus on the accounts and meaning that mothers held in relation to their pain and their relationship with their child. However, it became evident that more than this was necessary and that to explore the impacts of pain on their relationships required a multi-model and multi-phase approach. Hence a variety of methods including quantitative, qualitative and idiographic approaches were chosen. The choices evolved as the study progresses so that each phase presented new questions and directions for exploration. For example, the exploratory study looking at online forums for mothers set the scene and prompted a specification of some the more specific questions that were developed. It has been offered before this methodology section because it helped to shape the methodologies that were subsequently chosen

This chapter begins with the presentation of the aims and research questions for the whole study. The aims for each individual study are then discussed in more detail, with explanations as to how and why they were investigated, and how they contribute to the overall study aims. This is followed by an explanation of the design and methodology used for this project: first the mixed methods design is introduced, secondly, why each aspect of the design approach was selected for this study is explained and critiqued, and finally, the related ontological and epistemological considerations are examined. Methods used for four phases of data collection are then presented and critiqued, with a rationale for the decisions made.

### **5.2    Aims and Research Questions**

The aim of this research was to examine the role of attachment in the development of

pain behaviour in children of mothers with persistent pain conditions. In particular, it aimed to examine differences in the transmission of pain behaviour occurring in children of persistent pain sufferers with a physiological aetiology, such as rheumatoid arthritis (RA), than in children of persistent pain sufferers with a more equivocal aetiology, such as fibromyalgia syndrome (FMS), and the extent to which attachment may moderate these effects.

The key aims of this research were to;

1. explore the mother-child relationship where mothers suffer with two distinct persistent pain conditions (RA and FMS). This included examining how mothers parented their children and how parenting patterns influenced their children's pain behaviour;
2. examine how children in these relationships learn to make sense of and express their own pain, for example, do they learn they should not bother their mother with any pain they might experience, or that they need to exaggerate their pain experience in order to be heard above their mother's own pain;
3. investigate whether there are differences in how this occurs between children of mothers who have a clear, unambiguous medical diagnosis of their pain (RA) compared to those of mothers with more contested pain conditions (FMS), meaning whether the nature of the mother's pain condition affects how her child experiences and expresses pain;
4. to investigate what those differences were and how they manifested in behaviour;
5. gain a relational understanding of how the mothers' and children's pain experiences and attachments are shaped, and were in turn shaped by their relational dynamics, meaning whether and how childhood experiences influence attachment behaviour, if these are linked to the development of specific pain expression, and whether and how these then influence the next generation's pain experiences and attachments;
6. explore the possible underlying affective and cognitive mechanisms that shape how children learn to make sense of and express their pain, for example, whether a reliance on

processing more affective or more cognitive information influences the way pain complaints are signalled to attachment figures. Some specific questions of interest were to explore what kinds of functional strategies children of mothers with persistent pain may develop. For example, the possibility that their unconscious, adaptive processes shape them to display an increase of pain complaints to get their physical, mental, and emotional needs met. In turn to explore possible transactional processes, such as whether the mothers' own attachment strategies influence the development of specific, self-protective, and functional attachment strategies in their children.

### 5.2.1. Aims and Study Design

In order to achieve these aims and research questions, they were broken down and investigated via a series of studies, as can be seen in fig.1.

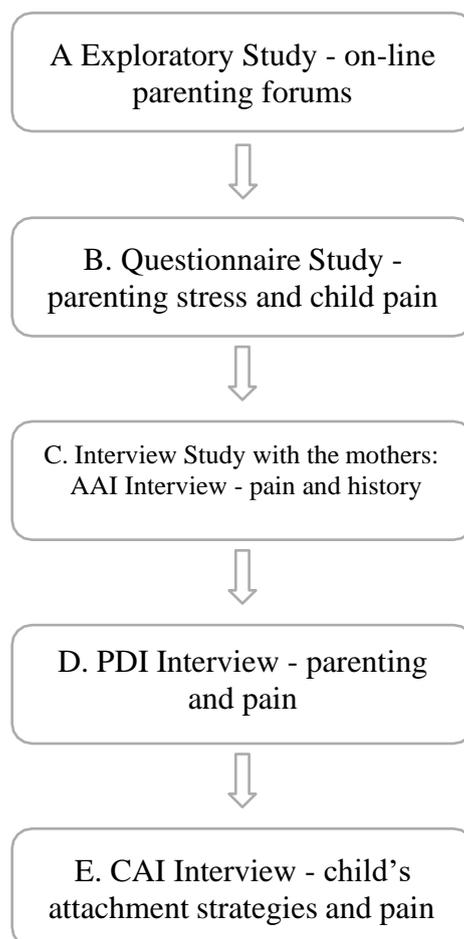


Figure 4: Study flow chart

- A. An exploratory study examined threads from four online parenting support forums looking at how mothers suffering from RA and FMS discussed their illness and

motherhood. Specifically, how they discussed a variety of issues relating to their relative persistent pain condition, its impact on their lives, motherhood, and support. The aim of this study was to provide an enriched understanding of motherhood and persistent pain through the experiences of those who live it, and to investigate the differing ways in which mothers suffering from RA and FMS might discuss their illness and motherhood, and how discourse made reference to experiences of seeking and providing care in their families.

- B. The next study investigated parental perception of child pain, alongside levels and type of parenting stress by means of two questionnaires (the Varni-Thompson Paediatric Pain Questionnaire (PPQ) and the Parent Stress Index (PSI-4-SF)) filled out by mothers. Based on the findings from the exploratory study and the literature review, the prediction was higher levels of reported child pain intensity and frequency would coincide with higher levels of parental distress and difficult child scores. More FMS mothers were predicted to score higher on both the PPQ and the PSI-4-SF, meaning they would report higher levels of parental distress, parent-child dysfunctional interaction, and difficult child than RA mothers, as well as higher levels of child pain intensity and frequency. The aim of this study was to examine whether parental coping styles influence perception of their child's pain complaints, by using maternal health stress as an indicator, and whether these findings would differ between pain groups.
- C. The third study examined participant mother's family background and illness history. These consisted of both narrative interviews regarding their backgrounds and elaborated by use of the Adult Attachment Interview (AAI). The interviews explored memories of the mothers' childhood experiences to assess the strategies they evolved to protect themselves, and those they currently use, and outlined their AAI classifications. The AAI is a qualitative structured attachment interview and the data were analysed using a DMM led discourse analysis. An aim of this

study was to examine whether attachment patterns and illness histories were differentiated by pain condition.

- D. The same mothers were interviewed again in the fourth study, which focussed on how the mothers viewed the relationship with their child, and the nature of these developing relationships. In particular, it provided relational context for considering how pain and discomfort were managed within this relationship. This was done using a qualitative structured interview (the Parent Development Interview (PDI)) and was analysed through the use of a comprehensive method of analysis which examines dispositional representations, or systems of beliefs and attitudes the parent has towards their child and their relationship (the Meaning of the Child (MotC)). The MotC analysis uses attachment theory and patterns of discourse regarding relationships to focus on the parent-child relationship rather on attributes of the parent, how they think and talk about their child, and their ability to mentalise on behalf of their child. The aim of this study was to observe the nature of parenting patterns and mentalisation ability, the ways in which mothers dealt with their child's distress and/or their child's pain, and observe what might influence variations in parenting patterns.
- E. The final study examined how the children of the participating mothers experienced family relationships, to assesses their attachment representations, and to understand how their experiences of being parented might differ from their mother's experience of parenting them. Of particular interest was their experience of being in pain or when ill, and how they described the care they received at such times. The Child Attachment Interview (CAI) was used to examine the children's representations. Interviews were videoed, since children and adolescents are unlikely to be able to verbalise their attachment representations fully, the children's body language whilst talking was taken into consideration. The aim of this study was to explore the nature of the child attachment patterns and note

comparisons between the pain groups.

### 5.3. Summary of the Design

This is an in-depth multi-methods research study. Exploratory descriptive analytical measures were employed using structured inventories and questionnaires, alongside qualitative discourse analyses of in-depth structured narrative attachment interviews, forming multiple exploratory case-studies, to uncover variations in the links between attachment and pain within each family. This breaks down as follows:

1. Questionnaires = 16 (FMS=10, RA=6)
2. Multiple exploratory case-studies = 5 (3-FMS, 2-RA)

Each set of interviews are presented as individual case studies, with each subsequent interview drawing on the information of the former, to gather cumulative insight into patterns of behaviour, the findings from which were integrated with the data from the questionnaire study.

#### 5.3.1 Methodology

**5.3.1.i. Qualitative research.** The qualitative component of this study was chosen for several reasons; firstly, much of the existing research around familial and maternal persistent pain has been quantitative, affording statistically based nomothetic accounts of pain behaviours, perceptions, and emotional states. For example, quantitative research has established that children of mothers with persistent pain tend to have higher depression and anxiety, more behavioural problems, poorer general health, and more pain complaints than children of healthy mothers. Additionally, quantitative research has found poorer family environments and higher levels of family disfunction in families with maternal persistent pain (Higgins et al, 2015; Evans, Keenan, & Shipton, 2007; Jamison & Walker, 1992; Schulte & Petermann, 2011; et al, 2013). However, the limitation of a quantitative approach, which offers nomothetic data, is that it homogenises the pain experience, when in fact pain is an

extremely subjective, multi-dimensional experience. The epistemological perspective of quantitative research does not lend itself to subjective, and often plural, meanings of the pain experience and can have the effect of nullifying or dismissing the unique and subjective aspects of the lived experience of many individual pain sufferers, meaning we get a somewhat one dimensional understanding.

Secondly, there has been a dearth of qualitative research in this area, so that less is known about these idiosyncratic experiences of pain. Qualitative research methods allow an investigation of individual lived experience, meaning making, and personal perspective (Hammarberg, Kirkman, & de Lacey, 2016), and these are important to understanding pain because pain is a uniquely subjective experience. The pain experience is often a private, individual one, and is therefore very difficult to quantify. A qualitative approach to pain research, therefore, can better reflect the multiplicity of meanings that the pain experience embodies in a way that would be unreachable with other approaches. Therefore, the use of qualitative research brings another perspective to the existing quantitative research on familial persistent pain. In summary, there is already a good understanding of *what* is happening – quantitative research has already brought that to the fore – therefore, through the use of a qualitative research design, this existing understanding can be furthered to include why and/or how some children of mothers with persistent pain develop pain themselves, whilst others do not

Thirdly, there has been very little research exploring the emotional and defended aspects of the experience and impact of pain. Since emotions and emotional regulations are central to attachment theory it was chosen for this research as the appropriate method to facilitate this. Importantly, attachment is also relevant to a study of pain since how this is signalled and responded to is a fundamental component of the parent-child relationship. Pain signals discomfort and dangers, and how this is signalled and requested, how comfort is

sought and provided, is a central feature of an attachment relationship. It can provide an insight into some of the affective and cognitive influences in the transgenerational effect of maternal persistent pain, which is central to this research. This lent itself to a more qualitative approach.

There are three different methods of data collection utilised in this research, all of which are necessary to build a fuller picture;

1. questionnaires were used to gain a general picture of the landscape of the familial pain experience;
2. narrative interviews were used to explore the nature of this experience;
3. attachment measures were used to explore unconscious processes shaping the experiences of mothers and children.

**5.3.1.ii. Inductive Reasoning.** Inductive reasoning is associated with qualitative research, and involves ‘bottom up’ thinking, in that it moves from specific observations to broader generalisations and theories. This is contrary to deductive reasoning associated with quantitative research, which moves from more general theories to a specific observation. Inductive reasoning begins with the specific observation of patterns and themes within the data, goes on to formulate tentative hypotheses which can then be explored more thoroughly, and ends by drawing some more general conclusions or theories.

Whilst there may not be a generalisation of findings to the wider population with the inductive reasoning process, there may be some relevant transferability, where findings from a qualitative study may be transferred to other studies with similar sample groups, but this is not the same as being generalised, or representative for the wider population. This is because qualitative research usually focuses on specific groups. For example, in the case of this research, the wider population are not mothers suffering from a persistent pain condition, or

the wider population are not the children of mothers suffering from a persistent pain condition, therefore it does not make sense to attempt to generalise this information.

**5.3.1.iii. Ontology/Epistemology.** The ontology of this research is concerned with what and how groups of women and their families construct their view of life with persistent pain as the backdrop. Hence, rather than predominantly accepting an ontology of pain as predominantly a physiological entity, the study adopts a biopsychosocial ontology in viewing pain as also constructed by personal and societally shaped processes of meaning-making. In other words, pain is seen within people's own personal reality of living with persistent pain, the everyday hurdles pain brings with it. In turn, these perceptions and how pain is managed, is considered within socially constructed discourses, including norms of how it is managed medically, is regarded as unchangeable, and in turn how these culturally shared discourses shapes conversations, or 'pain talk' within the family. By using multiple case studies, the aim is to understand the joint constructions of reality, and the possible reasons for the being of this reality for pain sufferers and their families, as well as the personal and individual truths that are constructed within each family and each individual. This can then be compared with the wider social truths that health care clinicians and society as a whole construct for them. Thus, truth is constructed locally, within and between families, as well as within society, yet the reality of these truths may be dependent on individual or pain group experience. Therefore, the multiple realities and multiple truths constructed around persistent pain lend itself to a social constructionist paradigm<sup>8</sup>. Due to this, the epistemological theory becomes one of being aware of the joint consensus gleaned from the individual constructions of the participants and that of the researcher. Researcher reflexivity becomes essential, and subsequent research validity can then be conferred<sup>9</sup>

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<sup>8</sup> The social constructionist paradigm is considered in more depth in Chapter 2 - Conceptual Framework

<sup>9</sup> Researcher reflexivity is considered in Chapter 8 - MotC PDIs

**5.3.1.iv. Quantitative Study – Questionnaires.** This study had been planned to employ a quantitative, quasi-experimental, between group design, involving the use of questionnaires, and the difference between the two group means were to be analysed using correlations. However, due to difficulties in recruitment<sup>10</sup> the sample size did not reach that which would generate the necessary statistical power, therefore the difference between the two pain group means were analysed using exploratory descriptive analytical measures - an exploratory content analysis was used and the results were reported descriptively<sup>11</sup>.

**Procedure.** 34 mothers agreed to participate (RA=16, FMS=18) and were sent two validated questionnaires; the Parent Stress Index (PSI-4-SF) (Appendix 2) and the Varni-Thompson Paediatric Pain Questionnaire - Parent Version (PPQ) (Appendix 3). 16 completed questionnaires were returned (FMS=10, RA=6)<sup>12</sup>.

**PSI-4-SF.** The PSI-4-SF SF is a 36-item inventory evaluating the magnitude of stress in the parent-child system, and is broken into three domains, Parental Distress (PD), Parent-Child Dysfunctional Interaction (P-CDI), and Difficult Child (DC), which combine to form a Total Stress scale. The Parental Distress domain assesses factors related to parenting, such as parenting competence, stress connected to parenting-related restrictions in other areas of life, conflict with child's other parent, lack of social support, and levels of depression (Abidin, 2012). The Parent-Child Dysfunctional Interaction domain evaluates parent perceptions on whether their child does not meet their expectations, whether parent-child interactions reinforce them as parents, whether the child is viewed as a negative force in the parent's life, and whether they view themselves as abused or rejected by their child (Abidin, 2012). The Difficult Child domain focuses on the parent's perception of whether they find elements of their child's characteristics difficult to manage. Characteristics are temperament-orientated,

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<sup>10</sup> Recruitment issues is discussed in greater detail in Chapter 6 - Questionnaires

<sup>11</sup> The rationale for which is discussed in greater detail in Chapter 6 - Questionnaires

<sup>12</sup> Reasons for the level of questionnaire return rate are discussed in Chapter 6 - Questionnaires

meaning they are part of the child's make up and potentially unchangeable, but also include elements of negative learned behaviour (Abidin, 2012). The domain of Total Stress indicates the overall stress experienced within the parenting role, and include elements such as personal parenting distress, stress from parent-child interactions, and stress related to child behaviour (Abidin, 2012).

Scores for the first three domains are calculated per domain to locate a raw score for each, these are then added to generate a Total Stress score, each of which correspond to a percentile. Normal ranges are scored within the 16<sup>th</sup>-84<sup>th</sup> percentile, scores within the 85<sup>th</sup>-89<sup>th</sup> percentile are considered high, those above are considered to be at risk. Scores below the 16<sup>th</sup> percentile indicate parental withdrawal/passivity. In clinical settings, domain score interaction would be examined to determine levels of risk and necessity of intervention for the child, however, this is not something that will be considered in this research.

***Reliability and Validity.*** A testable form of reliability, known as internal consistency, allows consistent measurement of scale items via item-total correlations and coefficient alphas. The PSI-4-SF scales, or domains, have all been found to be near .90 (Abidin, 2012; Roggman, Moe, Hart & Forthun, 1994; Haskett, Ahern, Ward, & Allaire, 2006), suggesting a high internal consistency, and therefore reliability. Likewise, correlations between the PSI-4 and PSI-4-SF produced exceptionally high scores (TS=.99; PD=.99; P-CDI=.98; AND DC=.97) (Abidin, 2012) conferring validity.

***PPQ.*** The PPQ (parent version) addresses parent's perception of their child's pain intensity, with sensory, affective, and evaluative aspects of their child's pain experience, symptoms, treatments, the situational factors influencing pain perception, and family pain and illness history using a variety of qualitative and quantitative questions, Visual Analog Scales (VAS), and front and back Body Outlines to indicate pain locations and pain intensity for each.

***Reliability and Validity.*** High correlations have been found in the VAS pain intensity ratings between parents, physicians, and patients. Significant correlations have been found between the questionnaire's pain ratings, sensory, affective, and evaluative pain descriptors, emotional states that influence pain, and other pain questionnaires, such as the McGill Pain Questionnaire indicating consistent reliability and validity (Varni, Thompson & Hanson, 1987; Gragg et al., 1996).

### **5.3.1.v. Qualitative Studies: Interviews and Narrative Attachment Explorations.**

***Narrative Background Interview.*** Three interviews were undertaken; AAIs, PDIs, and CAIs. These interviews were delivered in a slightly different way than usually administered, meaning that although they are structured interviews, where specific questions are asked in a specific order in a specific way, for this research all three interviews were delivered more informally. For example, in the AAIs questions around illness, pain, and comfort were focused on and elaborated upon, subsidiary questions asked, and themes followed up on, allowing participants to answer more fully, giving their perspective of events, and the personal meanings these evoked. Where the subject of illness, pain, or comfort came up in other sections of the AAI these were again focused on and followed up with subsidiary questions. This made the interviews more qualitative and narrative-exploratory in nature than they would usually be. The same themes around illness, pain, and comfort were explored in the PDIs and CAIs. In addition, contrary to how the interviews are usually conducted, in this research mothers sat in on their child's more informal CAIs. Mothers provided confirmation of the 'facts' of what their child was saying, either by how and when they commented, but also where they did not interject to correct their child's narrative.

***Interviews with Mothers.*** The second phase of the study employed a mixture of narrative attachment measures with the mothers from the two pain groups (FMS=3: RA=2).

All three interviews in this research are structured, meaning set questions are presented in exactly the same order for each participant, in the same way, which provide data that can be employed ideographically to determine the dominant self-protective attachment strategies employed by the mothers and children. In addition, the content of all interviews in this research were analysed to examine the dominant representations used by mothers and children to make sense of their experiences of illness and relationships.

***Procedure.*** Adult Attachment Interviews (AAI) (Appendix 4) and Parent Development Interviews (PDI) (Appendix 5) were carried out with participating mothers (RA=2, FMS=3). The standard AAI is a clinical and research tool offering reliable and valid assessment of adult attachment (Besharat, 2011), revealing self-protective strategies used by participants through 20 questions. When it is used in the standard way it reveals how mothers discuss their experiences at different representational levels; procedural, sensory, semantic, episodic and integrative. For example, how different types of information at these levels may be distorted or excluded. Importantly, it also reveals how sensory information may be excluded from conscious awareness, and what semantic beliefs operate to distort or exclude, e.g. expressions and awareness of emotional distress or anger. These indicate what attachment strategies each mother uses, revealing her attachment classification<sup>13</sup>. In this research, the AAI was used in a two-fold way; to accomplish the above, but it was also used as a narrative tool, combining a narrative interview format with the AAI sections. This was in order to investigate how the mothers interpreted their individual experiences, how they conveyed the ‘facts’ of their lives as they subjectively experienced it. This was approached via a case study analysis, analysing the events, family systems, illness histories, personal experiences, beliefs, etc. within the boundaries of each individual case, against the backdrop of the representational levels in the specific AAI sections. The prescribed AAI discourse

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<sup>13</sup> A more in-depth discussion of attachment can be found in Chapter 2 – Conceptual Framework

analysis was then used to highlight specific discourse markers. By using this approach, both the subjectively experienced ‘facts’ of their lives *and* how they talked about these facts were focused on, gleaning rich, multi-faceted, in-depth data.

The PDI utilises 45 questions investigating representations parents have regarding their child, themselves as parents, and their relationships with their child, assessing their current, developing, ‘live’ parent-child relationship, rather than past relationships. In particular, it provides relational context for how pain and distress are managed within this relationship. The PDI was analysed using the Meaning of the Child (MotC) analysis, a sophisticated coding system based on Crittenden’s DMM of attachment and integrates concepts from the CARE Index, which is an observational measure of parent-child attunement. The parenting aspects of the measure are categorised as Sensitive, Controlling, or Unresponsive, and also assigns a degree of ‘risk’ in terms of potential dysfunctionality of the relationship and risks for the child’s development. An early study into the validity of the MotC found a strong correlation between the risk found in parental representations of care giving and the risk in parent-child relationship using the CARE-Index, as well as patterns of interaction identified by the MotC (Grey & Farnfield, 2017).

Adult Attachment Interviews (AAI) and Parent Development Interviews (PDI) were conducted via an online video interaction (Skype, FaceTime, or Messenger), and recorded using Debut V 5.01 by NCH Software.

The raw interview data was transcribed by the researcher and three psychology undergraduate apprentices<sup>14</sup>. The Discourse Analysis used to code the AAI data (identifying discourse markers within the transcribed narratives) was done by the researcher and the 2nd supervisor (RD). Blind testing was used, meaning RD was unaware whether the transcripts were from the RA or FMS group. PDI transcripts were independently coded by Dr Benedict

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<sup>14</sup> Psychology undergraduates volunteered to assist with this research through Plymouth University’s apprentice scheme

Gray, who developed the MotC model of analysis. Transcripts were analysed further by the researcher, with support from the second supervisor (RD) who trained in the MotC analysis and elaborated within a broader attachment and thematic analytical framework.

**Child interviews.** The next phase in this research employed the Child Attachment Interview (CAI) (Appendix 6), using a more informal, qualitative approach than commonly used (RA=2, FMS=2).

**Procedure.** Adapted from the AAI, the CAI was developed by integrating behavioural and representational factors. Since it is believed that children/adolescents are not fully able to vocalise their representations, body language and behavioural changes are also taken into consideration during the interview. These include anxiety behaviours, eye contact, tone of voice, and discrepancies between behaviour and narrative content (Privizzini, 2017). The CAI is a narrative based assessment, using 17 key questions (along with appropriate prompts), designed to elicit children's dispositional representations of attachment relationships, and allows children to describe and reflect on their current attachment relationships and experiences of being in a family. Whilst the interview was initially used with 8 to 12 year olds, it has been also been used with adolescents. A study on the reliability and validity of the CAI found correlations with other attachment measures, suggesting the CAI is high in both reliability and validity (Shmueli-Goetz, Target, Fonagy, & Datta, 2008)

The CAI was conducted via an online video interaction (Skype, FaceTime, or Messenger), using Debut V 5.01 by NCH Software.

The raw interview data were transcribed by the researcher and three psychology undergraduate apprentices. The CAI transcripts were blind coded by the second supervisor (RD), meaning he was initially unaware of which pain group each child belonged to. The transcripts were then analysed further by the researcher, with support from the supervisors

(RD and JS), who have trained in the CAI analysis, and elaborated within a broader discourse analytical framework.

## **5.4 Analysis**

### ***5.4.1 Discourse Analysis***

A form of case study analysis, analysing discourse, was used, which combined the narrative interview, which elaborated on the themes of illness, pain, and comfort, with the AAI segments. This form of analysis was chosen due to its usefulness in analysing language. It includes analysis of face-to-face talk, language of non-verbal interaction, and language in transcription. It offers ways of investigating meaning, through conversation and culture (Shaw & Bailey, 2009). Using this form of discourse analysis in the attachment interviews allows researchers to interpret lapses in discourse, sudden change of subject, specific language used in relation to probing of particular memory systems, the way in which the individual talks about their attachment figures reveals distortions in cognition or affect, and how well they can integrate both. It provides a way of looking at what is being said, as well as how it is being said, the meaning to the speaker, as well as the meaning within a wider social context, revealing unconscious processes, as well as conscious processes.

## **5.5 Ethics**

### ***5.5.1 NHS Ethics Procedure***

NHS ethics was applied for through the South West - Cornwall and Plymouth Research Ethics Committee (REC). A research application was completed and submitted through the Integrated Research Application System (IRAS) for NHS Health Research Authority (HRA) approval. In addition, an NHS HRA research protocol was developed and submitted along with the IRAS application, as well as supporting documents; participant

information sheets for each phase (Appendix 7), with separate participant information sheets for children. Children's information sheets were separated into 3 different groups; younger children aged 5-8, children aged 9-12, and older children aged 13-16 (Appendix 8), with varying age appropriate language, parent, and child, and family consent forms. A REC meeting was held on 17 May 2016, where the committee's questions regarding elements of the research were answered. On 31 May 2016 an initial unfavourable opinion was issued with 9 points of recommendations, which were responded to with either reiteration of why the recommendations were inappropriate or were complied with. A second REC meeting was held on 19 July 2016, which the DOS (JS) attended, where further questions were answered. A provisional favourable opinion was given with 6 points of clarification sought, which were answered, and a favourable opinion was finally given on 18 August 2016. Ethical approval from Plymouth University was confirmed once HRA approval had been granted.

### ***5.5.2 Limitations***

The REC ethics approval stipulated only NHS clinicians be the first point of contact regarding recruitment. This proved to be a serious issue for recruitment. It became clear that clinicians were overstretched during clinic hours, and, despite every good intention, were not able to hold the research study in mind whilst seeing patients. This included both Derriford Hospital and the Royal Devon & Exeter Hospital rheumatology department consultants, and pain management clinic clinicians and health workers. No pain patients were referred to the study from any NHS departments<sup>15</sup>.

### ***5.5.3 Changes in Design***

Due to lack of referrals from the designated NHS sites, new ways of recruitment were devised. Firstly, ethical approval was sought to widen the child age inclusion criteria from 5-12 years old, to 5-16 years old. Ethical approval was granted from the South West – Plymouth

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<sup>15</sup> One patient from Heavitree, Exeter Pain Management Clinic was referred to the study, but did not respond when contacted.

and Cornwall Research Ethics Committee on 29 June 2017, and Plymouth University ethical approval was granted based on NHS REC approval. On 22 May 2017 ethical approval was granted by Plymouth University to begin recruiting participants from online pain support groups, including social media, as long as written consent was gained from social media forum moderators, and support group admin. Posters were retweeted and shared on Twitter and Facebook, and help was sought and gained from the National Rheumatoid Arthritis Society, Fibromyalgia Action UK, and UK Fibromyalgia. However, due to interview participants being widely dispersed throughout the country, ethics was again sought to conduct the interviews via Skype and Messenger. Additionally, due to participating children being aged between 10 and 16, ethical approval was also sought and approved to change the originally intended Story Stem Narratives to the Child Attachment Interview. This was deemed more age and interview-medium appropriate.

The next chapter will describe the recruitment process and the questionnaire study.

## CHAPTER 6            QUESTIONNAIRES

### 6.1 Introduction

Initially, the research described in this chapter was planned as a quantitative, quasi-experimental, between group study, involving the use of questionnaires; the Parenting Stress Index (PSI-4-SF), and the parent version of the Varni-Thompson Paediatric Pain Questionnaire (PPQ), analysing the between group mean scores using a t-test. To have achieved the moderate statistical power required, 128 participants (RA=64, FMS=64) needed recruiting. Herein lay the problem; recruitment proved to be far more difficult than first expected, and sample size did not reach those needed for statistical analysis. Therefore, this chapter will begin with a brief reminder of the 2 questionnaires used in this study and will go on to discuss the issues with recruitment, what might have contributed to this, and what that might inform the overall study about chronic pain sufferers and the state of the NHS. The results of the questionnaire analysis, and finally a summary of the findings will bring this chapter to a close.

#### 6.1.1 *The Questionnaires*

The PSI-4-SF is a 36-item inventory evaluating the magnitude of stress in the parent-child system, and is broken into three domains, Parental Distress (PD), Parent-Child Dysfunctional Interaction (P-CDI), and Difficult Child (DC), which combine to form a total stress scale<sup>16</sup>.

The PPQ (parent version) addresses their perception of their child's pain intensity, with sensory, affective, and evaluative aspects of their child's pain experience, symptoms, treatments, the situational factors influencing pain perception, and family pain and illness history<sup>1</sup>.

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<sup>16</sup> A more extensive explanation about the nature of these questionnaires, and how they are operationalised is found in Chapter 3, the Methodology Chapter

The expectation was to find higher levels of parenting stress in the FMS group, corresponding with a greater perception, and possibly higher instances of affective evaluative aspects of their child's pain than reported by the RA group, however, this hypothesis could not be tested quantitatively.

## **6.2 Recruitment difficulties**

Recruitment started with positivity and an extra-large dose of new doctoral student naivety. Pain management clinics and rheumatology departments at two regional general hospitals were approached. Ethics stipulated clinical staff were to be the first point of contact for participants, so letters, research packs, and posters were left with the four secondary care sites to be distributed to patients. The researcher visited regularly to discuss progress, and ways of reminding clinicians to introduce the study to patients. However, after discussing the research with patients in pain management groups, visiting and emailing the clinics, checking on recruitment progress etc, a year passed and only one participant had been recruited. Why had this fool-proof recruitment method failed? The ethics committee's stipulation that the researcher could not approach patients proved to be inhibitory. Despite the enthusiasm of all the healthcare staff for the research, it became apparent that they were incredibly overwhelmed by the sheer volume of patients coming through their departments, and with restrictive time limits set for each consultation, it was extremely challenging for clinicians to discuss their patient's individual needs *and* remember to promote the research, despite notices on consultants' desks, piles of research packs on shelves, and posters in waiting rooms. A new tact desperately needed to be employed.

Over the next few months, internet searches were done looking for local chronic pain support groups, some of which were provided by NHS primary health centres and local town councils. Emails were sent out, calls to team leaders made, requesting permission to recruit

from their members. Unfortunately, after many follow up calls and emails, being passed from department to department, it transpired that due to government NHS and council cuts, all the support groups across Cornwall and Devon had sadly been closed down. So, after discussions and advice from the supervisory team, a similar social media tact to the exploratory study was considered, and Facebook pain support forums were approached requesting permission to recruit from their members. It was at this point that another unexpected issue was encountered.

### 6.2.1. Forum Gatekeepers

From the 15 requests sent to moderators of Facebook FMS pain support groups via Facebook Messenger, 12 were not responded to, although they had been read<sup>17</sup>, and 3 moderators replied with negative responses (see figures 1-3).

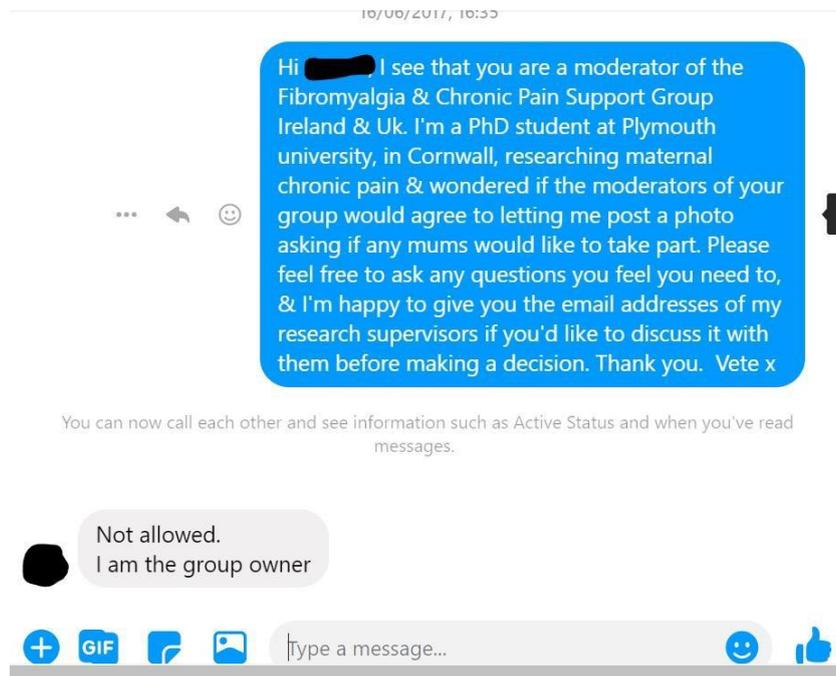


Figure 5: Facebook FMS support group moderator response<sup>18</sup>

<sup>17</sup> Facebook Messenger indicates when sent messages have been read by the recipient

<sup>18</sup> Vete is the shortened version of Movita and is used by family and friends, and is therefore used as the Facebook profile name



Figure 6: Facebook FMS support group moderator response

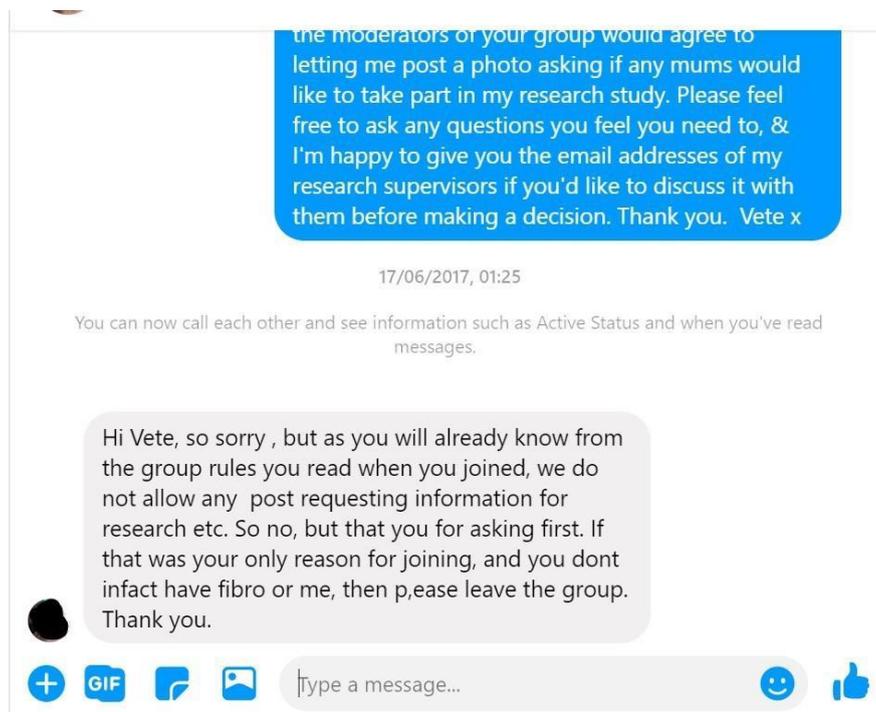
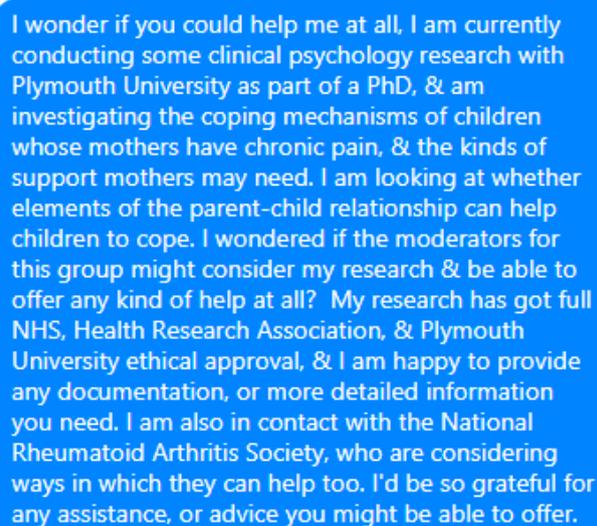


Figure 7: Facebook FMS support group moderator response

Due to these seemingly defensive responses the wording of the recruitment requests was altered slightly, and further requests made to different forums (see figure 4). However,

no additional responses were received from Facebook FMS pain support group moderators, but a favourable response was received from the one RA Facebook pain support group approached.



I wonder if you could help me at all, I am currently conducting some clinical psychology research with Plymouth University as part of a PhD, & am investigating the coping mechanisms of children whose mothers have chronic pain, & the kinds of support mothers may need. I am looking at whether elements of the parent-child relationship can help children to cope. I wondered if the moderators for this group might consider my research & be able to offer any kind of help at all? My research has got full NHS, Health Research Association, & Plymouth University ethical approval, & I am happy to provide any documentation, or more detailed information you need. I am also in contact with the National Rheumatoid Arthritis Society, who are considering ways in which they can help too. I'd be so grateful for any assistance, or advice you might be able to offer.

*Figure 8: Amended Facebook pain support group request*

Due to the negative responses from the Facebook FMS support group moderators, national pain societies, FMA-UK, UK Fibromyalgia, and NRAS (National Rheumatoid Arthritis Society) were approached to assist recruitment. A call for participants was put out via their websites, newsletters, and social media platforms (Facebook and Twitter). In addition, a copy of the clinic participant poster was posted on the researcher's Facebook profile and was shared by 'friends', and, with consent from moderators, was posted on several FB research group pages; The Qualitative Research Group, The Research Companion group, Assistant Psychologists UK - Psychology group.

In all, 34 mothers (FMS=18, RA=16) responded and were sent a research pack containing information sheets, consent forms, and the two questionnaires, with a freepost self-addressed return envelope, and instructions on how to complete them and return them to the university. After chasing participants up twice, and on some occasions re-sending the research pack, 16 (FMS=10, RA=6) participants returned the questionnaires and consent

forms. Therefore, due to the small sample size statistical analysis became inappropriate, so it was decided that the results for the PSI-4-SF would be reported descriptively and that an exploratory content analysis of the PPQ may be helpful. The possible reasons for recruitment difficulties and low questionnaire return will be considered in the discussion section.

## 6.3 Results

### 6.3.1 PSI-4-SF

The descriptive data for the PSI-4-SF shows that the FMS had higher mean scores for Parent-Child Dysfunctional Interaction, Difficult Child, and Total Stress.

FMS	DR	PD	PD%	P-CDI	P-CDI%	DC	DC%	TS	TS%
1	19	28	62%	21	48%	27	56%	76	56%
2	20	32	70%	15	18%	16	8%	63	30%
3	22	40	90%	40	96%	51	>99%	131	>99%
4	12	17	14%	26	66%	25	46%	68	40%
5	11	18	20%	14	14%	27	56%	59	24%
6	22	37	82%	27	70%	33	72%	97	74%
7	25	41	92%	25	62%	31	68%	97	74%
8	17	30	66%	30	78%	28	58%	88	68%
9	21	37	82%	31	80%	34	76%	102	78%
10	18	35	78%	44	>99%	53	>99%	132	>99%
Mean	19	31	66%	27	63%	33	64%	91	64%

Table 4: FMS PSI overall scores

There were also more scores in the ‘danger zones’, so very high stress scores (indicated by numbers in red (‘off the chart’ indicated in pink) and orange highlighting) and very low passivity/withdrawal scores (indicated by red numbers and orange highlighting), indicating the child is at a higher risk of neglect or abuse.

However, the RA group had a slightly higher mean score for Defensive Responding, and a higher score for Parent Distress, although one ‘off the chart’ score drags the mean score for Parent Distress down.

RA	DR	PD	PD%	P-CDI	P-CDI%	DC	DC%	TS	TS%
1	21	35	78%	12	4%	12	<1%	59	24%
2	23	32	70%	32	82%	36	80%	100	76%
3	19	29	64%	25	62%	26	52%	80	60%
4	13	24	46%	15	18%	21	26%	60	26%
5	19	32	70%	18	32%	28	58%	78	58%
6	30	48	>99%	21	48%	19	18%	88	68%
Mean	20	33	72%	21	48%	24	40%	78	58%

Table 5: RA PSI-4-SF overall scores

As can be seen here, there is not as much variability of ‘danger zone’ scores, meaning lower total stress overall, and better overall coping.

A closer look at the percentiles of these scores makes this clearer (highest mean group scores in bold).

FMS	PD%	P-CDI%	DC%	TS%
1	62%	48%	56%	56%
2	70%	18%	8%	30%
3	90%	96%	99%	99%
4	14%	66%	46%	40%
5	20%	14%	56%	24%
6	82%	70%	72%	74%
7	92%	62%	68%	74%
8	66%	78%	58%	68%
9	82%	80%	76%	78%
10	78%	99%	99%	99%
Mean	66%	63%	64%	64%

Table 6: FMS PSI-4-SF percentile scores

FMS group percentile scores clearly indicate the higher scores in Parent-Child Dysfunctional Interaction, Difficult Child, and Total Stress, but lower score for Parenting Distress.

RA	PD%	P-CDI%	DC%	TS%
1	78%	4%	1%	24%
2	70%	82%	80%	76%
3	64%	62%	52%	60%
4	46%	18%	26%	26%
5	70%	32%	58%	58%
6	99%	48%	18%	68%
Mean	72%	48%	40%	58%

Table 7: RA PSI-4-SF percentile scores

RA group percentile scores clearly indicate the slightly higher score in Parenting Distress than seen in the FMS group, and ultimately, lower overall Total Stress scores.

### 6.3.2 PPQ

Based on the questions asked in the Paediatric Pain Questionnaire, the exploratory content analysis revealed 14 mutually exhaustive categories. The analysis was performed by defining units of meaning by recording an exhaustive list of words or phrases in response to the questions. For example, one of the first questions in the PPQ asked mothers to list any health problems their child had. Initial meaning codes for this question were recorded as a list of all the health issues mentioned for each group, which were then coded into that of biomedical issues, behavioural issues, mental/emotional issues, etc, as reflected each groups responses, and organised into categories, reflecting both questions and answers. The categories are shown in the table below.

Category Number	Category Name
1	Pain site
2	Comorbid issues
3	Pain accompanied by
4	Pain precipitators
5	Maternal health
6	Sibling health
7	Paternal health
8	Grandparent health
9	Difficulties in coping (FMS only)
10	Dealing with child pain
11	Child can help their pain
12	Life without child pain
13	Descriptions of pain
14	Worries

Table 8: PPQ Categories

Because both groups completed the same questions within the PPQ, and there was little space for variation or elaboration, the categories were ultimately the same. However, only the FMS group expressed difficulties in coping, hence category 9 only applies to them.

The differences between group responses are seen in the coding, which is represented in the table below.

<b>Code No</b>	<b>FMS code</b>	<b>FMS Categories</b>	<b>RA code</b>	<b>RA Categories</b>
1	Tummy pain	<b>Pain site</b>	Tummy pain	<b>Pain site</b>
1	Head pain	<b>Pain site</b>	Leg/joint pain	<b>Pain site</b>
1	Leg/joint pain	<b>Pain site</b>	Child back pain	<b>Pain site</b>
1	Muscle pain	<b>Pain site</b>	Muscle pain	<b>Pain site</b>
1	Neck/shoulder pain	<b>Pain site</b>	Foot/heel pain	<b>Pain site</b>
1	Child back pain	<b>Pain site</b>	Hand/elbow/wrist pain	<b>Pain site</b>
2	Comorbid child biomedical conditions	<b>Comorbid issues</b>	Comorbid child biomedical conditions	<b>Comorbid issues</b>
2	Child behaviour issues	<b>Comorbid issues</b>	Child overweight	<b>Comorbid issues</b>
2	Child mental/emotional health issues	<b>Comorbid issues</b>	No child comorbid conditions	<b>Dealing with child pain</b>
2	Comorbid neuro-atypical condition	<b>Comorbid issues</b>		
3	Child pain causes dizziness/sickness	<b>Pain comes with</b>	Child pain causes dizziness/sickness	<b>Pain comes with</b>
3	Child lethargy	<b>Pain comes with</b>		
4	Affect induced pain	<b>Pain precipitators</b>	Affect induced pain	<b>Pain precipitators</b>
4	Seasonally induced child pain	<b>Pain precipitators</b>	Seasonally induced child pain	<b>Pain precipitators</b>
4	Other life stresses	<b>Pain precipitators</b>	Other life stresses	<b>Pain precipitators</b>
4	Child pain is worse when mum is stressed	<b>Pain precipitators</b>	Child experiences sympathy pain with mum	<b>Pain precipitators</b>
4	Child pain is worse when mum's pain is bad	<b>Pain precipitators</b>	Swelling indicates onset of child pain	<b>Pain precipitators</b>
4	Temper induced pain	<b>Pain precipitators</b>	Exercise precipitates pain	<b>Pain precipitators</b>
4	School changes/workload precipitated pain	<b>Pain precipitators</b>	Difficult family interactions	<b>Pain precipitators</b>
5	Maternal pain condition (FMS)	<b>Maternal health</b>	Maternal pain condition (RA)	<b>Maternal health</b>
5	Maternal comorbid biomedical condition	<b>Maternal health</b>	Maternal comorbid biomedical condition	<b>Maternal health</b>
5	Maternal comorbid somatoform condition	<b>Maternal health</b>	Maternal dysphoria	<b>Maternal health</b>

5			Maternal fatigue	Maternal health
6	Sibling biomedical condition	Sibling health	Sibling biomedical condition	Sibling health
6	Sibling mental health condition	Sibling health		
6	Sibling neuro atypical condition	Sibling health		
6	Sibling behavioural issues/conditions	Sibling health		
7	Paternal biomedical condition	Paternal health	Paternal biomedical condition	Paternal health
8	Grandparent's biomedical conditions	Grandparent health	Grandparent's biomedical conditions	Grandparent health
8	Grandparent mental/emotional health issues	Grandparent health		
8	Transgenerational somatoform conditions	Grandparent health		
9	Child pain difficult for mum to cope with/unable to cope	Difficulties in coping		
9	Child has difficulty coping with their pain	Difficulties in coping		
9	Child becomes emotional when in pain	Difficulties in coping		
10	Provide comfort for child – cuddles	Dealing with child pain	Provide comfort for child – cuddles	Dealing with child pain
10	Medication given for pain	Dealing with child pain	Medication given for pain	Dealing with child pain
10	Distraction used to deal with child pain	Dealing with child pain	Distraction used to deal with child pain	Dealing with child pain
10	Mum under responds to child pain to avoid escalation	Dealing with child pain	Mum under responds to child pain to avoid escalation	Dealing with child pain
10	Ice/warm packs for pain	Dealing with child pain	Ice/warm packs for pain	Dealing with child pain
10	Mum sends child to school anyway	Dealing with child pain		
10	Not believing/dismissive of child pain	Dealing with child pain		
10	Mum minimising child pain	Dealing with child pain		
10	Just physical needs cared for	Dealing with child pain		
10	Mum rationalises pain away	Dealing with child pain		

10	Massage for child pain	<b>Dealing with child pain</b>		
10	Use mum's tens machine to relieve pain	<b>Dealing with child pain</b>		
10	Mum gives self-care advice to reduce pain child	<b>Dealing with child pain</b>		
11	Mum believes child should exercise more	<b>Child can help their pain</b>	Mum believes child should exercise more	<b>Child can help their pain</b>
11	Child needs to take insulin more regularly	<b>Child can help their pain</b>	Mum thinks child should keep pain diary to track triggers	<b>Child can help their pain</b>
11	Mum thinks mindfulness would help child pain	<b>Child can help their pain</b>	Mum thinks child should stretch to relieve pain	<b>Child can help their pain</b>
12	Not having child pain would relieve maternal stress/worry/anxiety	<b>Life without child pain</b>	Not having child pain would relieve maternal stress/worry/anxiety	<b>Life without child pain</b>
12	Absence of child pain would make no difference to mum	<b>Life without child pain</b>	Absence of child pain would make no difference to mum	<b>Life without child pain</b>
12	Absence of child pain would make no difference to family	<b>Life without child pain</b>	Absence of child pain would make no difference to family	<b>Life without child pain</b>
12	Without child pain mum would feel less guilty/frustrated	<b>Life without child pain</b>	Without child pain mum would feel less guilty/frustrated	<b>Life without child pain</b>
12	Without child pain family would be happier and less frustrated	<b>Life without child pain</b>	Without child pain family would be happier and less frustrated	<b>Life without child pain</b>
12	Not having child pain would make no difference to child	<b>Life without child pain</b>	Absence of child pain would make no difference because it is not severe enough	<b>Life without child pain</b>
12	Not having child pain would cause less family fights	<b>Life without child pain</b>	Child would be happier without pain	<b>Life without child pain</b>
12	Not having child pain would improve family communications	<b>Life without child pain</b>	Child would be more confident	<b>Life without child pain</b>
12	Child would be more active without pain	<b>Life without child pain</b>	Child would have more strength to stand up to their father & his 'regimes'	<b>Life without child pain</b>
12	Mum would be happier	<b>Life without child pain</b>		
12	Child would relax more without pain	<b>Life without child pain</b>		
13	No 'abnormal' child pain	<b>Descriptions of pain</b>	No 'abnormal' child pain	<b>Descriptions of pain</b>

13	Intermittent child pain	<b>Descriptions of pain</b>	Intermittent child pain	<b>Descriptions of pain</b>
13	Mum believes child pain to be v low	<b>Descriptions of pain</b>	Mum believes child pain to be v low	<b>Descriptions of pain</b>
13	Mum believes child pain to be moderate	<b>Descriptions of pain</b>	Mum believes child pain to be moderate	<b>Descriptions of pain</b>
13	Pain often interferes with everyday activities	<b>Descriptions of pain</b>	Pain often interferes with everyday activities	<b>Descriptions of pain</b>
13	Child pain does not generally interfere with activities	<b>Descriptions of pain</b>	Child pain does not generally interfere with activities	<b>Descriptions of pain</b>
13	Mostly sensory pain descriptors used	<b>Descriptions of pain</b>	Mostly sensory pain descriptors used	<b>Descriptions of pain</b>
13	Some evaluative pain descriptors used	<b>Descriptions of pain</b>	Mostly evaluative descriptors used	<b>Descriptions of pain</b>
13	Some sensory pain descriptors used	<b>Descriptions of pain</b>	Some sensory pain descriptors used	<b>Descriptions of pain</b>
13	Mostly emotional pain descriptors used	<b>Descriptions of pain</b>	Mum believes child pain to be high	<b>Descriptions of pain</b>
14	Mum worries pain will develop into fibro	<b>Worries</b>	Mum worries child pain is JRA	<b>Worries</b>
14	Grandparents intense worry child pain will develop into FMS	<b>Worries</b>		
14	Mum believes child uses pain to avoid disliked activities	<b>Worries</b>		
14	Mum contradictory about child pain	<b>Worries</b>		

Table 9: PPQ group coding differences

This table reveals more family illness in the FMS group; more child and sibling behavioural issues, more child and sibling mental health/emotional issues, more neuro-atypical conditions (such as ASD), whilst none of these are found in the RA group codings. Additionally, there are instances of transgenerational somatoform conditions in the FMS group, but none in the RA group, however, both groups have instances of maternal comorbid biomedical conditions, but only the FMS group have instances of maternal comorbid somatoform conditions, such as CFS and IBS. Unexpectedly, codings of maternal dysphoria and fatigue were only reported in the RA group.

Furthermore, only the FMS group mums reported that they and their child struggled to cope with child pain, and that the child became emotional because of the pain, but neither of these codings were seen in the RA group. FMS mums had a wider range of ways of dealing with child pain, those in common with the RA group tended to be practical, and those that differed from the RA group tended to be predominantly emotionally distancing or child blaming, such as not believing child pain complaints. The two groups tended to have similar thoughts regarding how their child could help their pain right now, such as exercising more. The differences were that RA mum's ideas tended toward the practical, such as keeping a pain diary to track triggers. FMS mums' thoughts tended to have a slightly more child blaming slant, such as one example of where a FMS mum reported believing her 9 year old child needed to take their insulin more to manage what sounded like the effects of peripheral neuropathy.

The codings for what life would be like without child pain tended to be similar between the groups, but differences were the FMS groups seemed to revolve around family unity, such as there would be less family fights, and better family communication. Only the RA mums mentioned the child would be happier without pain, and whilst pain descriptions tended to be very similar, only RA mums believed child pain to be high.

#### **6.4 Discussion**

The results generally conformed to expectations, in that there was a trend towards higher levels of parenting stress and higher instances of affective evaluative aspects of their child's pain found in the FMS group than in the RA group. However, the expectation of finding greater perception of their child's pain for the FMS group than the RA group did not seem to be shown. In fact, the PPQ showed that only mothers in the RA groups believed their

child's pain to be high, whilst those in the FMS group tended to believe their child's pain to be minimal.

The PSI-4-SF results indicated that overall total stress was higher for FMS mothers, P-CDI (Parent-Child Dysfunctional Interaction), and DC (Difficult Child) also being higher for FMS patients than RA mothers, whilst RA mothers seemed to have higher PD (Parenting Distress) than FMS mothers. According to the PSI-4-SF scoring manual, the parental stresses linked to the PD subscale involve an impaired sense of parenting competence, lack of social and familial support, depression, other areas of life being restricted by parenting, and partner conflict. Although the PD mean score was higher for the RA group, there were two FMS scores in the 90<sup>th</sup> percentile, and one in the low scoring percentiles indicating an element of passive withdrawal, whilst only one in the RA group scores was in the 99<sup>th</sup> percentile in an otherwise middling set of scores, thus dragging the mean score up. This suggests that in fact, more FMS mothers appeared to be suffering greater levels of impaired parenting competence, lack of support, and partner conflict than those in the RA group.

The PSI-4-SF manual describes the P-CDI subscale as concentrating on the parent's perception that the child does not meet their expectation and their interactions do not reinforce them as a parent, the child is a negative element in their life and they are being persecuted by the child. High scores indicate possible insecure attachments, and scores in the 96<sup>th</sup> percentile suggest risk of child neglect or abuse; only one RA group score was high and none in the 96<sup>th</sup> percentile, whilst four FMS scores were high, with two in the dangerous 96<sup>th</sup> percentile.

The DC subscale is outlined in the PSI-4-SF as focusing on parent's ability to manage basic behavioural characteristics of their child, including defiant, noncompliant and demanding child behaviour. If scores are in the 90<sup>th</sup> percentile or higher parents are struggling with their child's behaviour and would benefit from some child-oriented intervention. There

were no high scores in the RA group for DC, and five high scores in the FMS group, two being in the 99<sup>th</sup> percentile. Altogether, this suggests that FMS mothers in this sample may be struggling more with parenting stress than those in the RA group.

The most salient points to come out of this analysis is the history of family illness observed in answers from the PPQ. For the FMS group there seemed to be the suggestion of other family health issues, such as child and sibling behavioural issues, mental and emotional issues, as well as comorbid ASD. From discussions with health clinicians at the pain clinics initially involved in this study, children with ASD appear to often accompany parental FMS<sup>19</sup>, meaning parents with FMS seem to be more likely to have a child with ASD. Additionally, there were several reports of transgenerational somatoform conditions, such as maternal, grandparent, great-grandparent FMS, including reports of maternal sibling FMS in a transgenerational FMS family, as well as comorbid biomedical health conditions for other family members. So, for the FMS group, this seems to indicate a ubiquity of diverse health conditions peppered throughout the close and extended family that was not reported in quite the same way by those in the RA group.

The way in which other answers in the PPQ differed between groups may hold some insight into possible contributory factors in the ubiquity of diverse family health issues in the FMS group, possibly through embodied stress. For instance, only the FMS group specifically reported difficulties in coping with child pain, intimating high levels of distress, correlating with the PSI-4-SF results. This might be interpreted from how pain is dealt with, for example, FMS mums appeared to report more emotionally distancing ways of dealing with child pain, by minimising, dismissing, rationalising pain away, quite possibly because of the sheer weight of their own and other family members' health issues. Interestingly, only mums in the FMS group believed family relations would improve in the absence of child pain, and this

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<sup>19</sup> The pervasiveness of ASD amongst the children of FMS sufferers may be explained in some part by McKenzie & Dallos (2017) study, who found evidence of an overlap of ASD symptoms and attachment difficulties

might hint at possible systemic implications which would need further investigation. Notably in the category of ‘what life would be like in the absence of child pain’, the RA group reported believing their child would be happier in this instance, whilst the FMS group revealed believing mum would be happier. It is a subtle, but poignant difference in use of language, and if viewing talk or language as performative action this is telling us that FMS mums are feeling overwhelmed (Horton-Salway, 2001). It could be that mothers used the questionnaires to get their own needs met in some small way, by demonstrating their struggles with their children’s pain and behavioural issues, ASD, etc., all whilst dealing with their own pain. For this group it seems there is a filter of ‘I can’t cope’ overlaying the data.

Despite an almost identical number of FMS and RA participants recruited (FMS=18; RA=16), more FMS participants returned the questionnaires (FMS=10; RA=6), meaning 56% of FMS and 37.5% of RA. If RA mothers are relatively less stressed and overwhelmed, that fewer returned their questionnaires creates an anomaly. It could be due to FMS being a contested illness, and more mums responded as they felt someone was listening to them. This intersects with the findings from chapter 4 (the parenting network exploratory study), where one of the FMs group themes was ‘the battle for validation and vindication’, explaining how FMS group members were constantly battling for their condition to be recognised by family, friends, and medical practitioners, their pain to be believed, and for them to be understood. So, for the women who did participate, it may have been about the chance to ‘talk’ and get their point of view across.

The further difficulties encountered in recruiting participants, such as the immediate shutdown from the FMS Facebook forum moderators, may equate to an emotional response to what the initial approach meant to them. It appeared as if the moderators behaved like gatekeepers, protectors of the group from the judgements and misunderstanding eyes of outsiders, and this reaction might feed into the negotiation around contested illness. That is to

say, where the illness is contested, i.e. trauma induced, for example, it is prone to blame, and can lead to accusations of ‘it’s all in your head’. One solution for those suffering with contested illnesses has been to adopt a biomedical explanation, as seen in Chapter 4, and anything that leaks outside that may be experienced as threatening. So, however the research is framed, unless it has a clear biomedical focus it could potentially be experienced with suspicion and fear. However, when the research was endorsed by national FMS societies, this appeared to lessen the fears of potential participants, and they felt safe enough to offer assistance. Another solution is to either completely ignore what may be experienced as a potential threat from outsiders, or to shut the threat down immediately. So, the refusal to reply to participant recruitment requests and the immediate shutdown from FB forum moderators could actually have been a defensive closure to avoid emotionally arousing questioning.

Although RA participants seemed willing, and were happy to engage with the idea of participating in the research on the forums, the response rate was particularly low when it came to returning questionnaires. The trends from the questionnaires seemed to indicate high parenting stress, depression, and anxiety for the RA group, and from the exploratory study (Chapter 4) the evidence pointed to high levels of invasive pain, and despite all the good will in the world, it might be that for mothers with chronic pain further tasks, on top of everything else they are dealing with, may have prevented them from filling in and returning the questionnaires, whereas for the FMS group it may have felt like a chance to unburden themselves.

This potentially suggests that despite the difficulties in recruitment, and early closure from support forum moderators, the low response rate, the fact that 34 participants actually came forward and 16 participants returned their questionnaires, makes the data that more meaningful and valuable. The one to one interaction with the researcher each participant had

prior to agreeing to the research seems to have allayed their fears, they then trusted the researcher was sensitive to their situation, allowed for the building of a trusting relationship, and they seemed to experience the engagement as very meaningful and supportive. Therefore, the fact that in order to get any sample at all a lot of incredibly hard work needed to be put in beforehand, suggests that this data is actually extremely valuable, because it has opened a small window on some issues that might be probable. Consequently, tentative hypotheses could be ventured based on these recruitment difficulties.

Firstly, the FMS forum moderators' response to a research recruitment request seemed to generate an avoidance of threat behaviour, either through ignoring the request or an immediate shutdown, therefore this suggests possible attachment related strategies that may be worth following up.

Secondly, only mums in the FMS group believed family relations would improve if their child's pain disappeared, which suggests possible systemic implications in families with contested pain conditions.

Thirdly, and with links to the second hypothesis, there seemed to be some evidence of transgenerational somatoform pain in the FMS group, as well as other comorbid health conditions, including behavioural problems, neuroatypical conditions, high levels of stress, and difficult parent-child interactions, which may stem from and lead to intergenerational attachment issues.

Fourthly, some of the mothers seemed to have slightly child-blaming beliefs regarding how their child could help ease their pain, which may stem from mothers feeling overwhelmed with their own pain.

Another hypothesis highlighted by these exploratory research findings is that parents seem to be struggling with interpreting their child's pain, and exploring this in the context of attachment might be valuable.

Lastly, there may be some value in using case studies to research these tentative hypotheses. This sample, with hindsight, appears to be very rare because mothers with chronic pain did not seem to be investing in being research participants. This raises the significance of the data that was collected, meaning it may well be unique in nature, and therefore the descriptive statistics are worthy of further in-depth, descriptive examination. So, even though the data in this study is only exploratory, it raises some very important questions that may have implications for supporting mothers with chronic pain and their children.

The next chapter will begin the case studies by examining AAIs with five mothers.

## **CHAPTER 7            ADULT ATTACHMENT INTERVIEWS**

### **7.1     Introduction**

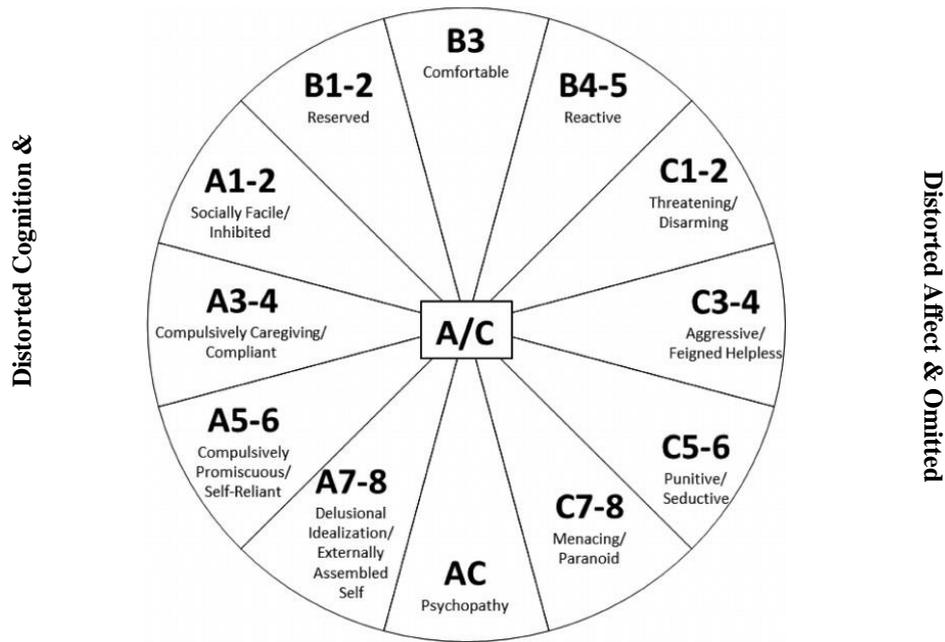
Five participants involved in the questionnaire study, and their children, agreed to take part in the interview studies. The first interview study to be conducted involved Adult Attachment Interviews (AAI). The DMM-AAI explores people's memories of their childhood experiences to assess the strategies they have evolved to protect themselves, and that they use currently. It examines their experiences by exploring different memory systems, for example the words (semantic labels) used, the sensory images evoked, their stories or episodic memories, and their reflective awareness. In effect, it asks different questions about the same events in order to probe different memory systems. This helps to indicate what is present and missing in their representations, and also possible conflicting memories that reveal levels of integration. In short, this gives an indication of the 'coherence' of their narratives in terms of the extent to which different memory systems are used, what information is omitted, and how information from different representational systems is integrated, conflictual or dissociated. However, when these narratives about the past lack coherence, they are less helpful in assisting people to anticipate the future, and deal with challenges and dangers to themselves and importantly to their children.

So, this chapter begins the initial phase of constructing multiple-case studies, which will be continued in the following chapters. It will provide the family background and illness history of each participant, before outlining a summary of their individual AAIs. AAIs can be seen to present two types of information: 1 - 'facts' about what events have occurred, and 2 - interpretations about these events. Attention is particularly paid to the 'facts' that indicate dangerous events and where these have been extreme and inescapable, possibly leading to traumatic states. However, even the 'facts' need to be viewed with some caution since

memories can be selective, and in-turn influenced by our self-protective attachment strategies. For example, someone who is pre-occupied with anger at her mother may have forgotten the times she was caring and available. The lack of explicitly remembering these events does not mean that they did not occur. Acknowledging such exceptions is in part the purpose of therapy, however in the AAI clues may emerge that ‘other’ events may have occurred, even if they are not explicitly mentioned. However, the meanings that are given to these is significant, and in particular the extent to which their parents were held as responsible or to blame. It is extremely tempting in the reading of the AAIs to feel a sense of injustice, anger, and blame on behalf of the participants. This is particularly the case when the dangerous events are recounted in a matter-of-fact way, and with exoneration of the parents. In some AAIs people present the events in a way to elicit such sympathy from the interviewer by subtly presenting themselves as victims of events. The analysis of the AAI, therefore, is a fine balance between treating the accounts with a degree of credulity, and employing our own empathetic responses to the emotional impact of the events described.

The summary of the AAIs is presented along with an indication of dangerous and traumatic events. The section of the AAI which explores memories of comfort, illness, and distress is a key focus in the extracts below. The DMM framework – strategies wheel is presented below for reference in Figure 11.

**True Cognition      Integrated True Information      True Negative Affect**  
**(Type B)**



**False Positive Affect      Integrated False Information      False Cognition**

Figure 9: Dynamic Maturational Model (DMM) of self-protective strategies

The AAIs in this study all indicated various forms of dangerous events on the mother’s lives, which in many cases were not resolved and were indicative of traumatic states. In the DMM based analysis of the AAI, traumas are seen as comprising two forms of information, which embody the inhibiting (A-dismissing) and hyper-activating (C-pre-occupied) core attachment strategies. The dismissing forms of trauma comprise strategies of dismissal/minimisation, where the severity of events are minimised, and memory of events are blocked, so no dangerous event is remembered. or claimed, or displaced, such that the effects of the event appear to pose no outward source of concern. In contrast, the pre-

occupying forms of trauma consist of a continual state of emotional arousal, a vicarious experience of dangerous events that have occurred to others, living in an anticipated state of fear or dread of events happening, or imagined traumas where there is no clear apparent source for such fears. Broadly, in the AAI, for dismissing forms of trauma, the indicators of traumatic states are where dangerous events are minimised and described with a lack of detail and expected connotative language, sometimes relayed with a smile, laughter, or protestations that it has had no effect on them. However, the presence of the trauma may be revealed by ‘intrusions’ of affect breaking through, such as tears. In pre-occupying patterns there is a continual re-living of the dangerous events, relayed as if they are still being experienced, with an apparent inability to store them in the past. Therefore, the aim of this study was to provide family background and illness histories of each of the five participants, to outline their individual attachment classifications, and to observe differences in these between pain groups.

## **7.2 Case Studies**

Five mothers agreed to be interviewed, three of whom have fibromyalgia, two with arthritis. Initially, the children of all five mothers agreed to participate, two of whom withdrew consent later in the process, both belonged to the fibromyalgia group. Reasons for their withdrawing will be discussed in the case studies below. All the participants and their families are white, three of whom are English, two are Welsh, the three FMS participants are from working class backgrounds, and the participants with RA are middle class.

### ***7.2.1. Carrie***

Carrie is a single mum, lives with her two children, Ellen (13) and Sophia (7), and suffers with fibromyalgia, with coexisting chronic depression and anxiety. She was married

to Ellen’s father, but, after an abusive marriage where he was both physically and verbally abusive, they acrimoniously divorced. Carrie’s mother, with whom she had a distant relationship in childhood but is now close to, has also been diagnosed with FMS. She has two younger siblings, who are mentioned, but remain shadowy, undeveloped figures within her story. Both siblings have FMS symptoms, though as yet undiagnosed. Carrie described their family relationship as co-dependent, which she finds a great strain. She has a very difficult relationship with her eldest daughter Ellen, who she finds challenging to parent, reporting that Ellen is both physically and verbally abusive, which Carrie believes she does to impress her father. She describes Ellen as having a weight problem, and that she is ‘always moaning that she’s aching’ all over, but Carrie believes this is because Ellen is unfit. Her younger daughter, Sophia is a very anxious child who complains of tummy pain, headaches, knee and back pain, and this appears to be taken a lot more seriously by Carrie than Ellen’s pain complaints.

**7.2.1.i. Adult Attachment Interview (AAI-DMM).**Carrie described herself as experiencing two significant dangerous events; an indication of emotional neglect and loss of her maternal grandmother at age nine, to whom she described as being very close, with some bullying by local older children as a possible third.

Taken all together, as the interview progressed the picture of a lonely child emerges. This impression is strengthened by descriptions of busy, duty bound parents, an emotionally unavailable mother whose own nameless emotional issues lurked ominously in the background, and a memory of her father mocking her feelings.

‘I think I’ve been, sort of, let down by men. I’ve felt, like, when I told my father when I was a teenager, I felt let down by him because he just mocked how I felt’

As a young child, Carrie described numerous events where she appeared to receive insufficient or inappropriate comfort when bids were made, learning not to ask for solace as

she grew older. Carrie reports just knowing she had to take care of her younger siblings and keep them from ‘bothering mum’ whilst she was grieving for her own mother.

Carrie’s childhood loneliness appears to have resulted in attempts at closeness to others her age, or at least allowing inappropriate closeness, manifesting in a form of sexual play. Unfortunately, upon discovery, she felt humiliated by her mother as a result. This is evidenced by an uncharacteristic display of burgeoning affect within the narrative, an intense sensory auditory image of her mother shouting “what the bloody hell you doing?” She immediately repeats this phrase as if for emphasis. It is the uncharacteristic swearing, the lack of visual imagery, and specific the use of speech as it was said that demonstrates the break of affect through her usual repressive coping style that is a marker for unresolved trauma here. A more in depth analysis of Carrie’s representational systems can be found in Appendix 9.

#### **7.2.1.ii. Critical Cause of Danger.**

*Emotional Neglect.* Carrie presented her mother in an idealised way; as a loving, nurturing parent. However, although not explicitly stated, or possibly even fully realised, hints at levels of emotional neglect leaked out through the narrative.

‘That’s a hard one as well because my mum wasn’t an overly affectionate person. Um, when I was little. Well, still isn’t, you know, that’s just how she is’

‘My mum wasn’t a very, sort of, ‘huggy’ person if you see what I mean.’

‘...But definitely give [my children]\* more affection, I would say. Because I didn’t really have that when I was a child...’

\*researcher added for clarification

*Loss of Maternal Grandmother.* The loss of her maternal grandmother appeared to be experienced as traumatic and unresolved, as indicated by the absence of emotive language or reflection on her feelings of loss for her. However, as can be seen in the passage below, there were intrusions of negative emotion into her otherwise dismissing account, revealed by her

tears. At the end of the quote her own disallowed or disturbing emotions appear to be projected onto her grandmother where she says ‘she just couldn’t handle it’

‘...And I went into the room and we were only, sort of, allowed a few minutes just to, sort of, I guess in essence to say goodbye, but I just got the lasting memory, really, of her, um...(two second pause) she turned away from me and she was crying um...(two second pause) you know, she just couldn’t handle it (Crying)’

**Bullying.** There was the suggestion of a period of time when Carrie was bullied by local older children, the memory of which appeared to leave its mark on her.

‘If one of the older kids, which was quite often to be honest, if one of the older kids was starting their nonsense and whatever...So I could see, I can see the older kids being spiteful. Um, and obviously, um, I’ve sort of come in up the steps to the house and come into the house, um, and was a bit upset’

### **7.2.1.iii. Trauma and Loss.**

#### ***Sexual Play/Humiliation***

‘...I mean, that one there, that was kind, I did feel a bit, sort of, humiliated there, that was one of them when I was young’

#### ***Intrusions of Emotion ‘Bloody’***

‘...my mum walked in on it one day and, sort of, said, “what the bloody hell you doing?”, and I can remember “what the bloody hell you doing?” and we were like “nothing, nothing” and I felt really, sort of, really embarrassed and sort of, I dunno, a bit weird, really’

#### ***Loss of Nan***

‘...I went into the room and we were only, sort of, allowed a few minutes just to, sort of, I guess in essence to say goodbye...(Crying)’

‘... I, sort of, I knew she was really ill, um, but I didn’t realise...how bad, well, I did, and I didn’t, I can remember once I was in the flat upstairs with my Nan and um...she, um, sorry, I’m getting (crying), um, she was, like (inaudible) her face where she was in pain and I was frightened, and I didn’t know what to do’

**7.2.1.iv. Ill Health.** Carrie reported a childhood full of serious family illness and loss, with her paternal grandparents having been disabled in a road traffic accident before she was

born, her maternal grandmother dying of sinus cancer after a protracted illness when Carrie was nine, and a year later the death of her 20 year old cousin from a brain tumour. As a late teen, due to feeling her childhood grief was too invalid to be talked about, this cumulative mourning effectuated a break down after the further loss of her paternal grandparents.

Despite there being an apparent fissure in her childhood relationship with her mother, it is of note that in later years the shared pain condition of fibromyalgia is what seemingly allowed them to grow closer in adulthood. The only explicit reference to being happy was when relaying a memory of being ill as a child. Although chickenpox is often accompanied by some uncomfortable symptoms, especially when the spots spread to the mouth and throat, Carrie recollects only positive feelings. In a significantly image-free narrative, she paints a vivid picture of two small children happily dancing around a darkened room to the tune of Postman Pat, and recalls their delight at hearing their names mentioned on the radio as a special shout-out for being poorly. She appears to completely dissociate from the unpleasantness of being ill, entirely in favour of the specialness of it all.

It is not inconceivable then that these childhood experiences mean the maintenance of adult relationships becomes more difficult. In order to keep safe in the future, the only information we actually need is information regarding the future; to guide our own behaviour and the expectancy of behaviour in others. However, the only information we have is that which is linked to our past experiences; how we have behaved previously and how others have treated us as a result. So, for Carrie, it might be that she has found maintaining romantic relationships difficult due to the unresolved trauma around her early sexual humiliation and childhood emotional neglect, burning into her unconscious that physical intimacy and relationships are wrong, and the only time it is appropriate to have cuddles is when one is ill.

Further solidifying this view is Carrie's report of growing significantly closer to her mother in adulthood, due to the development of a mutual pain condition. Emotionally

unavailable to her in childhood, the only gateway to her mother's affections appears to have been through a shared illness. For Carrie, this can only further reinforce the belief that illness is the only acceptable form of physical and emotional intimacy.

#### **7.2.1.v. Attachment Classification.**

*A (3-6) Compulsive Caregiving, Self-Reliant.* Based on this, Carrie is likely to be using Type A3/A6 attachment styles. According to the DMM, an A3 classification describes a compulsive caregiving strategy. This strategy is precipitated by withdrawn, sometimes depressed attachment figures, who avoid, dismiss, or draw away when their child asks for comfort. This results in children learning to care for their attachment figures in order to get their needs met (Crittenden, 2006; Farnfield, Hautamäki, Nørbech, and Sahhar, 2010). A classification of Type A6, or an attempt at A6 as a child, describes a compulsive self-reliant strategy. This is where the individual no longer believes close relationships will provide protective or emotional support, and so try to live without depending on others. This strategy develops in adolescence, but an attempt at this kind of strategy can be seen when children give up asking for protection or comfort (Crittenden, 2006; Farnfield et al., 2010).

#### **7.2.2. Linda**

Linda is 42, is married to an older man, Mark, has two children; Jago (12), from a previous relationship, and Elisse (4). She suffers with FMS and a blood clotting disorder called Factor V Deficiency. There is a history of FMS within the family, with her mother having been diagnosed with FMS in 2005, but having suffered symptoms since Linda was a child, and her maternal grandmother, diagnosed with FMS in 1995. Linda has always had a tempestuous relationship with her mother, she describes herself as having a close relationship with her father, who has cancer, and has an older brother, who was awaiting a diagnosis of FMS at the time of the interview. Her 12 year old son, Jago, has a diagnosis of what Linda

reports as ‘Perfection Personality Disorder’, asthma, and Factor V Deficiency. Her four year old daughter, Elisse, also suffers with Factor V Deficiency and asthma. Linda also reports Jago has suffered with reoccurring neck, back, and shoulder pain, accompanied by leg pain, stomach and headaches since he was around 8 years old. Jago’s reoccurring pain has caused her and her mother considerable anxiety and worry, their main fear being he is developing FMS. Linda is currently doing a foundation degree in counselling at her local college.

**7.2.2.i. Adult Attachment Interview (AAI-DMM).** Linda reports a very unsettled and dangerous early life; abandonment by her mother at aged four, living with a violent/frightening father, being forcibly removed from home to live with her mother, violent arguments between her parents, separations, continuous house moves, several men coming in and out of her life via her mother, all of which builds a picture of a bewildered and frightened child unable to rely on the adults around her for protection. She recalls how she found school safer than home, and described her Nana’s house as a haven of security. Her paternal grandmother (Nana) is described as an attachment figure, but there is also some indication of idealisation of this relationship. Evidence of care by her Nana is offered, but this is tinged with verbal attacks on her mother, with no consideration of the effect on Linda’s feelings. Her Nana also seems to use Linda to support her in her own loss of her son (Linda’s uncle), initially, and later after the death of her husband (Linda’s grandfather).

The interview progresses from the dire to the dangerous, as she describes how, at aged 13, she became involved with an older man (22 years old) and subsequently became pregnant. Her interview suggests the possibility that her initial attraction to an older boyfriend may have been an attempt to find the protection, consistency, and closeness to another human being that was so lacking at home. It is perhaps significant that he was so much older than she was, considering the unpredictable home environment she experienced. This makes it even more poignant that events took the catastrophic turn they did. The fear she felt is

palpable as she describes confessing her ‘mistake’ to her father, and seeing the ‘disappointment and contempt in his eyes’. She described how, for the first time in her life, the father she idealised was violent towards her, first beating up her boyfriend and then dragging her down the stairs by her hair. She described a series of dangerous and catastrophic events; being forced to have an abortion on pain of being put in care, after which her boyfriend hanged himself and she found his body. She recounts how she was banned from attending the funeral, and within the week her father abandoned her to her fate and moved abroad. She went on to describe that she became an angry adolescent, dabbling in drugs and promiscuity, entered into at least one violently abusive relationship, and made two attempts at suicide, all by the age of 16.

An important issue may be that she was involved in two major triangulations: between her parents, who continue to be antagonistic; and between her Nana and her mother (Nana did not like her mother). A more in depth analysis of Linda’s representational systems can be found in [Appendix 10](#).

**7.2.2.ii. Critical Cause of Danger.** Linda described a number of events in her childhood that appear to have been dangerous physically and emotionally for her:

*Abandoned by Mother at Aged Four.* She stated that her mother left suddenly when Linda was four years old. Her father picked her up from school, took her to their car, where she remembers being told that her mother had left and would not be returning. There was no further discussion on the subject, no comfort offered nor requested, leaving Linda frozen in shock.

‘...we got in the car, my brother was in the front seat crying, and I got in the back car and my dad just said ‘Your mum’s left and she’s never coming back’ ...that was it, and I didn’t say anything I just froze, I just froze, I didn’t cry didn’t do anything, I just froze, my brother was hysterical...’

‘I remember feeling like I wanted to scream, cry like my brother was and I didn’t do anything, I just stayed quiet (3 second pause) just didn’t respond’

**Parents' Divorce.** Linda's parents got back together when she was eight years old, only to separate again within a year, and later divorce. This return and re-separation lead to chaotic living arrangements, with Linda being forcibly removed from her father's house four or five months after her mother initially left the family, which did much to destroy what little trust and security that was left in Linda's world.

'...mum & dad separated...up until I was about eight, then they got back together, and then they separated within another year (2 second pause, shakes head)'

'So I went ba...back to live with me mum and when that happened I, it was horrific for me, I was clinging onto the door frame, I didn't want to leave...Oh it was dreadful, I just didn't want to leave me dad, I didn't want to leave me dad, I didn't want to leave me brother, I was happy where I was, I didn't want to go live with me mum'

'...it was horrific, yeah, yeah, really, really te-it was like being-I had no control over what other people were doing to me yeah-and nobody, I just felt like nobody was listening to me'

**Violent Father – Especially to Her Brother.** There are multiple accounts of her father's violence throughout Linda's childhood, some implied, some explicitly conveyed, the horror and terror palpable in her recounting.

'...he basically-dragged me down a flight of steps by my hair (2 second pause) threw me in the back of the car, took me to me mother's house, and I don't think I touched the floor'

'I could see my brother was in-was hurting erm and that-I was fearful of that...my dad scared me, it was, it was like he was out of control, well he was, he was out of control'

'I still remember hiding behind the sofa, and I still remember screaming at my dad to stop...I think he told me to shut up...I was shouting 'Don't hurt him, don't hurt him, get off him' and then he'd be like 'Don't get involved, sit there and don't get involved' - erm - which could be quite frightening again because he'd say that with aggression'

**Abortion at Age 13.** At aged 13 Linda became pregnant with her 22 year old boyfriend. After summoning the courage to tell her parents, she was coerced into having an

abortion under threat of being put into care, arousing feelings of helplessness, and fears of being abandoned once again.

‘I was at my mother’s house, me dad came over and they confronted me together, and told me if I didn’t-erm, comply with what they wanted I’d be put in care...I remember pleading with them (shaking head) to try and (closes eyes and shudders) - surely you wouldn’t do that type of thing, but-I was just, they were just ‘if you don’t do that, this is what’s going to happen’’

‘I-I just felt awful, part of me wants to say angry, I was angry that they were saying this to me, and part of me was so scared at the thought of losing them an-an-and not having contact with them...so it was scary, but at the same time erm (2 second pause) I thought it was e-even then I thought it was a low move, d’you know what I mean? Even then I thought ‘That’s, oh come on, that’s not right, what you’re doing is wrong’ and morally it didn’t seem right, even then, you know?’

***Boyfriend’s Suicide.*** Within weeks of being beaten up by Linda’s father, and in the wake of the abortion, Linda found her boyfriend’s body hanging in his flat. To compound the distress further, his family blamed her, and refused to allow her to attend the funeral or tell her where he was buried, leaving this shocked and grieving child with no means of finding resolution.

‘...he took his own life. He hanged himself and I found him’

‘I wasn’t allowed to go to the funeral...I just wasn’t allowed, I begged, actually, I begged them to go and they just wouldn’t let me, they said no they said it wasn’t my place to be there’

‘...I felt completely out of control of the situation, I was dealing with, with adults and I was a kid um...and I was being told in no uncertain terms that I had no say in any of it...it was just “This is nothing to do with you, this is our family and our business”, so it was real helplessness’

***Mum Alcoholic.*** Linda recalls an ongoing tempestuous relationship with her mother, not helped by her mother’s alcoholism.

‘Um, with mum it’s up and down. It’s up and down ... she’s an alcoholic as well, so’

‘I think worse since she’s got diagnosed with fibro. It’s affected her pain. Because she drank for the pain. Or she used the drink as an excuse for the pain, to drink more. And then it became, it went from habitual to addiction’

***Suicide Attempts.*** Possibly unsurprisingly, Linda recalls two suicide attempts whilst still a young teen. The second, at age 16, was a bid for care from the violent man she was involved with.

‘Um, I had two attempts. One at 14 and one at – 16’

‘... the first one was a few months after my partner died ... Um, I-I took an overdose ... I-I know the reason why was I just wanted to be with him. That was t-t-the sole purpose’

‘... the second time ... I wanted, at the time, I wanted nurturing ... The bloke that I was with at the time ... it was quite a violent relationship I was in, but he had a real nurturing side when he wanted to, like most controllers, and I remember know, I remember thinking “if I do this it’s gonna bring that out in him” and it did.’

### **7.2.2.iii. Trauma and Loss.**

#### ***Father’s Violence Toward Her Brother - Unresolved Trauma (Vicarious\*)***

‘I could see my brother was in-was hurting erm and that-I was fearful of that...I still remember hiding behind the sofa, and I still remember screaming at my dad to stop’

#### ***Parents Arguing – Unresolved Trauma (Dismissed)***

‘erm...didn’t feel safe when they were arguing’

‘or if my mum and dad were arguing as well, that, that felt quite dangerous...when they were really shouting at each other, that was frightening’

#### ***Mother Leaving - Unresolved Loss (Pre-Occupying)***

‘We got in the car, my brother was in the front seat crying, and I got in the back car (sic) and my dad just said ‘Your mum’s left and she’s never coming back’ ...that was it and I didn’t’ say anything I just froze, I just froze, I didn’t cry didn’t do anything, I just froze, my brother was hysterical...’

***Boyfriend's Suicide – Unresolved Loss (Pre-Occupying)***

‘...I was fourteen when he died and he took his own life, so, um, we, he took his own life. He hanged himself and I found him’

‘My husband has a motorbike, um, and...if he hasn't checked in with me he's in bits of a highway, on a m-motorway somewhere um, I can never just think “oh, he's...(three second pause) you know, ‘he's stopped for a brew’ or whatever., in my head he's had an accident and I automatically, t-t-there's old, there's old traits there, old behaviours where I still link straight to the worst possible ending’

**7.2.2.iv. Ill Health.** A strong theme weaved throughout the narrative is from early on the only maternal comfort she received was when ill. Linda describes being nurtured by an emotionally distant and physically inattentive mother, being tucked under a blanket on the sofa, watching Charlie and the Chocolate Factory on the television, and mum bringing her Heinz tomato soup. Amongst a sad narrative, these moments of illness appear to have occasioned some of the few warm memories she had as a child, certainly the only warm memories recounted from her relationship with her mother. She recalls how she would long for this ‘nurtured feeling’, and would often pretend to be ill to feel it again.

‘I always felt nurtured by my mother when I was ill...and I remember thinking-feeling in that moment ‘I don't want that feeling to end’...erm...yeah, that's...and I can't really remember feeling nurtured when I was feeling well’

Yet, while these times of maternal care were described as ‘nurturing’, there was no mention of physical closeness, or physical care, no cuddling, or stroking.

‘she was always in the kitchen, she never sat with me, she was always in the kitchen, but it always felt so good, it was really, really good (laughs) I don't know why, I could start crying, it was-it was just like, oh it was lovely you know, it was like this is the best thing’

Nevertheless, this appears to have set up a pattern for illness behaviour as a way of eliciting attachment responses. In fact, she makes the link between her second suicide attempt, which, in her words, was an effort to elicit nurturing and care from her violently

abusive boyfriend, and her pretence at illness as a child in an effort to trigger nurturing from her mother.

It is also significant that her mother was later diagnosed with FMS, which Linda believed contributed to her mother's alcoholism and used as an excuse to dull the pain, and loss of work. She was able to make a link between this and her own development of the condition as an adult. From the interview discourse it seems that pain/illness talk was prominent within her mother's house, which was Linda's primary childhood residence.

#### **7.2.2.v. Attachment Classification.**

*A (4- 6) compliant, self-reliant.* The interview is predominantly dismissing. Linda tells the facts of difficulties and dangers, but does so without unleashing angry criticism of her parents, or any form of connotative language at all. At times there is some indication of anger towards her mother, but this is not developed, and her memories appear to be overtaken by the trauma rather than her articulating any anger or resentment. Dangerous and traumatic events are retold in a very objectively descriptive and matter-of-fact way. There is strong mention of corrective scripts, to be totally different to her parents. This almost tips her strategy into some C-pre-occupied patterns, but she exonerates her parents historically, by describing the 80s as a time when parents did not think so much about the impacts of divorce on their children.

Her account is disrupted by several unresolved traumas and losses. It is evident that these broke down her attachment strategies, such that retreat into illness, drugs, alcohol, and promiscuity appeared the only channels for survival for her.

#### **7.2.3. Karys**

Karys (43) lives with two of her three children, Warren (20) and Luna (13), and her husband, Martin (48). She has an older daughter Lorrie (23) who lives in Manchester with her

boyfriend. Karys is close to both of her parents, her mother has osteoarthritis and rheumatoid arthritis, but also suffers with FMS symptoms, although this has not been diagnosed. Her youngest daughter, Luna, suffered depression following the deaths of her paternal grandparents, and has bouts of abnormal tiredness, and reoccurring joint pain in her knees and ankles. Karys attributes Luna's pain to either 'growing pains', or the result of bereavement.

**7.2.3.i. Adult Attachment Interview (AAI-DMM).** Karys described a happy and stable childhood with little in the way of conflict, and a close relationship with her Nan, who appears to have been the lynch pin of the extended family. Her earliest memories were positive, she evokes a happy image of a toy pram she received for Christmas, yet there is an undercurrent of loneliness and emotional withdrawal, and a sense of her trying to tell a positive story of rather emotionally disengaged parents. For example, she describes herself as a daddy's girl, stating that he was, her world, yet she also describes her father as working hard 7 days a week for over 12 years, and not physically very present. She also describes her mother as physically available, but most of the memories, although positive, are of practical activities with very few, if any, memories of cuddles or expressions of love. Karys's narrative is devoid of any mention of friends, school related memories are largely absent, as are mentions of boyfriends, and at adolescence, although she describes some rebellion, this appears to have been quite mild, such as coming home slightly later than agreed.

Comfort and care were asserted to have been available, but there were few explicit memories to back up the claim, until, that is, she talked about being ill as a child. Then the comfort and care was described most clearly and emphatically, for example Karys suffered reoccurring bouts of tonsillitis, and had clear memories of staying at home, whilst her mother pottered around in the background, cleaning the house and bringing her ice cream. A stark omission in the narrative was where Karys reported having no memories at all of being upset

as a child, or of ever having been told off. In fact, she claimed to have been ‘an angel’ as a child, and having left the disruptive behaviour to her brother.

The account changes when the subject of loss is broached. At the mention of her Nan’s death, she became distressed and found it difficult to talk about her without shedding tears. Up until that point there was a feeling of determined positivity, and even in her apparent distress, Karys continually displayed false positive affect to compensate for the negative discourse. This false positive affect, laughing or smiling whilst wiping away tears, was repeated when she described losing her father-in-law, with whom she reported being quite close. So much so, that she still keeps the watch he wore the day they lost him in her jewellery box, the time set to the minute he died. It appeared that her father-in-law may have filled the paternal role that her own father could not. Loss seemed to permeate the rest of the interview, and her feelings about separation from her children and concerns about their safety.

The integrative part of the interview was not particularly developed, and stayed at a practical level of wanting to repeat with her children holidays she’d had as a child. The corrective script was to encourage her children to be more self-reliant and to be able to do housework, as she said she was never taught or allowed to do anything herself. However, this conflicts directly with an early memory of her sweeping and cleaning with her mum at age 3, and her stating how her mother taught her how to keep a house. At a few points she uses strong language when referring to her mother, which contrasts to the very mild style throughout the rest of the interview; ‘She’s a bloody clean freak’.

Overall, there is a feeling of sadness, her first memory of the pram is lonely and wistful, of a young girl yearning for connection and idealising a rather absent dad. There is the feeling that nothing in this family is resolved through talk, there are descriptions of family fallings out, and parents not talking for days on end, her mother and her Nan disagreeing and

not speaking for 12 years before her Nan died without the disagreement having been resolved, which caused Karys to harbour anger towards her mother. This anger was never outwardly expressed, and she let it go for fearing history repeating itself. This non-resolution via talk may account for the feeling of lack of depth throughout this interview. There is a sense that expression of emotions or disagreement is dangerous, and to be avoided, which may explain why Karys appears to block out and shut down discussions of how she was treated when upset as a child, and ultimately we are left with a sense of something missing or being suppressed in the interview. A more in depth analysis of Karys's representational systems can be found in [Appendix 11](#).

### **7.2.3.ii. Critical Cause of Danger.**

***Nan's Death.*** Karys was very close to her paternal grandmother and was profoundly affected by her loss. During the interview she struggled to talk about her without tears, and gave a confused, disjointed, sometimes contradictory retelling of her death. Her narrative became dysfluent, with some displays of false positive affect, suggesting a struggle to control a surge of negative affect as the memory played through her mind. She reported after her Nan's death it was 20 years before she could enter her Nan's house again.

‘Well, it-it's-it's even-even talking about her still upsets me’

‘but um...I, I couldn't go up where she lived...an...(shaking head vigorously)...no...it took me, it took me (pause, smiling) really until about 3 years ago to be able to go in the house’

***Father-in-Law's Death.*** Karys appears to have felt the loss of her father-in-law keenly, veering off into irrelevant detail when she talked about the circumstances surrounding his death, possibly as a way of avoiding the upsurge of negative affect that flooded over her at the memory. Several years later she still struggled to cope with his loss to such a degree that she was unable to have a photo of him on the front of her fridge.

‘Erm, well he was in hospital for 9 weeks...beforehand...um...he went into hosp-I went in the ambulance with him in the hospital...I remember it was a Saturday night, he rung us because he wasn't very well, we got up there & I said 'Look you've got to go up the hospital' & he would never-if he went to a hospital appointment & they'd tell him it's late, he'd leave (laughs) he'd just, he'd be difficult (laughs) he was terrible, & I said 'You need to go to hospital' & he said 'Yeah, ok', so I knew he knew he was ill, So, I said to him, my husband was working on the Sunday, I said 'Look, I'll go down with him' I said 'I'll just come home in the morning' I said 'You know what they like, they'll just keep him 24 hours, blah blah blah blah' so I said 'You go home' cos our youngest came with us as well, cos she just ad-ored her grandpa...’

‘Oh yeah, that still affects me...daily...(laughs heartily, takes of glasses & wipes eyes)’

‘I've got a photo on the side of my fridge (wiping eyes) I can't put it on the front where I can see it (smiles) so I got it on the side...& it's him on his last birthday (wiping eyes again)’

**Depression.** After the loss of her Nan Karys became depressed and had counselling as a result. Through the year that followed, she describes being on autopilot while looking after two small children, memory loss of that time, and she as she talks a feeling of numbness and loneliness is evoked.

**‘OK, do you think there was any long term consequences for you?’**

K ...um... Well it did, it did...I-I think it did, it did trigger the depression, in a way...that's something I w', one of the things that...that started it...off...’

‘I had counselling with the-wi-through the dr a few years later...(sniffs)...& I-I remem-I remember going in, the first hour I just sat there & I broke my heart, I just cried (pause) by the time I stopped crying it was time to go (pause) so (laughs) I-I-I'm ready to talk now, said 'Well your time's up now', you know...’

### **7.2.3.iii. Trauma and Loss.**

#### ***Loss of Nan – Unresolved Loss (Pre-Occupying)***

‘...I didn't go to the cemetery for years and years...cos every time I'd go in there I was breaking down, and (shakes head)...well, it-it's-it's even-even talking about her still upsets me, you know...it does’

***Loss of Father-in-Law – Unresolved Loss (Pre-Occupying)***

‘Oh yeah, that still affects me...daily...(laughs heartily, takes off glasses & wipes eyes) I've got a photo on the side of my fridge (wiping eyes) I can't put it on the front where I can see it (smiles) so I got it on the side...& it's him on his last birthday (wiping eyes again) with our Luna, our youngest (wiping eyes)...oh...& um...& I do, I-I chat to him when I'm cooking’

‘...oh god...[his watch]\* is still in my jewellery box, & I-I put 4.06, I set it on the time [he died]\*, & I-I pulled the thing out the side & I left it at the time (pause smiling) & it's in my jewellery box’

\* Researcher added for clarity

***Hints at Emotional Neglect – Unresolved Trauma (Dismissed)***

**‘Is there one specific memory that you can relate (of mother as loving)’**

K: ... (Bites lip)... (Shakes head, looks away)...no I can't think of anything...specific...(looks down)...I can't think of one thing’

**‘Right, so anything sticks out when you felt particularly loved (by father)?’**

K: No...not that I could think, nothing...that, you know, jumping out at me’

**7.2.3.iv. Ill Health.** There is a theme of comfort coming through illness. When relaying a memory of her relationship with her mother being warm, Karys remembers her reoccurring tonsillitis, conjuring very clear memories of being tucked under a blanket on the sofa and her mother ‘waiting hand and foot’ on her, bringing her ice cream and drinks, watching *This Morning* on the television, and the reassuring feeling of her mother ‘just being there’. When asked what sensory memories she had of this time, rather tellingly she replied she remembered the smell of furniture polish, and it was at this time she explicitly stated she

did not feel alone. This memory of receiving comfort through illness is revisited when reciting a memory of when her relationship with her father was caring. Karys remembers how he would spend time with her on the sofa before his shift, helping her with her colouring, and again Karys explicitly uses the phrase ‘just being there’ with her, suggesting perhaps that her parents did not usually ‘just be with’ her when she was well. The description of the earliest separation from her parents also has an illness turn. Karys describes a distressing school residential trip. Whilst away from home she developed toothache, which her teachers thought was a psycho-somatic symptom of homesickness. Karys spends quite a bit of time justifying that it was no such thing. She also describes how her parents did not come to get her, even though the residential was just over half an hour away from home. It might be that this may be the beginning of part of an on-going narrative about her illness not being believed.

#### **7.2.3.iv. Attachment Classification.**

*A+ (4-6) Compliant and Self-Reliant.* Karys’s interview is predominantly dismissing, there are gaps and some inconsistencies, with an overall sense of a forced false positive affect, manifest in instances of laughter when discussing difficult memories. Her strategy changes later in the interview, and her self-reliance begins to fragment when discussing the loss of her Nan and father-in-law, and fear of losing other family members. This change in strategy is evidenced by countless intrusions of affect, and tears.

#### **7.3.4. Analie**

Analie has two children, Chico (9) and Alanah (4), and lives with her husband, Stephen. Analie has been diagnosed with Rheumatoid Arthritis, and had Osgood-Schlatter’s disease, painful inflammation of the tendons in the knees, as a child. She also had a hole in her heart at birth. Analie’s older sister, who was three when Analie was born, had congenital heart failure, and was one of the first children ever to receive a heart transplant. However, her

body rejected the heart and she died when Analie was six months old. Analie states that Chico has been ‘headhunted’ by the Royal Ballet School in London, and they practice their ballet positions together as this helps Analie’s joints. Chico has non-specific widespread on-going pain.

**7.3.4.i. Adult Attachment Interview (AAI-DMM).** Illness and grief feature from the outset of Analie’s interview and permeate throughout her account. She describes a wealthy father, who was not only a successful town surveyor, but also a national level track and field athlete in the days before professional athletics, and her mother as a primary school teacher. Her older sister died at aged 3, when Analie was still a toddler, having undergone one of the first ever heart transplants after suffering congenital heart failure. Analie also had a hole in her heart and this was important to her development, but in the sense of pushing herself to be fit. She was a ballet dancer and very physically active before the pain of Osgood-Schlatter disease forced her to quit ballet school at age 12/13. Up until that point, ballet seems to have been a creative outlet for her, possibly negating some of the emotional neglect she encountered at home. She describes ballet as having been her main focus, spending after school and weekends pursuing, so the loss of this outlet was a huge blow. One she possibly struggled to get over.

Her story features parents who were deeply unsuited, and had a tempestuous marriage, with frequent ferocious rows, culminating in days, often weeks of silence. Her mother appears to have been immersed in grief having lost her eldest little girl, and as a result was described by Analie as self-centred, emotionally withdrawn and unreliable, and engaged in several affairs. Analie described her as being bohemian and a free spirit. Eventually her mother left the family when Analie was 13, although she would still see her each day at school where her mother was teaching, but there the relationship stayed strictly teacher/child. The picture of a somewhat neglected child emerges, her parents steeped in grief and their

own marital issues, not having the emotional space to take care of the child that was left, with numerous faceless Nannies and au pairs in and out of her early life, and it seems that Analie clung to ballet as the escape from the often stormy scenes at home. She reports having been closer to her ballet teacher than to any of her Nannies or au pairs, dismissing them as ‘those people’. Her mother’s leaving appears to have coincided with her forced withdrawal from ballet, which must have felt like a double blow, and a double loss.

She describes herself as a ‘daddy’s girl’ and, from when her mother left, was brought up by her father, and appears to have somewhat idealised him. However, she also reflects that he was emotionally avoidant, but showed his love for her in practical ways, claiming she could always rely on him, although caveating that with ‘when I was younger’. When Analie was 14 he met and begun a relationship with a woman only eight years older than herself and would frequently leave Analie at home at weekends to visit his new girlfriend. Analie felt grown up to begin with, but without any means of transport and being all alone for the whole weekend, this soon began to pall, and feel nearer neglect, although she never outwardly expressed dissatisfaction at the arrangement. Unsurprisingly, she conveyed some hostility towards her mother, but this does not completely overtake her, and she often covered this hostility with laughter. This can seem like false positive affect, but it may also mask her hostility. However, it never escalated into overt derogation.

When Analie was 16, her 17 year old boyfriend died when the car he was driving hit a tree. Although she claims the event did not have a huge effect on her and that the relationship was ‘no great love’, the effects can be seen to reverberate through the years. She describes how she is often frightened her husband has had a road traffic accident when out of her sight. So much so, that when they bought a new car she chose one with GPS tracking, and will message her and the emergency services if the airbags are deployed.

A strong theme of her interview is that when she showed emotions or needs as a child, she could anticipate the first reaction from her father to be irritation and/or anger, and as a result she describes her strategy subsequently as becoming ‘self-sufficient’. Although she was able to articulate the short-comings of both her parents, she did not become pre-occupied with these, and never engaged in derogation. Instead, she consistently showed a balanced ability to reflect on her own feelings, and even empathise with her parents. There is a hint of idealisation in this, but the balanced reflection indicates a more integrated perspective, indicative of moving towards a secure attachment pattern. A more in depth analysis of Analie’s representational systems can be found in [Appendix 12](#).

#### **7.3.4.ii. Critical Cause of Danger.**

***Mother Leaving.*** After several affairs and much disruption, when Analie was 13 years old, her mother left the family home, leaving Analie to be brought up by her father

‘...things got unstable again (laughs)...because bless her, my mother...my mother is...a bit of a free spirit umm and a bit of a bohemian type of a character, and the marriage between my mother and my father...just wasn’t right umm so and she left when I was 13’

‘the day that it happened I made myself ill because I didn’t want to be out of the house...I wanted to try and stop it umm...but I was...she sent me off to my best friend’s house...and so I’d thrown up, I made myself throw up because I thought well if I made myself sick she can’t send me to my friend’s house...it didn’t work’

‘...in the middle of the night she came to see me, and I woke up and ...I knew she’d been watching me...she’d been in the bedroom and she told me that she was leaving dad, and that this was what was going to happen’

***Parent’s Conflicts.*** Before Analie’s parents separated she remembered frequent heated arguments, often verging on the violent, culminating in days, often weeks of silence

‘I remember my mum storming upstairs and locking herself in the bathroom then I remember my dad slamming his fist through the bathroom door because he was cross...he was

never physically violent...never...but she had wound him up to the extent (laughs) that he needed to vent and he slammed the door, and actually put his fist through the door'

'...I can remember hearing them argue...they were having a fight...and I could just hear them argue and I knew that I shouldn't be there...and that I shouldn't get involved'

'Putting the pieces together, I suspect the argument was because he'd found out she had a second affair umm but...at the time I didn't know that, I just remember this blinding fight about...the fact that she wasn't where she said she was going to be...and dad had caught her in this, and this was a big, big thing and it'd blown up and mum had thrown a set of crockery around, and there was bits of crockery flying around, and after that, after the explosion there was nothing and there was just silence...'

*Sexual Abuse.* Analie reported 2 separate episodes of sexual abuse. The first at the hands of an older boy who tricked her into a sexual act, the second, which sounded more serious, which she did not elaborate on. However, she did speak to a teacher about the first incident in the hope it would lead to a conversation about the abuse that was happening at the time, but it appears the incident was not taken further

'the first time was relatively early...and that was just inappropriate touching and when I look back at it...I realise how not good it was, but at the time...it was attention from a much older boy that I thought was quite cool'

'...fortunately the teacher...to this day I'm not sure what happened...I remember them asking me to sit outside the office and draw a picture of what happened...like a map of locations and a picture of the person but I lied in the picture of the person, because I didn't necessarily want to get him into trouble...because that was not what it was about it was about the other thing and that was all that happened...from that point nothing else occurred'

'I think the er abuse, the sexual stuff...I know caused me...trouble erm in later life...erm yeah i-it was a-Stephen a very patient man (laughs) it took him a long time to get anywhere, erm because trusting anybody to come into your life i-is hard after you've sort of been in that situation'

***Mother's Affairs.*** During the marriage to Analie's father, her mother had at least 3 affairs that Analie knew of

‘during my childhood she had 3 affairs that she will admit to’

‘...my mother's promiscuity, if you like, taught me that grass isn't necessarily greener on the other side of the fence...’

***Mother's Alcoholism.*** When Analie was 14/15 her mother went to live in Greece with a man, had an accident where she fell off the back of her boyfriend's motorbike, the boyfriend rode off and left her seriously injured in the road. She subsequently came back to England where the boyfriend stalked her, which led to her turning to alcohol to cope

‘...and mum just didn't cope well with any of this and turned to the whiskey bottle...so then spent the next few years drinking vast amounts of whiskey...which led to her doing things like most notoriously trying to commit suicide by throwing herself in front of one of the really old fashioned milk-floats...’

‘...after university I lived with a friend called Ruth and a number of times she'd come home and she'd find the phone on the mantelpiece and she'd say ‘It's your mum isn't it’ and I'd say ‘Yep’ because she was drunk again and talking and it didn't matter if anyone would listen, but I wasn't prepared to listen and occasionally I'd pick it up and go ‘yeah, yeah’ still talking (laughs)’

#### **7.3.4.iii. Trauma and Loss.**

##### ***Death of Her 17 Year Old Boyfriend – Unresolved Loss (Dismissing)***

‘We'd been going out for about a year ummm...we were doing our...first year of A-levels and he'd just learnt to drive...and we'd had an argument because I told him he'd had too many drinks to go out and he drove back from the pub with 2 other friends in the car and...he drove the car into a tree and umm he passed away, the guy who was directly behind him is paralysed from the waist down, the guy next to him had a broken arm and...that was it’

‘I can remember feeling...that sort of disbelief and then anger...cross-cross with him, cross with me, cross that we'd had an argument and that I was right...that was pretty...yeah unpleasant and then...It was...just lost...’

‘I worry about my husband, erm...I worry about him um, I worry about him getting overly aggressive, and competitive in a car, er, and just...losing control, I worry about that...when we bought a new car...it’s has a-it is a fully tracked car, so...if there’s an accident, if i-the airbag deploys, the car will contact er um...the car w-will, will first of all contact whoever’s driving, and if they don’t get a response it will then phone emergency services...and it’s tracked by GPS’

***Mother Leaving – Unresolved Trauma (Preoccupying)***

‘I still, I still have an overwhelming fear of being abandoned, of-of him going, and that’s a difficult thing to deal with, erm, ‘cause it’s a kind of visceral response, erm, and I think that fear of...a fear of abandonment, and fear of...I-uh-I wouldn’t-uh-since-in between the ages of 13 and university, I didn’t leave the house, as in, erm, I went to school, but I wouldn’t go and stay at anybody’s house, I wouldn’t have stayed over at anywhere, I never left, I wouldn’t go and stay over at friends, I wouldn’t have sleepovers, that didn’t happen, because that fear of when I came back dad wouldn’t be there, and then I’d be completely on my own, was-was massive’

**7.3.4.iv. Ill Health.** Analie had a long history of serious childhood illness, notably that she was born with a hole in her heart, which, although serious and required surgery as a newborn, was not the most important thing in her parent’s life at that time, as her 3 year old sister was dying of heart failure

‘...I also had a hole in my heart when I was born, so I was taken up to Great Ormond Street very quickly afterwards umm...and...which is where my sister was umm and...we were there for quite some time’

‘...because they found it very hard to cope umm...having lost a child and then having a second child who...who...wasn’t that well anyway, nowhere near as poorly as my sister but I think the two things on top of each other just were a bit of a mess...’

She mentioned many of the usual childhood illnesses with a theme of being relatively self-sufficient when ill. She recalls, without voicing criticism, the time she had chicken pox and her parents took her and some family friends to visit a National Trust castle, leaving her in the car on her own while they had a look round. She also recalls her father, rather than her mother, taking her for chest X-rays as a small child. Whilst she has memories of some of the

less serious childhood illnesses, such as mumps, cold, and sick bugs, she reflects how she has no memory of the serious surgeries she endured as a child. This may have some relevance in the fact that her mother appears not to have been overly involved during some of the serious heart procedures, and her father's emotional unavailability at these times, and is evident in her dismissive attachment classification. What is evident though, is Analie did not seem to learn comfort was given through illness.

#### **7.3.4.v. Attachment Classification**

*A reorganising pattern A (4-6) compulsive compliant, self-reliant/some C (3-4) aggressive, feigned helplessness (re: mother) - -> B (1- 2) reserved secure.* Analie's childhood strategies appear to have been compliant and self-reliant, with some hostility towards her mother, often masked by false positive affect in the way of laughter after recounting her mother's bad behaviour. However, since being in a loving, supportive relationship, she appears to have gained considerable insight and is able to reflect, so this interview is moving and possibly now reorganising to a balanced B strategy.

A couple of passages are convincing in demonstrating there is reorganisation going on, particularly in relation to how her parents coped with the loss of her sister:

**'When you were young then, did you ever feel rejected by your parents, although they may not have meant it or been aware of how you feel can you remember?'**

A: Yep.

**Can you remember an incident?**

A: Yep its very specific, umm...this was 5 maybe-maybe 6 because I could read I...remember we were moving house and I was supposed to be helping putting things in boxes...and I found two baby books and they were my sisters baby book and my baby book...and I remember going off and sitting down and squirrelling them you know little treasure and I remember looking at my sister's and it was full you know lots of family trees, photos...and I looked at mine and there was hardly anything in it and I remember

feeling at that stage that I was the wrong one...that...that  
umm yeah it should've been the other way round

**Why do you think your parents did that?**

A: time (laughs) I don't think it came down to anything other than she was the first...I remember when I was filling out my first babies baby book, it was thing you know take the photo of the first this, first everything else. When I was doing firsts, my sister was dying you know she died and I think they were in such a bad place mentally that the thought of taking a photograph sticking it in a book and remembering wasn't...something that they could do...neither of them if you talk to them remember when I first walked...they got no, that loss must have been so compounded, so for them to try and spend their lives with this stuff must have been so hard um because their heads weren't there and now that I have children of my own I can entirely understand that because um, but at the time you know at 4 or 5 it felt like rejection it really did'

**'You've kind of already said that your relationship with your parent's has changed now you're older, and you've kind of described it a little bit, but can you describe to me a bit more in what ways you feel that's happened?**

A: So, with my dad, I would now sort of class him as a friend, a bit more...you know, we have a laugh, I'll take him to the pub, erm...he will talk to me like a grown up, and it's very much more...yeah, it's jokey, it's still-I don't kiss him, and I don't hug him, that doesn't happen, erm, but it's very...yeah, relaxed and genial, erm with my mum...there are things we cannot talk about, full stop, that do not get talked about, erm, but now I have respect for her, and I don't think I did before, I didn't understand why she'd done these whole series of things, I don't think I necessarily blamed myself, I don't think I was that person, but I didn't get it, I didn't...now that I'm a parent myself, and know how that type of love feels, then I can begin to understand, and the thought of losing one of them in that way...just...I-I don't know how I would pick myself up from it, and I'm in a happy, loving relationship, and for her to pick herself up from it, when, actually, they were in a completely dysfunctional relationship, even at that stage...all power to the woman, dear god, you know, well done, 'cause I don't think I coulda done it'

**7.3.5. Zia**

Zia lives with her two daughters, Kerry (11) and Tania (9). Zia had an extremely acrimonious divorce from the girls' father, after a violently abusive relationship. After the split, Zia's husband refused to leave the family home, meaning Zia and the girls were forced to move into a chalet until the house was granted to the children for residency by the courts. Against her wishes, Zia was awarded joint-custody of the girls, meaning they stay with their father every Wednesday evening and every other weekend. This causes great distress to the youngest daughter, Tania, who suffers separation anxiety as a result. Zia suffers with RA, currently (at the time of the interview) manifesting mostly in her left knee, and although this can alternate to other joints, she described the pain intensity as generally manageable. However, stress can greatly affect her pain levels. Tania has a range of pain issues, including eye pain, headaches, and a 'fizzy tummy'. Zia described Tania's pain as all consuming, and emotionally charged, that her pain comes and goes, and when not displaying as pain, it manifests emotionally, e.g. comfort eating and/or temper tantrums. Zia reported that Tania also suffers from poor eyesight, sensitive skin (eczema), and being overweight. There does not appear to be any other history of pain conditions within the family. Zia described a close and supportive relationship with her parents in childhood, but, conversely, has little support, and subsequently little contact with them as an adult.

**7.3.5.i. Adult Attachment Interview (AAI-DMM).** The first part of the interview conjures images of very warm, loving relationships with her parents, all of which were well supported by memories and images. Zia described a happy childhood with little in the way of conflict or disruption. She described an attentive and sensitive mother, who supported her daughter's learning, was gentle and understanding with childhood mistakes, and a hard working father who found time to sit and read with his children. In this part of the interview Zia offered a lot of insight and spontaneous reflection on the episodes she described. She was

able to integrate her adult reflections with her childhood memories, producing a well-rounded and insightful narrative.

However, it is not until halfway through the interview that there is the first hint that all is not as it may seem. The happy family picture previously drawn by Zia omitted her mother left when she was 12 and her sister was eight, and that she did not see much of her mother subsequently. Her father became the main carer, and Zia described how he struggled to cook and take basic care of them. Her father was possibly depressed for a while after his wife left, and Zia described the shock of seeing her father cry at this time, stating it was something she would never forget. She also hinted that because her father was so consumed in providing physical care for his daughters, getting the girls to school on time, clothing and feeding them, he was not necessarily emotionally available for her. Zia was adamant that despite her mother leaving when she was only 12, she was well prepared for the departure, and was more than able to cope. She claimed that her mother had prepared the girls for her leaving, without actually explaining what she was doing or that she would soon be gone. The idea that a 12 year old was totally unperturbed by the surprise departure of a previously loving and attentive mother is difficult to comprehend.

Memories of childhood illness involved mention of lots of usually forbidden food, treats being brought to her to tempt her to at least have something. Later in the interview Zia talked about how having such sensitive and balanced relationship with her parents did not prepare her for meeting the man she married. She described how, due to her upbringing, she did not recognise blatant red flags, and it was not until after a very quick marriage, and two pregnancies in quick succession, that her new husband's behaviour became slowly increasingly violent and toxic.

Taken altogether the sense of a happy childhood with sensitive, but ultimately unhappy parents, emerges. It seemed like an interview of two halves, the first part of her life

reportedly very happy with warm, supportive, sensitive, engaged parents, and from age 12, just as Zia was negotiating the difficult transition from child to adolescence, the loss of her mother, loss of emotional support, and it is this that may have contributed to her finding herself in an abusive relationship as a young adult.

We are left with the impression of a deeply thoughtful, kind, and empathetic child, and the last part of her interview is maybe summed up by her memory of Jonathan the tramp:

‘...but I remember being really, really upset by the thought of this fella...sleeping outside and sleeping under er-er...so the point is there was something always in me, I think, that wanted to help,’

A more in depth analysis of Zia’s representational systems will be found in [Appendix 13](#).

#### **7.3.5.ii. Critical Cause of Danger.**

***Mother leaving when Zia was 12 years old.*** At aged 12 Zia’s mother left the family to go and live with another man, and Zia was left to witness her father’s devastation. Despite Zia’s assertions that she was unaffected by the departure of her mother, there is a lingering sense that a veneer of positivity is being applied.

‘Well, my mum left when I was 12...but again, oddly at the ti-er, and I er...I, you know, I’m only analysing this now, so you can’t be erm...er...er I don’t think it had much of an impact by then, and in hindsight I think she’d prepared us quite...well, in a way...without saying she was going’

‘so it was better...for...them to separate, and that fee-that, it did, there-there were other feeli-clearly, sadness for me father, and the absolute elation of me mother (laughs) so, you know’

***Domestic Violence as an Adult.*** Zia fell in love, quickly married, and had two children in quick succession. The relationship rapidly became physically abusive, something, due to her happy and stable upbringing, she was totally unprepared for, and did not recognise the signs before it was too late.

‘I think what I wasn’t prepared for was adults that aren’t like that...and I think that was the missing bit out of my...childhood really...there isn’t anything you can do and sometimes you have to say ‘I have to protect myself more than I have to (laughs) help you’, so I think i-if there, you know, was an impact of my childhood it was that’

‘it-it is the absolute text book...erm...grooming if you like, so it starts with something very small, a-a-and, you know, as it goes on, so by the end it was very violent, awful relationship, that-so toxic, it was...absolutely unreal, but by the time you’re at that point your self-esteem is on the floor and you think it’s all you’

**7.3.5.iii. Trauma and Loss.** There are several possible traumas which are largely dismissed or minimised:

***Her Mother Leaving – Unresolved Trauma (Dismissed)***

‘Well, my mum left when I was 12...oddly at the ti-er, and I er...er...er I don’t think it had much of an impact’

‘...I think really the only adversity was my mu-my mum leaving, but by then I think I had enough...strategies to cope...’

***Father’s Ostensible Emotional Neglect After Her Mother Left – Unresolved Trauma (Dismissed)***

‘...he didn’t have a clue about anything, y-you know, suddenly he did learn to cook, oddly, we had some very odd...cornbeef pie, oh I don’t know, just really odd like man food (laughs) but he did what he di-and you know, he kind of went with it and did the best that he could so...erm...a-and i-it’s not a criticism, but it...it...erm, he was loving, so it wasn’t he wasn’t loving, but I think erm...so I think probably still a lot of the er the sort of more emotional...guidance came from my mum I think...’

***Father’s Distress When Her Mother Left – Unresolved Trauma (Vicarious)***

‘Hmmm, erm ... I think my dad was devastated to start with, I think he was absolutely devastated, and it’s probably one of the only times I’ve seen him cry ... and that wa-that really did impact because I just didn’t know what to do, I just did not know what to do, so I-I remember that till the day I die ... but (laughs) but ...’

***Domestic Violence as an Adult – Unresolved Trauma (Dismissed)***

‘... and it-it is the absolute text book ... erm ... grooming if you like, so it starts with something very small, a-a-and, you know, as it goes on, so by the end it was very violent, awful relationship, that – so toxic ...’

‘and I am an assertive, y-you know, confident person, so how (laughs) did I get from that to that, i-in that time, I mean quite short space of time really ... erm, and again, text book ... we met and were married within 12 months, I’d always thought I’d never have children, and I had two children in less, y-you know, so I’ve been-met him, married, children, 3 years (makes speedy noise) ... erm (laughs) a-and actually, knowing what I know now that is another ... you know, that is a way ...’

**7.3.5.iv. Ill Health.** Whilst there are warm and slightly idealised memories of her mother whilst being ill, there is no sense of gaining comfort through illness. Zia mentions her mother fussing and bringing different treats to tempt her to eat something, but these memories in no way contrasts with the rest of the imagery or childhood events she recounts. What we are left with, however, is a possible sense of finding comfort through food, in some way at least.

**7.3.5.v. Attachment Classification**

***A re-organising pattern A (3-4) compulsively caring, compliant - -> B (1-2)***

***reserved.*** The first half of the interview conjures up images of warm and happy relationships with lots of reflection and insight from Zia, however the integrative section of the interview does not quite match some of the more spontaneous reflections she offers earlier in the interview. This suggests that the earlier description of her parents, which were positive and full of supporting images, are largely idealising, and whilst she does not blame her parents for any of this, the lack of some form of anger or any statement of her own upset suggests some dismissal of negative affect, and suppression of negative memories. However, there is a lot of

insight and reflection throughout the interview. Therefore, Zia shows an A (3-4) pattern, with re-organising towards a secure reserved B1 -2 strategy.

#### **7.4 Discussion**

The aim of this chapter was to provide family background and illness histories of each of the five participants, and to outline their individual attachment classifications. The AAIs present the participants' personal memories of, and interpretations about, events that occurred in their childhoods. Of particular interest was how their parents responded when they were ill or hurt as children.

Looking at the collective AAI data several patterns seem to appear; Firstly, all participants experienced some form of loss and/or trauma, which appeared to be in some way unresolved. In fact, three out of the five mothers experienced maternal abandonment, one of whom also experienced paternal abandonment in her early teens. The events being experienced as traumatic can be seen by the intrusions of negative affect when discussing the events, for example, both Carrie and Karys shed tears when speaking about the deaths of their grandmothers, and Karys when talking about the death of her father-in-law. This is indicative of a dismissing trauma, where the events are spoken about without any kind of emotive, or connotative language, but there is a burgeoning of negative affect, in this case manifesting in tears. Dismissing trauma in the cases of Linda, Analie, and Zia were evidenced when distressing events were discussed in a very matter-of-fact and objectively descriptive way, sometimes masked with a laugh, or with Zia, with claims that the event had had little or no effect.

Secondly, all FMS participants reported the only time they experienced attention or nurturing as children was when they were ill, one of whom overtly stated she would pretend to be ill to 'get that nurturing feeling again', suggesting they possibly learned to gain comfort

through illness. This is very important to the understanding of the transmission of pain behaviours. There is the suggestion here that these women learned to get some of their needs met through illness, and for Carrie, for example, this also appears to have been a conduit to finally having a relationship with her mother, who was emotionally distant through her childhood. For Linda, there was the explicit link between seeking nurturing from her mother through pretending to be ill, a strategy she repeated in later years to solicit nurturing from her violent boyfriend, which she did through attempting suicide. However, there was no evidence to suggest the same for RA participants.

Thirdly, FMS participants all reported having family histories of FMS diagnoses; mothers, siblings, and one reported their grandmother also being diagnosed with FMS. Histories of other serious and chronic illnesses were also reported as being proliferate among their wider families. These reports of receiving nurturing only whilst ill, coupled with what appeared to be emotionally unavailable parents at other times, suggests the FMS participants may have learned to get some of their attachment needs met through the subsequent parental attention. However, it was noteworthy that they appeared to have experienced a relational process whereby their parents were reluctant to respond, requiring them to increase the intensity of their demands for affection and comfort. This kind of attachment process was not reported in this sample of RA participants. Other than Anna's older sister, who died aged three when Anna was six months old, wider family illness did not appear as part of either RA narrative. Therefore, for the FMS participants, there may be some emerging evidence of a transgenerational effect, possibly precipitated by the ubiquity of poor family health and illness-talk as the family norm. In addition, there may be the suggestion that due to receiving nurturing predominantly during illness as children, and having developed dismissing attachment strategies, the FMS participants as adults may have learned to channel some negative affect through pain signalling in order to get some attachment needs met.

What does seem poignant is that unresolved trauma, often through loss, seems to be a key issue in this sample. How that affects these women's ability to parent remains to be seen. Whether these trauma cause issues with specific areas of their parenting, in other words whether their early traumatic childhood experiences and representations manifest in maladaptive progeny-protecting behaviour, and how this, along with their pain issues, affect their child and their child's bids for attention, particularly when it comes to pain complaints, will be investigated and discussed in the following chapters.

## **CHAPTER 8            PARENT DEVELOPMENT INTERVIEWS AND MEANING OF THE CHILD ANALYSIS**

### **8.1    Introduction**

This chapter continues to build the case studies by introducing data from the Parent Development Interviews (PDI). This focuses on how the mothers view their relationship with their child, and the nature of their developing relationship. In particular, it provides relational context for considering how pain and discomfort are managed within this relationship. Previous chapters considered expression of pain as a primary example of children communicating an attachment need to a parent. Research from attachment theory shows parents own childhood attachment histories, and consequently their attachment strategies, shape their attachment-figure responses when their children express distress and pain (Kozłowska, Foley, & Crittendon, 2006). However, in this research the mothers' lives are permeated by their experience of pain. Hence, each case study will explore the general dispositional representations the mothers have regarding their children, and specifically how this model is influenced by their experience of pain. As discussed in the aims and hypotheses sections in Chapter 5 - Methodology it has been suggested the mothers' dispositional representations and responses might broadly be expected to take two possible paths:

1. As a result of their own experience of pain they are more empathetic to their child's experience and expression of pain, and indicate a willingness to respond sensitively and fully to relieve their child's distress
2. Because the mothers are constantly in pain they are distracted and therefore have less capacity to consider their child's pain and distress.

3. However, a third possibility is that the mothers may oscillate between these two paths.

## **8.2 Meaning of the Child**

The MotC analysis of the PDI allows a sophisticated examination of dispositional representations, or systems of beliefs and attitudes the parent has towards their child and their relationship. Importantly, the analysis includes an examination of these in terms of multiple representations, including non-verbal aspects of their accounts. Thus, helping to illuminate the meanings the mothers hold in terms of implicit or unconscious embodied representations. This is particularly important for this research since pain is an embodied experience, and therefore it is possible non-verbal representations, and contradictions between conscious-verbal and non-verbal representations are a particularly important consideration.

A summary of the PDIs, using the MotC analytical framework, is offered for each participant followed by a detailed focus on their relationship in connection to the experiences of pain and illness.

The PDI transcripts were independently coded by Dr Benedict Gray, who developed this model of analysis. They were analysed further by myself, with support from my second supervisor (RD) who has trained in the MotC analysis, and elaborated within a broader attachment and thematic analytical framework.

The MotC model is based upon Crittenden's Dynamic Maturational Model of Attachment and integrates concepts from the CARE Index, which is an observational measure of parent-child attunement. The parenting aspects of the measure are categorised as Sensitive, Controlling, or Unresponsive, and also assigns a degree of 'risk' in terms of potential dysfunctionality of the relationship and risks for the child's development.

### 8.3 Personal Reflections

I used the MotC coded transcripts and the original interview transcripts, to analyse the data. As I did this, I found myself being drawn into using quite reductionist, somewhat pejorative language, forgetting the social constructionist element to the data. In discussions with Dr Grey, he agreed that the language can appear pejorative, but this was partly due to the development of the model in the context of ‘at risk’ children and children in social care. In these settings the courts and social services seek guidance on the assessment of potential ‘risk’ and ‘safety’ of the child’s relationship with the parent. He has also mentioned that the MotC terminology may be revised in the future to be less deficit and risk orientated (B.Grey, personal communication, 2020).

However, using the analysis and terminology in its current form led me, at times, to become more sympathetic to the children, which meant I seemed a little mother-blaming. When my supervisors pointed this out to me, I had to stop and think why this might have been. What was it about the childrens’ experiences, told from the mothers’ point of view, that resonated and caused me to empathise so deeply with them?

I realised that I was possibly unconsciously transferring myself as a child, onto their children. As the child of a mother with a horrendously debilitating and excruciating pain condition, I felt at times the mothers’ seeming lack of empathy deeply resonated. I could remember how it felt as a child in that position, watching my own mother scream in pain, or getting her tablets, helping her dress, or rubbing cream into her feet when I would rather have been playing. I remembered having been given chores and then being told off for not doing them properly, even though I had felt I had done my best. So, I think when the participants appeared frustrated or angry at their own children for not doing chores properly, or lamented the role-reversal that existed between them, this unconsciously tugged at something hidden away in the attic of my memory, and I unconsciously sided

with the children. At the same time, I was possibly becoming angry with the mothers, or maybe even with my own mother for having been so ill. Consequently, even though I was aware the mothers were in constant pain, there were times when I found it hard to maintain a neutral, more sympathetic position, and struggled not to get drawn into interpreting the data instead of reporting what was there. Once I was aware of this, I was able to put those feelings/biases aside and reassess the data whilst holding in mind a more neutral, social constructionist position, and really begin to see the mothers' individual reality and lived experience.

The data from the interviews is presented as a series of case studies. The PDI interview consists of an exploration of the parents' representations of their own childhood experiences, but this had already been covered in the AAI interviews. The second part is the meanings the parents hold regarding their child, and of their relationship with each other. This allows an integration of how the mothers' histories influence their relationships with, and understandings of their children, and specifically how these relate to the experience and management of pain.

## **8.4 Case Studies**

### **8.4.1 *Carrie***

Carrie suffers with FMS, has depression and anxiety, is a single mum to Ellen (13) and her younger sister, Sophia. Carrie had a physically and emotionally abusive relationship with Ellen's father, from whom she is now divorced. In adulthood Carrie was able to draw closer to her mother, due to their shared pain condition, but they had a strained, distant relationship in childhood. She describes Ellen as having a weight problem, and says she is 'always moaning that she's aching' all over, but believes this is because Ellen is unfit. Her younger daughter is described as an anxious child who complains of

tummy pain, headaches, knee and back pain, and this appears to be taken more seriously than Ellen's pain.

**8.4.1i. MotC Summary.** Within the MotC analysis framework Carrie's parenting was summarised as indicating a pattern of *controlling withdrawal*. Her main strategy appeared to be to control the narrative by presenting Ellen as a 'bad' child against whose machinations Carrie is helpless, thus withdrawing from responsibility in the generation of this 'bad' behaviour. Her interview was coded as indicative of some considerable risk for Ellen developing problematic attachment behaviours in the future<sup>20</sup>.

Carrie appeared to approach the interview to draw the interviewer onside, show herself as a well-meaning and long-suffering parent, and Ellen as a challenging child. She started by drawing attention to the difficulty with Ellen, and her tone throughout the interview was consistently negative:

'I dunno whether it'll shock you or not, really, she's like, um, she's made up things to create drama, like, um, like being pregnant for one...um, she's done it twice, I believe, twelve, maybe the first time, no, eleven. Twelve. Twelve. Twelve. She was twelve and she's done it recently as well, this year, and um, gone right the way through even as far as sort of getting photos from, I don't know where, scan photos and stuff off the internet. And photos of babies and really like, following through...so, yeah, real drama queen, she likes to create drama and she just thrives on it'

When invited to comment on Ellen's positive features, these tended to be undermined with either an explicit or implicit negative. Carrie tended to describe any positive features using a somewhat removed and cliched language. In contrast, Carrie's feeling, images, such as 'drama queen', and expressed emotion suggest an underlying pattern of anger and frustration with her daughter. She also expressed some negative feelings through repeated sighing during the interview, as well as frequent examples of

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<sup>20</sup> A more in-depth version of each case study can be found in appendix (x)

dismissing laughter. Carrie showed little or no mentalising for Ellen, and the occasional examples seemed to be coloured by projecting her own feelings onto her child. There appeared to be a lack of curiosity about Ellen's experience.

Carrie reflected on possibly having got some things wrong as a parent, but this appeared to generate anxiety for her, which she ostensibly attempted to reduce by shifting the focus of blame onto Ellen. There was a resigned and passive tone in parts of the interview, and she revealed that Ellen had spent periods of time living with Carrie's sister as the result of the friction between them (at the time of the interview, Ellen was living with her father for the same reason). Additionally, Carrie had occasion to call the police to frighten Ellen into good behaviour when Ellen's behaviour had become aggressive towards her. This indicates some evidence of a possible abdication of parental responsibility, and a sense Carrie has given up on her daughter as being 'too bad' to manage. Overall Carrie appeared to have little motivation to address the issues in her relationship with Ellen. There is a sense of her metaphorically shrugging her shoulders in exhaustion, deciding that she has done all she can do, and now someone else could take up the slack. A more detailed MotC analysis of Carrie's PDI can be found in [Appendix 14](#).

**8.4.1ii. Comfort: Illness and Pain.** There was no specific mention of Ellen's reported pain complaints, however Carrie did mention some episodes of her daughters' illnesses. When presenting her relationship with Ellen as strong, she relayed a story of how when Ellen was 12, she took two overdoses of Carrie's medication

'So she was hallucinating, and you know, all sorts, but there was, it was evident that, you know, she trusted me and, um, you know, besides anything else that was happening and whatever, you know, our relationship was strong, you know, she trusted me. I was the one that she wanted, you know, and needed, then, at that time, to bring her through, um, those times, you know, the hallucinations were off the wall and, you know, she was terrified, as was I, so yeah, yeah, so,

that's what, in my mind, resonates, you know, the strength there'

By the age of 13, Ellen had faked two pregnancies and taken two overdoses, yet there appears to be little mentalising from Carrie on what Ellen might have been going through to precipitate a series of such extreme actions. Whatever it was, it seems the overdoses may have finally prompted Carrie into the kind of caring-giving role Ellen desperately needed. Yet, for Carrie, this was evidence of a strong relationship rather than evidence of Ellen experiencing extreme anguish, this was what she needed to show that they were indeed close and love did exist between them. The MotC calls this projected mentalising, because she is projecting her own experience of what is happening, rather than truly empathising with Ellen. This sense of danger providing evidence of closeness to her children is repeated when she describes an episode when Sophia was very ill

'She had this terrible sickness bug...every time she had a sip of water it would come straight back up, she would be screaming, you know, she could feel it coming, she would be screaming and, you know, I literally, in the end, I was just sat there, I had nothing on because it was pointless, it was all covered in sick, I had nothing on except, like, I had a towel over me and her, and that's how we sat there, yeah, I just cradled her like that, tryna give her water to keep her hydrated, um, yeah it wasn't the best ...'

Carrie creates an evocative image of danger and fear with this episode, the screaming, the nakedness, the desperate cradling among the lashings of vomit, but in the midst of all of the danger there also seems an underlying feeling of fulfilment. It is noteworthy that these two accounts, illustrative of a strong relationship and loving parenting respectively, are both episodes of illness. For Carrie, illness appeared to be the only highlight in her AAI account, and the only vehicle through which physical comfort was permitted. It may not be surprising, then, that it is her childrens' illness which again provide her with feelings of love and comfort, and possibly even usefulness.

Whilst there is no direct mention of Ellen's pain complaints, there is an indication of the comfort Carrie gives her daughter when asked what happens when Ellen is upset. There may be relative transferability in her responses and we may extrapolate what happens in this situation

**'When she is upset, how does it make you feel?**

C: Um, helpless sometimes, and, um, guilty, to a degree. Because, um...(two second pause) It's almost like I want to be able to comfort her and...I, sort of, can't do that sometimes with her, because she won't even let me, sort of, cuddle her...

**What do you do, then? If she's upset and she's not letting you near her, what do you usually do if she gets upset?**

C: When she's upset like that, um, I just say to her, um, you know, "I'm here, Ellen, if you want to talk about it, I'm here", but that's about all I can say to her because if you say too much...you'll have a big, massive mouthful back, so I just let her, normally, calm down a little first because the anger is the first response rather than anything else, so it's usually when she's calmed down, then, that whatever is upsetting her, I can then, sort of, um, approach with her and, yeah'

Carrie reports here she tries to help but gets rebuffed, yet from Carrie's account of Ellen's attachment behaviour it would seem she has to go to extreme lengths to get her care needs met. Reading between the lines, it might actually be Carrie is inconsistent in her care-giving and emotional availability due to the overwhelming experience of her pain-condition, forcing Ellen into ever more extreme behaviour. It would seem that Carrie's responses to her child's pain complaints may take path two where, because she is constantly in pain, she is distracted, and therefore has less capacity to consider Ellen's pain and distress.

**8.4.1 iii. Attachment – Relational Formulation.** Carrie seems helpless in the face of what she experiences as overwhelming parenting. It seems to take dangerous events to

make her feel ostensibly in control, useful, and seemingly loved and needed. She seems exhausted, her love for Ellen nearly worn out.

Carrie appears to find it difficult to take her children's perspective, and this impacts directly on her relationship with both of her daughters. Sophia seems somewhat compliant and there seemed to be some evidence of role reversal, whilst Ellen seems angry and struggling, and there is evidence of real suffering in Ellen's reported behaviour, but Carrie does not seem able to fully understand Ellen's need for support and care, and instead blames her for what is not working. Carrie seems to prefer Sophia, the language she uses to describe her is completely different from the language she uses to talk about Ellen. She shows real joy in Sophia, but very little in Ellen.

There may be several reasons for this. Firstly, Ellen and Sophia have different fathers. Ellen's dad is reported to have perpetrated domestic violence against Carrie, therefore it is not inconceivable that Carrie is displacing her negative feelings for the father onto Ellen. There is the same sense of negativity and exhaustion when she talks about them both, and unconsciously she may not be able to separate them, and it appears that Carrie's anger at him may have affected her feelings about Ellen. The fact that she used the word 'interference' to describe her relationship with Ellen, when she was actually referring to her ex, suggests that she has muddled feelings about these two relationships.

Carrie has obvious problems finding positives not only in Ellen's behaviour, but in Ellen herself. This may be leading Carrie to engage in social discourses around 'the bad child'. The wider discourse around childrens' 'bad' behaviour tends to pathologise the child, to construct the child themselves as deficient, rather than just their behaviour (Janzen & Schwartz, 2018). This can be seen in Carrie's language, where she finds it hard to find anything positive in her daughter, even when pressed she seemed to caveat any positives with a closely followed negative. It appears that Carrie sees Ellen herself as

‘bad’, rather than recognising Ellen’s behaviour as desperate and increasingly more complex ways of getting her attachment needs met. To do this would mean taking another’s perspective, which Carrie seems currently unable to do, to recognise Ellen’s trauma and triangulation, and to accept some part in this. This would be a very difficult thing for Carrie in the current climate, and therefore she seems to embrace the easier route of constructing Ellen as ‘the bad child’.

In addition, it is evident that Carrie experiences her pain condition as overwhelming, it seeps into every aspect of her day, pain and exhaustion doggedly tug at her constantly, tainting every interaction, so it is unsurprising she has very little resources to give Ellen the attention and care she so desperately needs. This, coupled with her depression and anxiety, explains her resigned and passive responses, it is evident she is only just managing, and needs some input to help identify how she might work towards more healthy relationships.

#### **8.4.2 Linda**

Linda has two children, Jago (12), from a previous relationship, and a younger daughter from her current marriage. Linda suffers with FMS, and there is a history of FMS within the family, her mother suffering with symptoms since Linda was a child, and her maternal grandmother. She reports Jago has reoccurring neck, back, and shoulder pain, accompanied by leg pain, stomach and headaches since he was around 8 years old, which she worries will develop into FMS. Linda has recently finished a degree in counselling.

**8.4.2.i. MotC Summary.** From a MotC perspective Linda’s parenting was considered as having *controlling* patterns, with elements characterised as ‘*enmeshed-hostile*’. However, there were not sufficient ‘high risk’ markers to warrant a high risk coding, but a borderline coding between ‘intervention’ and ‘sensitive’. When she first

described Jago there seemed some idealisation, and at times of her possibly needing him to be older and wiser than a child his age would normally be expected to be, and some evidence of possible role-reversal:

‘...he’s loving on a regular basis with myself, especially if I’m struggling, if I’m having a bad pain day, he will love and he will hug me or he will ask me if I need anything, any support or...he’ll just say are, ‘Are you in pain today, mum’, and I’ll say ‘Yeah, why’ and he’ll say ‘Yeah, I can tell, is there anything you need me to do’, you know, he, yeah, and he’s like that with his sister as well, he’s, if she’s not great’

Linda expressed anxiety over elements of his development, such as concern about how he manages socially, which seemed unnecessarily intense for a child his age.

Initially, she seemed to use aroused tones and intense connotative language, which gave the impression she was keen to get her perspective across, although this became more moderated as she felt assured the interviewer was understanding, and by half-way her approach seemed less defensive, and more relaxed. However, there remained a sense of persuasion, and some self-justifying language.

As she relaxed, Linda became better at taking Jago’s perspective, and acknowledged her tendency to be over-protective, and even needy at times. However, she generally tended to stay in her own perspective, and this may have been because she experiences her own feelings as overwhelmingly strong. Thus, her awareness only appeared to go so far, remaining typically in the cognitive realm, rather than being fully integrated. Because Linda seems to find her own feelings overwhelming, she appears to struggle to distinguish her own feelings from his, and so mentalises from her own internal perspective, meaning Jago’s effect on her becomes her reference. As his development continues, she may have to work hard to ensure she gives Jago the space he needs, otherwise he could find her intense emotional expression, especially her anxiety about his

optimal development, somewhat overwhelming at times. A more detailed MotC analysis of Linda's PDI can be found in [Appendix 15](#).

**8.4.2ii. Comfort: Illness and Pain.** Linda's apparent health anxiety seems to extend to Jago's health

**'Ok, so when you worry about him, what do you find yourself worrying about most?**

L: ...I want to say his health actually I think, and that's definitely a reflection of me, that's definitely a transference from me without a doubt, um, but it is health

**In what way health? What kind of aspects of his health worry you?**

L: Um, I'm gonna be really specific and say Fibro, I think it is a really big worry, yeah, that he will, his mobility will be, will be, or that he'll have a physical, any physical limitation, I think that's what it is, it worries me that it might happen to him'

At first this may have looked like reflection, but as she continues it becomes apparent that Linda is more likely projecting her health anxiety onto Jago

'There has been...in the last few years, um, a couple of occasions where he's burnt out, um, and he also sees, er, he goes to a masseuse I would say every two to three months, I don't do it too often, um, and the masseuse will tell me he's got a lot of build-up in his shoulders, but that could be from carrying the school bags and stuff like that, um, but I'm trying to instill in him to look after himself physically and that massage isn't a luxury and you know, if you're tense it's, it's a good and therapy is not a luxury, that's what I'm trying to instill a little bit. But it's about his health really...I'd say out of everything I do worry about it being health'

Linda acknowledges that his shoulder pain may well be due to carrying a heavy school bag, but her anxiety over his pain causes her to go to relatively unusual lengths to ease it. Most parents would generally prescribe a warm bath, possibly some Calpol at a

stretch, so this level of gravity placed on ostensible everyday niggles may well give Jago a distorted view of his own pain.

The comfort Linda offers when Jago is upset could provide some insight into how she reacts when he's ill

**'And what do you do? At that time?'**

L: I just comfort him immediately, and then talk about what it is when he's calmed down, if he wants to talk about it, um, I'll just physically comfort him more than anything, I'll, I'll, I'll, now he's getting a bit older I'll ask him 'Do you want me to hug, do you want a hug?' rather than just go straight in, 'cause it's his space, when he was younger I suppose I just grabbed him, but now I'll ask him and he, he, he always says yeah, he always says he wants a hug so

**Does that help him?**

L: It seems to. And I'll ask does he feel better and he'll say, usually he says yes then I'll say do you want to talk about it, now you feel. Get him a drink and then do you want to talk through what it is that's, that's got you like that? You know what I mean? When he's a bit calmer'

From this, it would seem the comfort Linda provides her son at times of upset appears to be adequately sensitive. It would appear he needs only to ask and comfort is forthcoming. However, if we can generalise from this and her previous comment about her anxiety over his pain, there is the chance that Linda might be a little over-protective regarding his pain complaints. So, for Linda, as a result of her own pain experience, it seems she may be more empathetic to her son's experience and expression of pain. However, although she indicates a willingness to respond to relieve his distress, it may be that her feelings around pain are so intense that she becomes somewhat over-protective and possibly somewhat intrusive, and may respond in a slightly inappropriate way. This suggests her responses to Jago's pain complaints might possibly take an intensified version

of path one, where she is hypervigilant to her child's experience and expression of pain, and responds in a possibly maladaptive way to relieve his pain.

**8.4.2 iii. Attachment – Relational Formulation.** At the beginning of the interview Linda seemed to use excessive non-verbal communications, highly aroused tone, and intense connotative language. There was a sense that she was working hard to both get her perspective across and to make a connection with the interviewer. However, as she began to relax this became a little more moderated, although she tended towards some self-justifying language at times.

When Jago was first described, Linda presented him in a relatively idealised way, with a vague sense of her needing him to be older and wiser than a child his age would normally be expected to be. There was role-reversal in her episode of 'loving' where she spoke of him supporting her and showing concern about her illness. She also seemed unnecessarily anxious about issues that are actually entirely normal for children, such as how he gets on socially. There seemed an unusual intensity about her concern for him. However, as the interview went on her representation of Jago became more balanced, and she seemed more able to take his perspective, although at times her feelings seemed so intense, she was unable to veer from her own perspective. As she discussed Jago and the outside world, there was a sense that she was aware of her tendency to be somewhat over-protective and even needy, and that she was working to correct this with the support and help of her partner and best friend. However, this awareness only seemed to go so far, and remained mostly in the cognitive realm, rather than being fully integrated. Essentially, it seems Linda may find her own feelings overwhelming and struggles to distinguish them from Jago's, with the effect that she seems to mentalise from her own internal perspective, and her reference point is the effect he has on her.

That said, she has completed a counselling degree, which seems to have given her an anchor to an alternative identity than that of 'mother with FMS'. This appears to be quite important to her and she seems to use it to generate the strength to fight against her illness. Additionally, she is able to use her counselling to help her mentalise, but this seems a struggle at times. Much of what she has learned is experienced as an external, cognitive voice, which she often presents in general terms and then dismisses on the basis of her feelings. For example, she talks of her heart vs her 'parent' head, but her 'parent' sounds like her own feelings of frustration, and her 'heart' the kind of parent she possibly feels she 'should' be, so the discourse then appears to serve to dismiss Jago's perspective and justify her response.

However, there is warmth, and a picture of their relationship emerges. She is able to use this cognitive sense of the kind of parent she feels she should be, to moderate herself on occasion, and acknowledges the impact of her feelings on him. For example, she seems aware she is projecting her health anxiety onto him and tries to assuage that by taking him for massages. How this ostensible over-reaction to niggly child pain will impact Jago in later life remains to be seen. Anger seemed to be a theme in Linda's account, her anger, Jago's anger, their anger at each other, her frustration at their relationship, and it seems this is when she is least able to take Jago's perspective. It might be that anger triggers an unconscious memory to her childhood and the violent fury of her father, causing her feelings of discomfort. She may misinterpret these feelings as being generated by the situation with Jago, meaning her efforts to behave differently to her parents possibly cause her to stick to her own perspective in order to navigate her way out of it. It is this losing of Jago's perspective in key moments that possibly leads him to complain that she is somewhat intrusive/controlling in her parenting.

Her pain was another key theme, something that comes up again and again, but it is evident that she does her best to fight the effects of her illness overwhelming her. This may also be evidence of her corrective script, a valiant effort not to be like her own mother. However, in her exertions to be open and honest to her children about herself, evidently in direct opposite to her mother, there is the chance that the ubiquity of pain talk and pain behaviour becomes normalised to the extent that Jago also may begin to display pain symptoms. This, in addition to her seeming hypervigilance to his pain and her apparent maladaptive caregiving behaviour could possibly result in Jago developing somatoform pain (Kozłowska *et al.*, 2006).

From an attachment position, Linda's parenting would be considered as having controlling patterns, with elements of possibly hostile enmeshment. Linda's reality has been one of chaos and loss and violence and abandonment, so her need to control her environment as a parent, especially a parent with all-pervasive pain and exhaustion over which she has no control, is perhaps unsurprising. Likewise, with the elements of enmeshment within her parenting, having been abandoned by her mother as a small child, and then abandoned by her father as a young teen, she may be fighting unconscious irrational fears of abandonment as a mother, and the intensity of her parenting anxiety causes her to become too involved with every aspect of Jago's life.

#### **8.4.3 Karys**

Karys suffers with depression and has FMS, which leaves her with universal muscular pain, 'brain fog', extreme tiredness, and at times quite emotional. She lives with her husband and two of her three children. Her mother has RA, OA, and also has FMS. In her PDI Karys discusses her youngest daughter, Luna (13), who has bouts of extreme lethargy, and reoccurring joint pain in her knees and ankles. Karys's AAI categorisation

was compliant/self-reliant, and her story was punctuated with instances of false positive affect, and possible unresolved trauma around family bereavements.

**8.4.3i. MotC Summary.** Karys's interview was seen as indicative of difficulties regarding risk in her parenting, overall the interview was coded as both '*unresponsive*' and '*controlling*', with an over-riding focus on her perspective and her own needs. Her interview was therefore coded as 'high risk' for Luna developing damaging attachment behaviours.

There appeared to be role-reversal throughout this transcript, so Luna ostensibly takes on the role of her mother's parent and Karys seemed relatively content with this:

K: She's not like, you know, I don't have to shout at her or tell her off and stuff, and I'll say to her "right here are your jobs for today", she'll-she, I say "they don't have to be done now, but within the next hour", she-she'll do them, I don't have to keep on to her. So'

She appeared not able to mentalise on behalf of Luna, and, for Karys, the fact that Luna does not seem outwardly upset means that she is happy with the situation, thus Luna is often left on her own to navigate difficult emotional territory. At times, Karys showed some awareness of the problems, but seemingly not enough to be able to do anything about it. Parental responsibility often appeared abdicated, for example, for Luna's birthday, Luna suggested the birthday activity herself, and brought the products. Karys idealised and eulogised about Luna's caring role, and this could potentially be very difficult for Luna to live up to. She seemed to be compulsively care-giving and appears to have been expected to be an adult from a young age (see the example of her being an 'extra member of staff' at her pre-school). However, Karys does show some warmth and glimmers of possibly being able to reflect, but at the moment it is too difficult for her to think the situation is a

problem for her daughter. A more detailed MotC analysis of Karys's PDI can be found in [Appendix 16](#).

**8.4.3ii. Comfort: Illness and Pain.** Although Luna's reported pain was not specifically mentioned, Karys did bring up pain in the episode illustrating her parenting as 'loving'

'...Luna had her period a week and a half ago, she started about a year ago, so she's not regular, and it was, it was really bad, um, she went out with her friend, and she rung me within twenty minutes, she said "I'm coming home mam, I'm not well" and she, she cwtched up on her bed by here, so I got a hot water bottle for her, I went and bought her some chocolate, made her a hot chocolate as well, I ran her a nice hot bath, I put bubbles in it and candles for her, because she loves all of that, I really tried to cheer her up, gave her some painkillers, she, a few hours later, she was alright, because it passes doesn't it, you know, but um, just, just taking care of her when, when she needed it'

This episode seems consistent with the semantic representation of 'loving', Karys seems to demonstrate real understanding and tenderness, and giving appropriate comfort to Luna in pain, providing both physical and emotional comfort. She again mentions Luna's pain when asked when Luna needs help most

**'Is there any time she needs her mum more than others?'**

K: ...it's generally around her period time, really, you know, when she's getting emotional, and stuff, but in general she's way too independent for that (laughs)...

**So, when she's like that, how do you feel...when she's feeling a bit emotional and needs her mum?'**

K: Well, I can-I can empathise with her...I can...quite easily...you know, we all been there, ant we...

**Why is it that she needs you, needs help from you?'**

K: Well, she knows I understand...yeah...big time (laughs)'

Here Karys seems to oscillate between saying Luna needs help when dealing with the emotional side to being in pain, but also, she is too independent to need help from her mum, and she seems to then revert the focus back to herself. There seems little mentalising for why Luna might need her mum at these times, which is what the question specifically asked. Karys seems to be using her own experience as a general, possibly evasive way of avoiding thinking about Luna's needs.

What Luna does when she's upset sheds some light on her attachment strategies, and possibly on her mother's general responses to her emotional needs

'K: ...She tends to go off to her room...by herself...and I gotta and-I go into her then, an-and you know, I, then-then I see her crying...and she's like "Oh hell, leave me alone"

**And how does that make you feel when you see her upset?**

K: Awful...guilty, again...upsets me as well

**Why do you think 'guilt'?**

K: Um...she's got a lot more on her shoulders than a lot of 13 year olds have (4 second pause) you know? (2 second pause) but, she say's "I'll do this" and I say "Lune, you, you know, shouldn't be doing it, leav-I'll manage" and she's like "No mam, I'll-I'll help"...

**OK, so what do you do? So, you go into her and...**

K: Yeah, lie on the bed, and cwutch up with her, and we sit and talk...'

From this episode it would appear that Luna does not look to her mum for comfort, she seeks solitude, and when that solitude is invaded the vehemence of her exclamation 'Oh hell, leave me alone' is quite telling. This could be the push-pulling of teenage attachments, the needing but also not wanting assistance from mum, and it is important to take this into consideration, however, Karys's lack of mentalising on Luna's behalf would suggest Luna might not expect her mother to be of much help during these times. Toward

the end of this section Karys does show some awareness of the problems Luna is dealing with, but there remains a sense that this is more about her feelings than Luna's. From this, it appears that Karys may take the third path speculated upon, where due to the fluctuations in her pain, Karys may oscillate between being able to provide a sensitive response to her child's pain, but possibly have less capacity to respond to Luna's pain-related distress.

**8.4.3 iii. Attachment – Relational Formulation.** It appears Karys sees Luna's independence as a positive without recognising any of the dangers. To recognise it as a sad or dangerous thing for Luna might well create a feeling of dissonance for Karys, and would require her to address it in a way that would be detrimental to her own needs, and therefore possibly her health. Evans and de Souza's, (2008) qualitative study suggested that one of the positives of having a mother with a chronic pain condition was that children were often much more independent than their peers. However, in the literature review, it was argued when viewing this evidence through an attachment lens this independence looks more like compulsive self-reliance, which is a Type A6 strategy, and could be damaging if carried on into later life. The evidence presented here appears to back up not only what was found in the Evans and de Souza (2008) study, but also that this independence, coupled with the compulsive caregiving, puts the child at high risk of developing damaging behavioural patterns. It appears that Luna has been attempting an A6 strategy from quite a young age, however, whilst younger children do become somewhat self-reliant, the ability to employ this strategy effectively does not come into play until adolescence. This suggests Luna has been attempting to use it from before she was developmentally able to, meaning she has learned quite early on that her needs were not going to be met. However, there are likely to be benefits for Luna, as we can see, it allows her to remain close to her mother, and engenders her mother's gratitude and love. It may also afford Luna a special standing within the family, especially since she is the youngest

of three, and allow her to feel grown-up, which being 13 she may have the ever present desire to leave childhood behind. Whilst Luna may seem complicit now, there may be stormy time ahead as she gets older and her own needs become more dominant.

So, from an MotC position, Karys's parenting would be deemed both unresponsive and controlling. However, Karys's reality means she is continually distracted by the all-encompassing pain, forcing her to focus on her own needs. She is unable to see past the pain she is enveloped within to view her child's emotional needs clearly, but from the glimpses of reflection within her discourse, Karys probably would rather the situation was otherwise. The evidence gleaned from her interview suggests currently Karys is unable to reflect fully on how her pain condition might impact her child now, or how it may affect her in the future.

#### **8.4.4 Analie**

Analie suffers with RA causing severe pain and swelling in her joints, had a hole in her heart as a baby, and Osgood Schlatter's disease as a young girl which forced her to give up an early career in ballet. She lives with her husband and their two children, and her PDI discusses her son, Chico (9), who has recurrent, non-specific pain. Analie's AAI was complex, classified as reorganising from compulsive compliant/self-reliant, with some aggressive/feigned helplessness, to reserved secure. She described an often conflict-ridden childhood, how her parents were in deep mourning for her toddler sister when Analie was a baby, and as a result her mother left when Analie was 12.

**8.4.4.i. MotC Summary.** Analie's interview orientations towards Chico appeared to be a combination of being emotionally disconnected and not readily available to meet Chico's needs. Her leading dispositional representations regarding him were '*controlling*', in ostensibly wanting or needing him to be what she needed and wanted, as opposed to

putting his needs first. However, she also appeared to show some indications of a more 'unresponsive' pattern, where she seemed to withdraw from taking responsibility for Chico and their relationship. The interview was coded as 'high risk' for Chico developing damaging behavioural patterns.

While there were signs of understanding of Chico's needs, this interview seemed overwhelmingly about herself and her needs. Analie appeared a highly anxious mother, although at times she was able to acknowledge his emotional needs. Her expectations of a nine-year-old seemed very high, and at times she appeared frustrated when he behaved as a child

'I know I'm strict...and...sometimes...it has also led to sort of...um...hiding things?...'cause he'll do stuff that he knows is wrong...and th-then he'll hide it...um...because he knows that I won't-he knows there is consequences to actions as far as I'm concerned...um so, if he eats all the biscuits in the biscuit barrel (laughs) he will be in trouble for it, so he hides the biscuit barrel (laughs) (5 second pause) which then gets him in trouble twice (laughs)'

Analie seemed to struggle to distinguish the difference between her feelings and what Chico's might be, and although she tried, she did not always seem able to fully mentalise on his behalf. There appeared quite a lot of suppressed anger/frustration at Chico, which she seemed to mask using laughter. There was the sense that Analie believes herself to be a good parent and seemed to try to persuade the interviewer of this.

Chico appeared to choose things his Mum wants and wanted for herself, rather than what he might actually want, possibly in an effort to please and take care of her emotional needs; e.g. ballet training. Analie ostensibly struggled to focus on Chico when talking about a memory or episode, and often veered off to talk about her needs/her condition. Overall, she tended to lack reflective integration. For example, during the interview she described a time that would have been very difficult for Chico, but at the end of the

interview mentioned how he has had no set-backs and how he has had a 'charmed' life. A more detailed MotC analysis of Analie's PDI can be found in [Appendix 17](#).

**8.4.4ii. Comfort: Illness and Pain.** There were examples in this, and other interviews, that despite their own pain some mothers found it difficult to identify with, or be sympathetic to, their children's pain or illnesses. Sometimes this was exemplified by using evocative and negative images which objectified them as a 'drama queen', for example. The MotC would refer to this as objectifying imagery

'...(sigh)...he's a terrible drama queen...terrible, and um and a lot of the time, unfortunately, it comes down to pain. So if he gets hurt, he can't...he, he fi, he finds it very hard to see the difference in between a little bit of hurt...and a huge amount of hurt...um, and to try and calm him down and deescalate...i-is a hard thing, and he finds that hard...'

Analie seems to find his pain deeply frustrating, almost as if she is annoyed by his need for comfort. It is not inconceivable to assume from this episode that Chico escalates and exaggerates his levels of pain in an attempt to force his mother into giving him care and/or comfort. Unfortunately, Analie seems unable to mentalise on his behalf when it comes to pain, and it appears that his pain catastrophising irritates her. The MotC would view the initial sigh as a controlling marker, and underlying anger/frustration towards him. This becomes a little more explicitly apparent when she returns to the issue of his pain when asked what she likes least about Chico

'He has to win, has to have the last word has to, yeah...(laughs) um yeah, I, I, I find that difficult (2 second pause) and I find his reaction to pain very hard.'

In addition to this quite unambiguous example of her reaction to Chico's pain complaints, Analie's account of what happens when he is upset also helps shed light onto what comfort might be available to him in times of pain, illness, and associated distress

'...he quite often takes himself away um...he's not upset all that often he's a very-he's a very-he's got a very sunny

disposition um...but if he's...yeah when he is upset he'll go and take himself up to his room and...go and read a book or lie on his bed'

It would appear Chico is quite reliant on himself for comfort, and supplication to a parent may not be his initial strategy. He may find her rebuffing of his pain-signalling confusing, especially as it appears from Analie's account that he takes her pain so seriously. This could well subliminally tell him that his pain and affect are not important as that of others and lead him to repress affective information and pain signals in the future. Analie's apparent acceptance of the status quo may be interpreted by the MotC as possible abdicated parental responsibility. From this it is relatively clear that Analie takes path 2, where she is in such constant, overwhelming pain that she has less capacity to consider Chico's pain and distress.

**8.4.4 iii. Attachment – Relational Formulation.** There are several instances where the MotC would refer to Analie as abdicating parental responsibility, and it may lead to an example of where premature independence is being pressed onto Chico due to the situation created by her pain condition (Evans and de Souza, 2008), and it is certainly the explanation Analie offers for it. There are also instances where Analie is possibly less than aware of Chico's zone of proximal development, that what she's asking of him may be developmentally beyond him, and when he fails to carry out the tasks he's been allotted, she sets cognitive-driven punishments.

However, it could be said this lack of patience may be propelled by the intense pain she is constantly in. At these times, her temper and patience are entirely eaten up by the interminable pain, leaving her no room to mentalise on his behalf. She expresses deep shame at the fact that Chico feels compelled to help her when she is struggling, as if she is painfully aware of the role-reversal and that it is mortally wounding to her. Despite her physical disabilities and debilitating pain, her apparent repeated efforts to show her

usefulness, and skill at being a good teacher and mother, attempt to demonstrate she is still able to conform to the wider discourses and social construct of what constitutes being a good mother.

Chico seems to want to please his mum. He takes ballet lessons and cares for her when he sees her struggling with her pain, however, his young age does not always allow him to carry the heavy responsibility often landing on his young shoulders, and, from Analie's account, it can appear that sometimes his fear of the ensuing punishments may make him hide his mistakes. This was seen when Analie mentioned how he hid his shoes because, being unable to tie his laces, they were consequently full of knots. This behaviour may indicate possible failed efforts at self-reliance, and compulsive compliance/caregiving.

#### **8.4.5 Zia**

Zia lives on her own with her two daughters, she suffers with relatively well managed RA, which means it leaves her with inflammation, pain, and stiffness in her joints. Zia's marriage to her girls' father was abusive, which led to an extremely acrimonious separation and bitter custody court battle, which Zia still seems affected by. Her PDI discussed her youngest, Tania (aged 9), who suffers with eye pain, headaches, and a 'fizzy tummy', has reoccurring temper tantrums, and suffers from poor eyesight, sensitive skin (eczema), and being overweight.

**8.4.5i. MotC Summary.** Zia's interview was coded as *adequately sensitive*, with predominantly sensitive patterns in her parenting, but with some unresponsive and controlling markers. She reported a traumatic separation from her children's father, including an extremely bitter custody court battle, and aspects of this appear unresolved and her strong feelings around this remain present. Ultimately, though, Zia is able to hold

Tania in mind, and reflect on how her relationship with her childrens' father and her pain condition impacts them:

'...was I at a place in my head when she was born that erm...I was going through absolute...my ex-husband was i-y'know, he'd never hit me or anything like that, but he was real-really hard to live wi-er-er you know, you-er...you never really knew which way the wind was gonna blo-so there was a lot of that sort of (sighs) static tension all the time...then you've got all that in your mind about, you know "I've just had two young children, how can I have got this so wrong" (laughs)...and so my mind probably wasn't solely on my new baby and I had a 20 month old as well, so they were quite small...erm...so...d-did she feel rejected emotionally, may-y-maybe there was-I just wasn't there for her at times emotionally, 'cause I was too busy trying to deal with myself'

Zia finds Tania's behaviour challenging and is not always able to cope. However, she seems very aware of this and how her difficulty in coping might impact on Tania. A more detailed MotC analysis of Zia's PDI can be found in [Appendix 18](#).

**8.4.5ii. Comfort: Illness and Pain.** Whilst no direct comments were made to Tania's specific pain complaints, information regarding the reaction she might receive when she's poorly can be gleaned by looking at the comfort Zia offers when Tania is upset.

'...it can go one of two ways, it th-so now she's got more of the strategies she'll either say "I'm going upstairs for some time alone and nobody must disturb me" (laughs) we get that, or...er...she...er will go into that er-er that sort of argumentative...zone, where I...st-stay quite calm, I think, and reason with her...I try to make it easier by either we move rooms or we-er-there's the slightly distract technique "Now, do you want a drink now or are you, you know, what-what we doing, or you going to watch the telly" so I try to give her opportunities to come back from that, and quite often she will respond to that, so she does erm so she gets out of it quicker now than she ever used to...'

What is interesting here is it appears that Zia has interpreted 'upset' to mean 'angry', rather than distressed, frightened, or sad. Her response to Tania being upset/angry

seems to be quite cognitive rather than taking Tania's perspective, or even asking what the root of the upset/anger might be. This might possibly be a factor in the perpetuation of Tania's 'anger' issues. Although there is thought into how to defuse a potentially volatile situation, from this comment there appears to be little comfort given, or even thought of as being necessary. Further information about the comfort Tania receives when she's in pain or poorly could be gathered from the question of what happens when Tania needs attention

'...when it comes into her head I think (laughs) is when she needs it erm a-and then she needs it at that moment...erm and so it's...er-erm...there are times that I c-that I know will come, so when she comes back from her dad's, you know, I know that after school on a Monday when she's been there for the weekend, it's a really good thing to put me and her, just for half an hour, we'll have drinks at the kitchen tab-you know, so I can pre-empt those ones, I know when they're coming erm...when she's indicated that...she's thinking about something, or there's something unsettling, so might not just be th-that might be something that's happened at school, so I know she needs my attention for a bit then...'

From this passage it appears that Zia sensitively anticipates when Tania might need her attention and possible comfort, and although she does not explicitly mention comfort, her attendance to Tania's needs implies comfort will be offered. Time is set aside for the pair of them to spend time after school where Tania can express any worries or concerns. From these quotes it might be gleaned that although Zia finds Tania's expression of anger difficult to deal with at times, she is sensitive to her daughter's worries and fears, and is appropriately comforting. Consequently, it might be argued that some form of relative transferability can be applied to infer how Zia might manage Tania's pain complaints, and deduce Zia is likely to offer appropriate comfort and care. Therefore, taking into consideration Zia's sensitivity to Tania's need for attention, and the relative manageability of her pain condition, it is likely that Zia's responses to Tania's pain complaints takes path

one, where she is empathetic to her child's experience and expression of pain, and shows a willingness to respond sensitively and fully to relieve her child's distress.

**8.4.5ii. Attachment – Relational Formulation.** Whilst there is no direct mapping the MotC onto the AAI, certain aspects of Zia's reorganising attachment strategies are hinted at. Such as seeing Tania's anger as almost beyond her, feeling like opting out when things become too much, and possibly aspects of her unresolved relationship conflict, or at least where she felt powerless within the relationship and its consequent breakdown. This sense of powerlessness and lack of agency were also reflected in the early passages where she describes her response to Tania's anger. Zia's later ability to make use of the interview and interviewer to reflect, echoes the reorganisational patterns seen in her AAI.

What is evident is now that Zia has had some space from the relationship conflict, she has more resources and emotional availability to be able to reflect on both the difficult and the positive aspects of her relationship with Tania. She is able to reflect on what her own reactions are and what Tania's are, she is able to thoroughly mentalise on behalf of her child, and to produce nuanced, balanced, and insightful episodes that reflect this. It may also be that because the intensity of her pain is managed relatively better than the other mothers in this research, resulting in lower perceived pain levels, that this gives Zia further resources to put towards reflecting on her child and their relationship. From Zia's account, it seems that even during a flare up, she does not seem to be totally overtaken by the pain, it does not seem to be as all-encompassing as some of the other mothers in this research. She does get some respite and flare ups do not seem too frequent, giving her space to put to her children

What is apparent though, is that this is a well-functioning relationship where it may not always have been, and it is evident that Zia has put, and continues to put, a lot of work into making this happen.

## 8.5 Discussion

With the help of the MotC analysis of the PDIs, this chapter focused on how participants viewed their relationship with their child, and the meaning they attributed to their child's behaviour. A particular focus of this chapter was to consider how pain and discomfort might be managed within this relationship, especially considering the mothers' lives are permeated with pain. It was suggested that the mothers' dispositional representations and responses to their child's pain might broadly be expected to take several possible paths:

1. As a result of their own experience of pain they are more empathetic to their child's experience and expression of pain, and indicate a willingness to respond sensitively and fully to relieve their child's distress
2. Because the mothers are constantly in pain they are distracted and therefore have less capacity to consider their child's pain and distress.
3. However, a third possibility is that the mothers may oscillate between these two paths.

After careful consideration of how mothers reported responding to their child's upset and pain complaints, it appears their response paths mainly diverged into variations of the first 2 paths; those taking variations of path 1; Zia, and Linda, with Linda taking an intense, over-protective form of path 1. Mothers taking path 2 included; Carrie and Analie. However, one mother appeared to take path 3; Karys.

Path 1 - From her account it would appear likely that Zia responds in a sensitive way. Her attention to Tania's needs, and her own relatively well managed pain condition point to appropriate caregiving to Tania's pain complaints. Linda's responses are a little more complex. It would seem that her dispositional representations tie her past experiences

of FMS to her ongoing responses to her child's pain complaints. That is to say, her behaviour is organised in a progeny-protective manner. Therefore, due to her own FMS experiences, including the transgenerational form in which it manifests within her family, she has become hypervigilant and over-estimates the threat of Jago's pain complaints, resulting in an ostensible over-reaction, and placing over-importance on seemingly everyday child pain niggles. This then might be evidence for a fourth response path; one of hypervigilance due to parental health anxiety, precipitated by their own pain experiences.

Path 2 - Both mothers, Carrie and Analie, appear to find their own pain experience as overwhelming and are so preoccupied with their pain that they subsequently have few resources left to attend to their childrens' pain complaints and bids for attention.

Path 3 - Ostensibly, although Karys appears preoccupied with the effects of her pain condition, she seems to oscillate between paths one and two. Whilst she cannot countenance the effects of her condition on her child, she seems able to provide comfort and care when Luna complains of pain. However, there does seem evidence to suggest she is unable to manage Luna's pain associated distress, and Luna does not seem to look to her mum for emotional comfort.

This study does two things; an attachment theory informed analysis of the PDIs, but combining it with a wider recognition that childhood and unconscious processes are not the only influences on behaviour/discourse, but also the sense of having a flawed, inadequate identity, the mother they feel they should be, living up to the wider social discourse around what a good mother is.

Attachment theory uses neuroscience and information processing models, which leads the language to seem somewhat pejorative and positivist at times. It can seem as if it is asserting that individuals 'are' their attachment classifications, with prescribed behaviours, predictions, and origins. However, we can never be truly sure of what is in a

person's mind, what their intentions are, or what subjective stories about their lives actually are. By employing a social constructionist perspective, we can shift the focus to the individual's reality, their truth, what life is like for them personally, which may be slightly different from the reality or truth of the other individuals' within their stories, but are nonetheless valid and truthful. By viewing the mother's discourses as their own realities and truths that are constructed within and against the framework of their environments, we can move onto viewing their children's realities and truths as just as valid, even if they may seem contradictory.

The mothers seemed to use other discourses to lessen the psychological impact of not meeting the socially constructed ideas of what a good mother is, essentially meaning they used language as performative action. Either through using wider discourses of 'the bad child', constructing alternative identities through their study, work, talents, and skills, or by using over-praising language of 'the angel child'. The action these discourses performed was to shift the focus from 'failing' as the socially constructed idea of what a mother should be, to a more useful, palatable, and attainable version of themselves.

Linda, Analie, and Zia re-invented new identities for themselves as scholar, creative talent, and altruistic charity worker. By focussing on these alternative, successful identities, their pain-induced inability to be the mother they wish themselves to be can take a lower place, and becomes a useful strategy. For Carrie and Karys, they still solve the conflict of trying and 'failing' to live up to discourses of being a good mother, but they do so through their children, albeit via polar paths. Karys cannot allow criticism of the daughter who does so much for her and assuages the guilt and role-reversal through an 'angel child' narrative, whilst Carrie does this through a 'bad child' narrative.

Whilst this use of other discourses was not observed in FMS mothers in the exploratory study of this thesis (Chapter 4), there was similar strategies seen by RA mums

in the same study, and in a study of Korean women with RA (Hwang, Kim, & Jun, 2004) where the women were described as adapting their approach or adjusting expectations, in the form of searching for positives in their situation, or focusing on or setting of goals, goals such as study, creative outlets, or through work. Further research in this area, the success of this shift in focus and use of alternative narratives, and what stops other women with chronic pain from achieving this, might be useful.

In a wider social context, there is a limited repertoire of discourses that these mothers can draw on to explain what is going on between themselves and their child. The MotC strongly shows how this is problematic; they are not able to mother in the socially expected way due to the limitations their pain puts on them, but also, from a social constructionist point of view, the dominant biomedical discourses in our culture limits their repertoire of discourses further. The alternative is to turn it in on themselves, resulting in a sense of blame they carry, and we see them trying to find a way of managing this in these interviews through the use of ‘the bad’ or ‘the angel’ child, or by switching the focus to areas that are more socially accepted as ‘successful’. Attachment theory can dismiss this somewhat by focussing on semantic representations, having the effect of minimising the distortions people have and how they can be overwhelmed by the more powerful unconscious layers. Attachment theory does not always give enough weight to the fact there is limited availability in our language and discourses, and that the mothers found there are other ways of understanding their experience, and the interview made that possible.

So, for Carrie, for example, the performative action of her speech was not just about her struggles with parenting Ellen, she used the narrative to draw the interviewer onside to understand how difficult it was for her, and how irrational and how difficult her child could be. So, the way language was used in her account was a contrast formulation of

where part was attempting the interviewer to be more sympathetic and form some kind of attachment relationship with her, which she probably does in an unsatisfactory way with all her relationships.

From a clinical perspective, Dr Doug Crix, one of the supervisory team and lead clinical psychologist at the RD&E Heavitree pain clinic, found the findings in this research backs up what is found in the pain clinic. Namely, how important it is for patients to feel heard, to tell their story, to have a space to allow them to make links themselves. The experience of feeling heard is particularly significant, compared with seeing their consultant for 10 minutes, giving patients the chance to understand and make sense of their experience. However, pain clinics are currently unable to provide significant psychology services. They often are unable to offer patients sufficient psychological support in an ongoing way, particularly given the volume of patients coming through services. The hope is that this research will find a creative and plausible way of doing this.

How the mums in this study respond to their childrens' pain and distress is part of how they view their behaviour as mothers, and is part of their realities. How their children view their mothers' child pain responses may, however, be slightly different, reflecting their own realities. The next chapter will consider this.

## CHAPTER 9 CHILD ATTACHMENT INTERVIEWS

### 9.1 Introduction

This chapter continues to build the case studies by introducing the data from the Child Attachment Interviews (CAI). The CAI assesses attachment representations in mid-childhood to adolescents. It differs from the AAI in that children of this age are unlikely to be able to verbalise their attachment representations fully, and so the CAI also considers elements of children's physical behaviour during the interview<sup>21</sup>. The aim of this study was to explore the children's family experiences and in particular their experience of care when ill or in pain. A tentative hypothesis prior to the start of the research was that child attachment strategies might be split according to pain condition, and that the children of more preoccupied mothers may display more preoccupied and exaggerated pain complaints. However, the MotC analysis suggested that this may be an oversimplified understanding of family attachment systems, and that far more complex underlying processes may be occurring.

Child attachments differ to adult attachment in that fewer strategies are developmentally available to them<sup>22</sup>. According to the DMM, there are 5 developmental stages that children go through; infancy; preschool; school age; adolescence; and, eventually, adulthood. This means that as the child matures, more attachment strategies become available to them. So, for the children in this research study, who are aged between nine and 15 years old, the strategies available to them range from A1-4, B1-4, and C1-6 in school-age children, with A5-6 added to their strategy range for the older adolescents. It is worth noting that children in disorganised environments may attempt to use strategies developmentally beyond them. For example, school-age children using Type

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<sup>21</sup> A more in depth discussion of the CAI and its reliability can be found in Chapter 5 - Methodology

<sup>22</sup> A more in depth discussion of child attachments can be found in Chapter 2 – Conceptual Framework

A4 (compulsive compliant) strategies may attempt self-reliant strategies (Type A6), however because this is developmentally beyond them, they will not be able to use the strategy effectively (Farnfield and Stokowy, 2014).

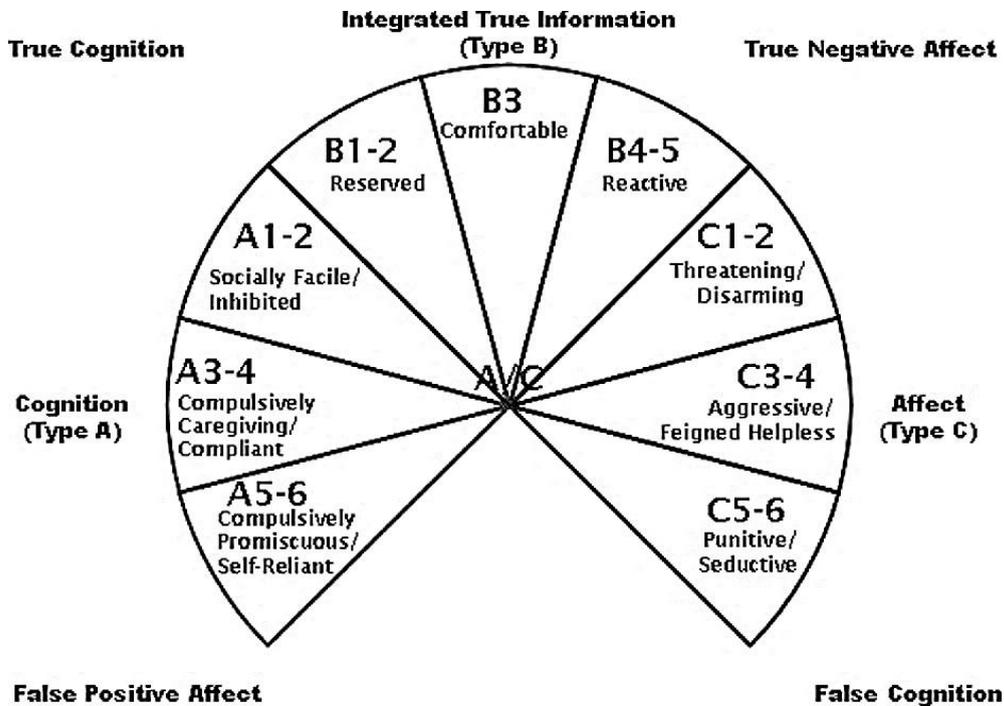


Figure 10: DMM attachment strategies in school-age children to adolescents

The aim of this study was to assess the children's attachment representations, and to understand how their experiences of being parented might differ from their mother's experience of parenting them. Of particular interest was the children's experience of being in distress, in pain, or when ill, and how they described signalling distress, requesting care, the care they received at such times, and how they behaved if there was an incongruity between requesting and receiving care.

The CAI transcripts were blind coded by Prof. Rudi Dallos<sup>23</sup>, meaning he was initially unaware of which pain group each child belonged to. The transcripts were analysed further by myself, with support from my supervisors (RD and JS), who have

<sup>23</sup> Prof. Dallos was the second supervisor and attachment expert for this PhD research project

trained in the CAI analysis, and elaborated within a broader discourse analytical framework.

## **9.2 Case studies**

Four children were interviewed using the CAI. Initially, all five children of the mothers participating in this research had agreed to take part. Later, two children withdrew; Karys's daughter, Luna, and Clarisse's daughter, Ellen. Luna withdrew as she did not feel comfortable talking to an adult she was not acquainted with, whilst Ellen became unavailable, however, she eventually participated later in the research process.

In accordance with the NHS and Plymouth University ethics guidance, all four children were given the option to have their mothers present during the interview. All four children requested their mums remained in the room with them. Three mums chipped in to correct their child's 'incorrect' memories, and all four assisted when their child asked for confirmation or assistance with memories or episodes, etc. Whilst unsolicited maternal interjections were revealing at times, what was also revealing was when mums did not interject to correct, such as when children described where they received physical but not emotional care, thus confirming their children's statements of lack of maternal care.

## **9.3 Child Attachment Interviews**

### ***9.3.1 Carrie's Daughter, Ellen***

Ellen was the eldest child participating in the CAI, being 15 at the time of the interview. This was because the initially scheduled interview had to be cancelled because Ellen moved to her father's due to friction between her and her mum. She later returned briefly, only to move back in with her mother's sister, again due to friction having escalated to violence from daughter to mother (as reported by mum). Ellen returned at the

beginning of the Coronavirus lockdown and requested to do the interview. By this time Carrie, who suffers with FMS and coexisting depression and anxiety, had a new boyfriend living with the family, and his presence had reportedly brought some calm between mother and daughter. Carrie described Ellen as having a weight problem, and that she is ‘always moaning that she’s aching’ all over, but Carrie believes this is because Ellen is unfit. Ellen’s younger sister, who has a different dad, also lives with them.

**9.3.1.i. MotC-CAI Summary.** Overall, Ellen’s CAI indicates a complex mixed attachment pattern. It contains elements of attempting to distance herself from difficult emotions, and to dismiss and deny her needs and vulnerabilities. However, she also indicates angry and emotionally aroused processes, including a lack of empathy towards her mother’s pain and difficulties. As is developmentally typical during adolescence, the attachment strategies are potentially in a state of flux due to the various new challenges that young people face, and also due to the increasing cognitive capacities that are developing. In particular, there is the potential for more sophisticated mentalisation and a growth of empathy, but also the potential for more subtle forms of self-denial or use of deception (Crittenden, 2006). Therefore, Ellen was categorised as having a mixed A/C pattern - anxious/ambivalent, but also with some dismissing indicators. However, it is important to note that strategies are being developed and are not yet coherent. A more detailed analysis of Ellen’s CAI can be found in Appendix 19.

**9.3.2.ii. Illness and Caregiving.** Putting together what we know from Carrie’s account of what happens when Ellen is ill or in need of comfort, and Ellen’s account, we can see there are some slight discrepancies; Carrie’s account indicates care and comfort is offered but is vehemently rejected by Ellen, whilst Ellen reports very little in the way of nurturing or emotional needs being met at such times. For example, when discussing

illness, Ellen recounted that minor illnesses are not pandered to. There was evidence of physical care with more serious illnesses, but no mention of nurturing being offered.

E: If I've got a cold, mum's like 'Get to school, I don't care, you're going to school' (*Mum laughs*) but if I'm dying of tonsillitis, which I usually am, 'cause I have tonsillitis all the time, she'll take me to the doctor's and then I'll come back and I'll just eat about three bowls of soup, because ... (shrugs shoulders) that's all I can eat

C: *What am I like with you?*

E: You just give me soup and then leave me in bed all day (laughs)

C: *And give you medicine'*

Although her mother interjected to try to hint that her caregiving is more than was being mentioned, she seemed to confirm that Ellen received physical care rather than nurturing. Likewise, with physical injury, care seems to be given, but is not indulgent in nature

'Erm (4 second pause) Depends on the injury, really, she'll either take me to the hospital, or just give me a plaster and say 'Suck it up''

Ellen gave an example of a very painful injury when she broke her finger and described her mum offering care that was met with a pithy teenage response

'She was like 'You ok?' and I was like 'Do I look ok?' ... like seriously (laughs) and then she was like 'Right, ok, well is it still hurting?', I was like 'Yeah! Why d'you think I'm crying?' and then she took me to hospital'

In this account Carrie seems to make a tentative attempt at enquiring after Ellen's emotional state, presumably to gauge what care is needed, but considering (from her AAI) the lack of emotional care she received as a child herself and her own dismissing strategies, coupled with her own subjective perspective of being vehemently rebuffed by Ellen when such care is proffered, it may not be surprising that their accounts differ. Ellen

may not recognise this tentative and hesitant enquiry as an attempt at nurturing, and so derisively bats it away as seemingly stating the obvious. Carrie, on the other hand, may be hindered by not having learnt how to manage emotional situations as a child and Ellen's perceived rebuff may be further evidence of rejection for her. From Carrie's PDI account of Ellen's illness behaviour (faked pregnancies and overdoses), this mis-cuing from both parent and child appears to have had the result of Ellen feeling the need to escalate her exaggerate her experience in order be heard above her mother's own pain. This escalation of symptoms, coupled with her A/C attachment strategies, could possibly lead to a later generating of medically unexplained pain in a similar vein to her mother and grandmother.

**9.3.2.iii. Attachment Formulation.** Ellen's interview revealed complex attachment strategies in possible flux. Being 15, Ellen is likely to be trying out different strategies to see which fit best (Crittenden, 2006, Erikson, 1968). During adolescence there can be a period of exploration within relationships, including rules of the relationships, roles with each other, pushing 'boundaries' of what is acceptable. There can be the confusing feeling of not quite being an adult, but also no longer being a child, which leads to the desire for physical and emotional independence, but also the need to still be cared for. During this time young people may request help from parents in managing their difficult feelings, and there can be a pattern, as with Ellen, of experiencing some reassurance through sharing these, but without resolution nor a sense of self-efficacy in their own ability to manage them. In effect, the parent can be in a position of left 'holding' the young person's feelings, whilst they deny their vulnerability by saying 'It's fine'. This pattern appeared to be a repeating one with Ellen, and it may be a demonstration of using her mother as a secure base, transferring her emotion onto her mother so she can be free to go out and reinvestigate the world. So, the kind of push-pulling volatility seen in Ellen's account is partly characteristic of teens. Their ability to reflect and integrate is developing,

but not yet in place, so whilst a lot is often made of teens becoming difficult and stroppy, it is often more that the system is still finding its balance, and they still require the parent to help manage and regulate emotions.

However, Ellen seems very triangulated, her parents are separated but conflictual. She sees her dad more as angry and mum as vulnerable, and the triangulation seems to lead to her being in a somewhat adult position at times. There is a sense of bravura, that she does not need comfort and does not show her vulnerability, but her mum in particular points out that at times she is emotionally needy, and this suggests an element of self-reliance. However, this could also be evidence of hostile and rejecting parental mentalisation of a child, all children are 'needy' but continue to demand if the need is not met. Self-reliance makes sense in context of Carrie's illness that Ellen has to withdraw into herself at times, yet interestingly she does not mention her mother's significant pain condition at all. In return, mum's response to Ellen's illness seems to be to provide practical care, whilst emotional care and nurturing appears to be minimal. Carrie's own experience of illness as a child was the opposite, it appeared to be the only bright spot in a fairly grey account, but it may well be that because she experiences her FMS as quite overwhelming and debilitating, she may not have the resources to provide the added emotional care that Ellen may need. Possibly as a result, there does not seem to be any sense that Ellen comes to her mum for comfort, she dumps things on her mum, and moans about friends with her, but there is no sense that she experiences any real comfort from that.

Despite past conflicts with her mum, Ellen's parents appear to be viewed as friends rather than having a parental role; 'chatting nonsense about' her ex-best friend with mum, sitting in the garden drinking with dad, dad shouts and the argument is resolved with a wrestling match. From Ellen's descriptions, she appears almost to view her father like a boyfriend; she appears jealous of his wife and prospective new baby, she can talk to dad

like a best friend as long as it is not about boys. At times Ellen appears as if married to both mum and dad, creating a very triangulated position. Ellen displays some pre-occupied (C) patterns where talk with parents (introduction of cognitive information) does not appear to be helpful as she may experience her parents as unreliable and talk cannot be trusted. Additionally, a triangulated position for Ellen seems likely as her parents appear to be more concerned with their own point of view to see the impact on their child.

Overall though, there is a sense that laughter and teasing is the main vehicle for conflict resolution, and there does seem to be an underlying warmth in their relationships, however, the reliance on laughter does not appear to lead to more functional strategies.

### **9.3.2 *Linda's Son, Jago***

Jago is 12 years old and lives with his mother, Linda, his stepfather, and younger sister. His father lives with his girlfriend, and Jago stays with them every other weekend, and during school holidays. His mum suffers with FMS, and is fearful that Jago's reoccurring neck, back, shoulder and leg pain, and stomach and headaches are the beginnings of FMS. He also has a diagnosis of what his mother calls Perfection Personality Disorder<sup>24</sup>, asthma, and a blood clotting disorder called Factor V Deficiency. He describes himself as high achieving. When asked, he said he preferred to have his mum present during the interview.

**9.3.2.i. MotC-CAI Summary.** Jago's CAI suggested a boy older than his 13 years with use of some analytic and psychological language, and slightly defensive body-language. He seemed to provide very few examples of the semantic representations he offered, and his mum tried to supply some of these for him. He tended to dismiss emotions, but did eventually include some statements that recognised his feelings about

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<sup>24</sup> No reference to Perfection Personality Disorder could be found in an online search to gain clarity

parental separation. Very little anger was expressed, although there was a slight hint of anger towards his step-father, but this was limited, and whilst few conflicts were mentioned in Jago's narrative, where they were discussed there was no mention of resolutions. Therefore, Jago's interview indicated a dismissive attachment style with his mother, and a slightly less dismissive attachment style with his father. A more detailed analysis of Jago's CAI can be found in Appendix 20.

**9.3.2.ii. Illness and Caregiving.** The passages regarding illness were largely dismissive and suggested little evidence of him receiving emotional care when poorly. He seemed to accept that he would be sent to school whether he was ill or not

'Erm, well, most of the time my mum tries to get me into school, she won't let me off with anything ... but if it-if it's serious enough, erm, fr-a-at one point I had appendicitis and I had surgery for that, but she- she does make sure I'm-I'm-I'm well, she looks after me ... um and she just makes sure I'm getting what I need, ee-eh-it, but if it's just a cold or something she'll send me to school'

And

'... Um, she usually just sends me to school and say "If it's bad enough, they'll send you back"'

In the first passage he says his mum makes sure he's getting what he needs, which appears to suggest physical needs. There is no explicit suggestion of her providing for his emotional needs. When he woke up with tummy pain, eventually transpiring to be appendicitis, he was still sent to school. In the explanation of what happened he agrees that that was initially the right decision. His mum being present in the interview may have caused him some internal tension regarding this, and possibly felt compelled to back up her decision. This is an important example of how having the parent present may indicate attachment strategies 'in action', for example, here he seems to be trying to appease his mother. This is something that would be seen in a dismissing attachment style

**'So, when you had appendicitis, for example, can you tell me what happened? You told your mum you had a pain in your tummy, what happened then?'**

J: Um, well, I-I did wake up with a pain in my stomach, well, what I thought was my stomach, but it wasn't serious enough, even I knew it wasn't serious enough to not make me go to school so ... she gave me some, I think it was some pain killers, and said um "You can go to school, it's not serious enough", which I agreed with at the time, and then over the school day it just got worse, and worse, and worse, and I realised there's something else going on here ... so ... I think ... m-I think school, I think school did eventually rang up because I just wasn't ... I just wasn't well ... and ... s-she originally took me to the doctors ... w-wwha-and when she picked me up, she-she ju-what did you think it were? Just a

*L: I thought it were-I know I thought myself it were appendicitis, the amount of pain you were in*

J: Yeah ... yeah ... so, she took me to the doctors, and they just said go to ... was it?

*L: Straight up t'hospital*

J: Yeah, straight up to the hospital, and then from there it just all unfolded, it-I did have appendicitis and within a few days I had had surgery, taken my appendix out, and for two weeks I was off school recovering'

In Linda's AAI she reported how her mother would keep her off school for any small ailment, leading Linda to fake illness to get 'that nurturing feeling', as this was the only nurturing she received from a relatively negligent mother. From first glance, Jago's mum's attitude could be seen as somewhat uncaring, but taking into account her mother's behaviour when she was ill as a child, where she would pander to any minor ailment, and Linda's AAI corrective script, this can be taken as an attempt to not be like her mum in any way whatsoever, but possibly, in the effort, going a little too far the other way. It seems her representations informing her parenting, and in this instance, potentially putting Jago at risk. From a social constructionist point of view, this attempt to be different to her own mum, could be viewed as Linda trying to conform to the wider discourses around being a good mother.

Being asked how he felt when sent to school when he was poorly seemed to cause some dysfluency, possibly appeasing or exonerating his mother

‘Um, yeah, I-I-I know what you mean, I, um, when-when she sends me to school, I-I-I, my original thought is “I’m not well enough but sure, okay”, but I mean aft-most of the time she’s right, and then halfway through the day I do feel ... much better, but there are times where halfway through the day I feel much worse ... and I feel I really shouldn’t have come to school today, so it’s-it’s-it’s just depends on ... if I get better, or worse throughout the day’

When asked whether his mother looks after him when he’s poorly, he seems to evade the question and veer off into seemingly irrelevant detail

‘It-it generally depends on ... whether she needs to go out or not. Um, I usually just lie in bed for like half the day, and then after a while, from just relaxing, or just er l-er, sleeping, I, most of the time I actually can’t physically get back to sleep, so I have to get up and, I feel like I have to get up and do something ... I usually just uh come and get on my pc, or just go on my phone for a bit, because I j-I can’t, I don’t feel like I can do much else, really’

When pressed further, he again mentions practical care

**‘And does your mum look after you when you’ve got a nasty cold?’**

J: Erm ... when she-yeah she, if she has to go she’ll obviously give me ... um, some medicine and she’ll tell me to, when to, um, she’ll like, tell me when to eat, or what I should eat, mainly if I ask, and if she is home then she’ll ... she’ll definitely look after me, yeah, she does, no, she will look after me’

Jago’s account of what happens when he is ill seems at odds with Linda’s account of her health anxiety for him and the possibility that he might develop FMS in the future, which seemed quite pronounced in her PDI. Her dismissive attachment style might be preventing her from displaying what she feels when he is ill/in pain, meaning Jago may not be experiencing being nurtured and emotionally cared for when he is ill.

**9.3.2.iii. Attachment Formulation.** Jago described himself as a high achieving boy and mentioned several instances of being anxious over his schoolwork and results. His narrative sounded older than a 13 year old, with some use of analytic and psychological language, and slightly awkward body-language at times. He had very few examples to offer, although his mum tried to help in this regard, and he seemed to have a limited emotional vocabulary. There were times when he would mention experiencing some negative emotion, which was followed by a cut-off, or the situation magically seemed to resolve itself. As a result, it appeared as if he tended to dismiss emotions, however some statements did eventually recognise separation and feelings.

His relationship with his mum seems to be influenced by her corrective script, and her attempts to be a better parent than she was parented. He reports several instances of her telling him off about school and homework, and she appears concerned with his behaviour and achievement, which may be pushing his need to achieve. His mother's corrective script is seen most clearly in the passages concerning him being ill or hurt. Although he reports her caring for his physical needs, making sure he has food when he's ill, or telling him to get a plaster, there was no clear reports of provision for his emotional needs or providing comfort. This coupled with his mother and grandmother's anxiety over his pain and the possibility of it developing into FMS, which did not come up during his CAI, could possibly implicitly convey to him that the only negative affect that is permissible to indicate is that of pain, and possibly put him at a higher risk of exaggerating pain signals as he develops.

### **9.3.3 *Analie's Son, Chico***

Chico is nine, and lives with his parents and younger sister. His mum suffers with RA, and Chico has non-descript, widespread reoccurring pain. His mother reports that he

has been ‘head hunted by the Royal Ballet’ and may go to ballet school with them in London when he is ten/eleven. Chico’s parents appear to be relatively wealthy, middle class, high achievers. When asked, Chico preferred to have his mum present during the interview.

**9.3.3.i. MotC-CAI Summary.** Chico came across as a quiet, compliant boy, and there seemed to be a slight role-reversal in him worrying about his mother’s disability. He reported being unable to feel safe or relaxed until he is home from school and can see for himself that his mum is ok, and it appears he suppresses his own emotional needs in order to not overburden his mother. During the interview Chico had a characteristic of pulling very expressive and over-exaggerated emotional faces. This would make sense if mum is a little unresponsive, by over-exaggerating his facial expressions it may be a way of signalling how he is feeling to ensure it would not be misinterpreted. Correspondingly, in her PDI, Analie seemed to rely on outwardly displayed affect in order to gauge her children’s feelings. Chico’s interview indicated a dismissing, compliant attachment style, with some preoccupying markers, for his mother, and a dismissing attachment style for his father, and it was evident how his compliance fits in with his mother’s controlling-withdrawing MotC classification. A more detailed analysis of Chico’s CAI can be found in Appendix 21.

**9.3.3.ii. Illness and Caregiving.** Chico gave the impression of having to be self-reliant when he talked about being ill

‘I get sent up to my bedroom and I usually spend the day in bed’

He uses the phrase ‘sent up to my bedroom’. This is often how children describe punishments and implies being up there alone with no comfort. He expands on this a little more when pressed

**‘Ok. So, you went to bed. So, you got sent to bed, is that right? And um, what happens when you’re in bed? What happened? Were you just in there? Did somebody come to look after you or?’**

C: No. I just had the Ipad. And some water’

His short reply above appears to confirm he receives little or no comfort when ill, just practical provision. Analie did not interject to correct this point confirming the veracity of this implication, again, not seeming to realise she could or should respond differently to his illness. Chico reported a similar situation when he hurts himself

‘If I’m bleeding or I had cut myself I’d have to go get a bandage. But if it was just a odd bump I would usually just get myself back up and carry on what I was doing’

There was no mention of him approaching his parents for help, in fact he says, ‘I’d *have* to go get a bandage’, which, on the surface of it, seems to imply seeking comfort is not his first thought. He also says he would get *himself* back up, rather than any implication of parental help. He later reported being hurt by a child at school, and had asked his mum for support, she confirmed this, however she also confirmed that, although he had been hurt twice, she was going to wait to see if he was hurt again before taking any action

‘C Straight away went and told the teacher. Teacher didn’t deal with it that well. Soon as I got home told mum

**Right. And what did mummy do?**

C: Well, if he does it again and the teacher doesn’t deal with it too well, mum will (crumples face up), mum will talk to the head (crumples face up) head mistress

**Right ok so how-**

A: *This happened on Thursday and again on Friday, so it’s very recent thing, so I haven’t followed through kind of, haven’t followed through, so yeah’*

Again, there is only the promise of practical support on the proviso it occurs again, there is no mention of any emotional care. He relays the episode in an objective, matter of fact way, but his facial expressions when explaining this indicate some possible internal conflict. Where he does use connotative language, this appears to be relatively limited, however, he is nine years old, which may have a bearing, nevertheless, for a nine year old Chico has a relatively wide vocabulary. He may feel he cannot be angry with his mum because of her disability, possibly causing a freezing of any anger. However, he did express anxiety about his mum's pain condition, and his fear appears resolved by his proximity to her, either so he has physical evidence of her safety, or so that he can be there to help

'C: I feel like something could happen to her bad when I'm away, yeah

**Oh ok, right**

C: So, I'm always quite worried and when I get home that's when I start to feel relieved

**So, you know that she's ok?**

C: (Nods)

**Yeah, ok. Um, what makes you think that something might have happened to her?**

C: Um, (2 second pause) well (4 second pause). When my, because my mum's disabled, it, it makes me feel unsafe that she's alone at home, because it's only her, and if she had an accident or she tripped or something, mm'

Disability seemed to be an important theme for Chico

'... I would not like to be disabled ... and I wouldn't like not being able to dance, and I wouldn't like not to be able to, be able to be more interactive, mm, (nods and looks at mum) interactive'

Observing his mother in pain and possibly the story of her having to give up a career in ballet as a direct result, may have stuck in his mind, bringing home the realities of living with a pain condition.

**9.3.3 iii. Attachment formulation.** Chico seemed to be a slightly sad, quiet, compliant boy, and despite generally being quite articulate, he used little or no connotative language, or images of comfort suggesting a suppression or ignoring of affective information. In possible consequence, and what appeared most striking, was the entire lack of examples of him being given emotional care, and instead he seemed to initiate the one episode of comfort he did describe. Whilst he does express anxiety about separations from his parents, these were often quickly minimised, either by himself or by his mother. It is telling that the separations he recalled involved anxiety around losing sight of his mum, either during a dance performance, or in a shop, or whilst he was at school.

Despite seeming to be a well-behaved congenial little boy, he described seemingly disproportionate parental anger being directed at him, yet he expresses no anger or blame towards his parents, and described these events as his own fault or responsibility. This may be because he feels he cannot be angry at his mum because of her disability, and indicates elements of idealisation. His slightly reversed role regarding his mother's pain condition seems to cause him a great deal of anxiety, and this seems to have made him think about growing up to develop pain himself. Evans & de Souza (2008) reported how some children in their qualitative maternal pain study experienced their mother's pain as frightening, possibly overestimating the threat to her and themselves.

#### **9.3.4 Zia's daughter, Tania**

Tania is nine years old and lives with her mum, Zia, and her older sister. Tania's mum suffers with relatively well managed RA, which leaves her with inflammation, pain,

and stiffness in her joints. After a bitter custody battle, Tania and her sister have overnight visits to their dad's home every Wednesday evening and alternate weekends, which Tania is said to find distressing. She suffers with eye pain, headaches, and a 'fizzy tummy', has some behavioural problems, and suffers from poor eyesight, sensitive skin (eczema), and mum describes her as being overweight. When asked, Tania wanted her mum to be present during the interview.

**9.3.4.i. MotC-CAI Summary.** Tania's parents are divorced, and there seemed to be some residual anxiety for her around this, as it is evident that there has been domestic violence between them. This seemed to potentially be traumatic for her, and her memories of it appeared to be blocked, or there was a refusal to engage with the memories. Her overarching emotional states seemed to be of fear and sadness, and her main strategy with her mother was to keep her needs to herself and not impose anything on her mother because of her arthritis. She engaged in considerable idealisation of her mother, yet, from her CAI, evidence for any affection or care provided by her mother appeared scant, although this was in direct contradiction to her mother's account. Tania was somewhat more able to state some negative feelings for her father, and especially her paternal grandmother, however this did not become pre-occupying blame but seemed to be expressed as fear and sadness. Therefore, Tania's interview indicated a dismissing attachment style, with some pre-occupying fear (anger) towards her father and especially her grandmother, and with possible depression. A more detailed analysis of Tania's CAI can be found in Appendix 22.

**9.3.4.ii. Illness and Caregiving.** Tania's reports around what happens when she is ill or in pain seemed to suggest she receives minimal care

'T: ... I started getting these pains in my eyes, and we went out ... and I was sick, and then I was sick another four times when I got home

**So you felt really poorly, and what did your dad do?**

T: Um, he put a bowl next to my bed in case I was sick in the night

**Did he give you cuddles and things to make you feel a bit better, or anything like that?**

T: Yeah

**What about when you're home, what happens when you're poorly at home?**

T: Um, I usually just go to my bed and lie down

**OK, what does mummy do?**

T: Um, I us-um I usually get told to go and lie in bed ... and stay'

She did not provide any details on what type of care or comfort she received from dad when she is ill, and there was no mention of comfort at all from mum, although she does seem to emphasise that mum expects her to stay in bed and not get up. This might have been Tania getting mixed up, as mum conveyed in her PDI that when Tania comes home from her dad's house she is usually restless for a few nights and gets out of bed 'nearly every half hour'.

Tania's concern for her mother's arthritis pain was quite pronounced

**'So, can you give me an example of when your relationship with your mum was loving?'**

T: Erm, when she hurts herself I get her a plaster ...

**What makes you do that, do you think?'**

T: Her arthritis'

And

**'You also said your relationship with your mum was gentle, can you give me an example of that?'**

T: Erm, if her arthritis flares up, I'm really gentle, in case it hurts erm her arthritis'

‘T: I don’t want arthritis (smiles, looks over at mum) ...  
‘cause I don’t want to get pains in my bones’

Here Tania used the example of caring for her mother to illustrate how their relationship is loving and gentle. Role reversal in this instance can indicate idealisation of the parent, and she seemed acutely aware that she must take care of her mother due to her pain condition, so much so that the roles at times seemed to be reversed, and there seemed to be some anxiety for her over mum’s pain.

**9.3.4iii. Attachment Formulation.** The tone of the interview was of a sad, lonely little girl, who was quite possibly depressed, and whose emotions seemed to be organised around protecting her mother’s illness. Tania seemed to be caught between two worlds: her father is a builder, physically active, ‘outdoorsy’, surfs and takes her surfing with him, but she seemed enmeshed with her mother who clearly was ill, and not able to be physically active, however they seemed to find crafting as a way to enjoy each other’s company in a meaningful way. Tania never mentioned anger in relation to herself, despite mum’s PDI relaying many episodes of temper tantrums, her difficulty coping with Tania’s anger, and the amount of work they have done to help Tania to manage this. Since there seemed to have been so much focus on her anger, it may be that Tania represses these feelings as she is learning it is unacceptable, and so replaces ‘anger’ with more acceptable labels of sadness or fear. Possibly, anger also generates anger or withdrawal in mum, whilst fear or sadness generates comfort or a softer maternal response. In addition, her father’s obvious anger issues may well create an intense desire to be different, thus transferring and reinforcing feelings of anger into fear and sadness. This suggests repression of certain negative affect. Her mother reported several different health issues for Tania, including that her pain ‘comes and goes, but if not displaying as pain appears emotionally’.

Kozłowska (2009) suggested that some children using Type A (dismissing) strategies, may

learn to use pain to channel certain forms of emotional distress, and this may be what is beginning to happen with Tania.

#### **9.4 Discussion**

Four children of the five mothers involved in the overall study were interviewed in this CAI study (2:FMS, 2:RA). A picture of what and how each child experienced family life revealed some similarities and differences. All the children indicated use of dismissive attachment strategies. This suggests that parents are unresponsive to, or withdraw from some displays of negative affect, and the children have learnt to organise their behaviour around the repression of those particular negative displays. Ellen, who was the oldest child interviewed and who arguably had the most disruptive home life, appeared to use distancing and dismissal of feelings of vulnerability and distress, which came across as gossamer thin bravado. Her mother's PDI indicated a lack of mentalisation for Ellen and, at times, a lack of ability to see past her own problems and pain. The effect of this on Ellen, coupled with the heavy triangulation she experiences with her parents' relationship, appears to have taught her to attempt to repress those feelings of vulnerability. However, her developing cognition may cause a tension between inhibiting her own needs, with a feeling of injustice at having to do so, which results in the oscillation between strategies seen in her CAI and reported in her mother's PDI. Teenager's ability to reflect and integrate information is developing at this age, but not yet in place, so whilst a lot is often made of teens becoming difficult and stroppy, it is often more that the system is still finding its balance, and they still require the parent to help manage and regulate emotions (Crittenden, 2006). This, in fact, is an important finding and observation; the process is something which some parents colloquially describe as 'dumping', where the child 'dumps' their emotional load on the parent, but this term may indicate minimal, and

possibly hostile, parental mentalisation, for example the child asks for support (returning to their secure base), the parent does not respond meaningfully to provide this adequately, and the child retreats. This is a failed attempt at securing reassurance and guidance, and they are both left in an unresolved state.

Jago, the second eldest at age 13, showed a complete lack of connotative language and showed flat affect across his account. This could be partly due to his age and gender, the particularly the acceptability of displays of affect for boys, however, his mother's PDI revealed elements of controlling withdrawal and intrusive parenting patterns. The withdrawal elements to her parenting would likely teach him that some negative affect was unacceptable to display, and intrusive parenting would likely reinforce his dismissive behavioural patterns. Likewise, Chico's dismissive attachment patterns through being compliant allow him to attempt to reduce his parent's anger thus maintaining the status quo. His mother's PDI showed predominantly controlling withdrawal patterns of parenting, and an inability to mentalise on his feelings, especially his distress at experiencing pain which reportedly results in her anger, and a use of predominantly cognitive-based parenting tactics. This corresponded somewhat with her AAI classification of reorganising from dismissive A strategies, which showed some aggressive patterns but relied predominantly on cognitive information, to a more balanced strategy. It is worth remembering that the MotC analysed PDI does not necessarily have a straightforward correspondence to the AAIs, and there is the potential to respond to and have different representations to each child in the family. However, in Analie's case, residual cognitive patterns can be seen in her parenting. This may mean that whilst she is in the process of reorganisation, when under pressure and/or feeling threatened – which also includes seeing Chico as a threat – information is being processed subcortically, meaning below conscious awareness. So, when she feels like this, Analie's strategies may temporarily return to what

is familiar, leading her to implement more cognitive led parenting strategies. In contrast, Tania appears to have been in the process of redirecting feelings of anger, which, from her CAI and her mother's PDI, appear to be one of the displays of negative affect that produces a withdrawal or negative response from both parents, to more parentally and/or socially acceptable displays of sadness or fear.

In relation to illness it was striking that although all the children reported receiving physical care when poorly, there was no mention of nurturing or comfort during illness. Notably, the children whose mothers suffered with FMS made no mention whatsoever of their mothers' significant pain condition, despite FMS group mum, Linda, mentioning how concerned Jago often was about her pain. On the other hand, the children whose mothers suffered with RA displayed an anxious concern over their mothers' pain, and both stated how much they would not want to develop their mothers' illness when they grew up. This ostensible lack of awareness in children in the FMS group, or complete lack of mention at least, about their mother's pain links to some findings of the online forum exploratory study in Chapter 4, and to previous research findings (Söderberg et al., 1999; Hellström et al., 1998, Gorman & Gorman, 2019), and may support the idea of families not believing, or at least fully supporting or understanding FMS pain. All FMS mothers in their PDIs seemed to describe being overtly upfront about their pain struggles, and the way this is manifested within the family may actually be different to how the RA mums display pain signals, possibly explaining the difference in their children's responses. It appeared from the RA mothers' PDIs that positive and caring responses from their children to maternal pain were rewarded with some level of sensitivity and grateful thanks, and this may reinforce the caregiving behaviour in the RA group children. In contrast, in neither of the FMS mother's PDIs was there a consistent sense of appreciation of their pain struggles

from their children, with one mother (Carrie) indicating often hostile and exasperated responses to her pain from her child.

In addition, the lack of connotative language in large parts of the childrens' CAIs may possibly be due to them not having learnt how to express emotions. Considering all the mothers were Type A, or reorganising from a Type A, thus relying predominantly on cognitive information and repressing affective information so would possibly not be able to adequately express emotions themselves, it is likely they have been unable to teach their own children how to recognise and manage negative affect (Kozłowska, 2009).

There were two important justifications and findings in having the mothers present during the CAIs. Firstly, it allowed the observation of attachment dynamics in action, and secondly, mothers' responses offered validation that the 'facts' of the childrens' accounts were correct, through parental interjections or by not interjecting to correct the child's account. Contributions from parents can be seen as exemplifying MoC patterns, some did not say much and only interjected when asked, however some mothers were more involved than others, producing some interesting interactions and real-time insight into the relationships with their children, particularly interesting are the points at which some of the mothers interjected. Two of the mothers interjected to correct their child's account, one possibly a little derisively, which seemed consistent with the 'controlling' MotC categorisation aspect of their PDI, the other to point out her daughter might be a little more vulnerable than she allows herself to believe. Zia kept very quiet, but has a background in research, so possibly has better understanding of how her presence may have influenced Tania's answers, but her MotC patterns were also sensitive, and it may have been her sensitivity that allowed her daughter to speak unhindered. In speaking to the mothers post CAI, all expressed how they found it very interesting to hear what their children had to say, and some stated feelings of pride in their children.

Differences in the way the children discussed how their mothers cared for them when they were ill/in pain, compared to how their mothers discussed providing care at these times highlights the importance of understanding dual realities and subjective experience. One's subjective experience of being cared for may actually be completely different from how one's carer may imagine they are providing care. For example, Josh indicated he received adequate physical care when ill or in pain, but the examples he gave suggested his discomfort was often dismissed, as with the instance of being sent to school with appendicitis, which later required emergency surgery. His mother, on the other hand, conveyed an intense anxiety and hypervigilance over his pain, explicitly stating her fears of him developing FMS. The discrepancy here could possibly be explained in the type of pain each were talking about. In his CAI Jago talked about his mother's reaction to acute pain, which he indicated was always dismissed, however, Linda's concern was related to Jago's persistent muscle pain in his shoulders, neck, back, and occasionally his legs, which, interestingly, Jago made no mention of. It might be that this ongoing muscular pain is more familiar to her through her FMS and thus activates progeny-protective anxiety, coupled with her MotC patterns of intrusive parenting, producing an exaggerated care response from her.

Ellen communicated how her mother dismissed her pain or illness, and although Carrie laughed, seemingly confirming her dismissal, and interjected to remind her that she provided Ellen with soup when she was poorly, she did not elaborate to include accounts of providing emotional care. Conversely, in her PDI Carrie professed to offering emotional care which was always rebuffed by Ellen. An insightful interaction between mother and daughter during Ellen's CAI provided an explanation of how both accounts might in fact intersect; Ellen recounted a story of when she broke her finger and her mother asked her seemingly obvious and silly questions, such as 'Does it hurt', which were met with angry

responses from Ellen, but in fact this may have been maladroit and misinterpreted attempts at offering emotional care. This becomes more feasible when considering Carrie's AAI, where she was not able to offer any examples of her relationship with her parents being loving, caring or nurturing (other than during illness), suggesting that Carrie may not have had an internal model to draw from in order to respond appropriately to her daughter's pain and distress, and this impairment might be what is causing the transactive miscue between mother and daughter.

How this manifests in the childrens' pain complaints can be seen from mothers' PDIs and their initial illness history reports from their PPQs<sup>25</sup>. What we see is some exaggerated pain displays for some, so for Tania, Ellen, and Chico, their mother's report of their child's pain experience seem quite intense. Tania is reported to have a variety of emotionally induced pain, Chico's pain displays are reported to be intense and difficult to manage, and Ellen appears to have to invent very intense scenarios for her mother to acknowledge there may be a problem. So, for these children it seems they may be exhibiting signs of repressed affect which may be beginning to be displayed as embodied pain. For Jago, it seems he can signal pain complaints, but certain complaints are dismissed while others are intensely focused on by his mother and grandmother. This may cause some confusion for Jago, and result in learning to over-emphasise pain that mirrors his mother's and grandmother's. Luna, although not involved in the CAIs, we know from her mother's PPQ and PDI that she has bouts of abnormal lethargy and joint pain, which her mother attributes to bereavement. This also indicates possible channelling of affect through pain. What seems to be happening with the children in this sample is that there are atypical pain processes occurring, which is directly linked to their mothers' pain and how pain and distressed is attended to by their parents.

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<sup>25</sup> The PPQs were analysed in Chapter 6 – Questionnaires but have not been individually commented on. The children's illness histories from the questionnaire have been reported in Chapter 7 – AAIs and Chapter 8 – MotC PDIs

This study highlights the importance of putting all the attachment information together to reveal a fuller picture of how pain signals can become distorted, and a fuller explanation of these findings will be discussed in the final chapter of this thesis.

## **CHAPTER 10      DISCUSSION**

### **10.1 Introduction**

This chapter will discuss the findings from each chapter and then discuss the clinical implications of these findings, finally bringing this thesis to a close with conclusions of the study. The aim of the thesis was to explore the mother-child relationship where mothers are suffering with two distinct persistent pain conditions. Specifically, a key question was how children in these relationships learn to make sense of and express their own pain. It was proposed that there are differences in how this occurs between children of mothers who have a clear, unambiguous medical diagnosis of their pain (RA) compared to those of mothers with more contested pain conditions (FSM) (contested due to their uncertain aetiology, unclear treatment, and disputed medical and cultural definitions (Gorman & Gorman, 2019)), and a key aim was to investigate what those differences were and how they manifested in behaviour.

Additionally, the research aimed to explore the possible underlying affective and cognitive mechanisms that shape how children learn to make sense of and express their own pain. Attachment Theory was used as part of a new conceptual framework as it focusses specifically on the parent-child relationship, and particularly considers how comfort is provided by the parent to the child. Further, it suggests that the way parents deal with their own pain and attempt to comfort themselves provides a model for the child regarding their own pain. It suggests the experience of pain and how it is managed includes a relational process, which is shaped by the parent's, and subsequently the child's, attachment strategies (dispositional representations).

Furthermore, the expectation, based on the available research literature of mothers' accounts of pain and coping, was that mothers with FMS would employ more preoccupying

attachment strategies due to how overwhelming they tend to experience their pain (McMahon et al, 2012), would have fewer resources to attend to their children's pain and distress, whilst mothers with RA would use more dismissing attachment strategies. These differences were hypothesised in the light of the possible differences in which FMS and RA pain is 'contested', hypothesising FMS patients would generally have more stress due to constantly having to prove their pain, meaning there would be possible differences in how emotionally available the mothers were to their child's experience and expression of pain.

However, due to early recruitment complications, sample numbers proved low. Difficulties with recruitment began with a low uptake at NHS secondary care sites, due to clinicians' heavy workloads meaning they were unable to distribute research paperwork to patients. Other recruitment methods elicited early closure from those approached, initially leading to a cautious hypothesis that many of those with contested illnesses may use avoidant defences to protect themselves from unsympathetic scrutiny. It became apparent that potential participants, including those with RA, were reluctant to come forward due to fears of being blamed, shamed, and exposed to unsympathetic and judgemental eyes. This, combined with the data from the internet forum study, led to exploration of further tentative hypotheses that mothers with FMS might be using more dismissive strategies than assumed earlier in the research, and these insecure maternal defences may negatively impact on the parent-child relationship. These hypotheses were investigated in much greater detail with multiple family case-studies once a trusting relationship was built with the few who were willing to participate. The purpose of which was to gain an in-depth understanding of the mothers' experiences and investigate whether their own pain obscured their understanding of their child and their child's pain.

## **10.2 Findings**

From the outset, this thesis had an ambition to integrate three theoretical concepts involved in the transmission of pain behaviour: current theories of the nature and causes of persistent pain, namely Cartesian Dualism, the biomedical model of pain, and the biopsychosocial model of pain; attachment theory; and social constructionism. The aim was to integrate these three perspectives to offer a new conceptual framework (chapter 2) to understand maternal persistent pain, and will be discussed later in the chapter.

The literature review (chapter 3) looked at the research available at the time of writing investigating the familial effects of parental and maternal persistent pain. The consensus was that families where one or both parents suffers with persistent pain are adversely affected, with greater levels of dysphoria, poorer family environments, and greater partner role strain. The research indicated that children in this group were at greater risk of increased pain complaints, in addition to depression, anxiety, behavioural problems, and attachment issues. Almost all the studies in the review cited social learning of illness behaviour as explanations for increased risk of developing pain in children of parents with persistent pain. An exception to this line of thinking was a study based in attachment theory by Ratnamohan & Kozłowska (2017) that found it was the quality of the parent-child attachment relationship that contributes to the development and maintenance of persistent functional pain in children. Additionally, an article by Kozłowska (2009) suggested that a subset of those with Type A (dismissive) strategies may learn to use pain to get their needs met. Kozłowska (2009) suggested that for this sub-group, pain signalling may be the only form of negative affect ‘allowed’ by parents/attachment figures, increasing the risk of developing somatoform pain. However, at that time, this hypothesis had not been specifically investigated. Nevertheless, the indicative findings of researchers in this review, and related research employing attachment theory, led to a formulation that attachment may be an important factor in the transmission of maternal persistent pain.

The exploratory study chapter (4) investigated the nature of the conversations between mothers with two distinct pain conditions, RA and FMS. Threads from four online parenting support forums, with corresponding RA and FMS pain support groups, were analysed thematically and the findings showed a number of dominant themes regarding their experience of their pain conditions; effects on family life; coping strategies; and the nature of support. Differences in the content and form of the themes emerged for the two groups: For the RA mothers' themes indicated relatively 'stoic' coping styles, whereas FMS mothers displayed more anxious and uncertain coping. In addition, these indicated differences in their linguistic styles; RA groups used relatively more succinct pain descriptions, while FMS groups used more emotion-laden pain-language in comparison. The findings indicated that perceived lack of support and preoccupation with their condition may leave mothers few resources to attend to their child. The findings were discussed in terms of how parenting responses may shape their children to inhibit affect and to express emotion through somatisation, and how attachment theory may explain some maternal coping strategies.

Chapter 6 was a descriptive exploratory chapter involving two questionnaires, the Parenting Stress Index (PSI-4) and the Paediatric Pain Questionnaire (PPQ). The PSI-4 indicated higher total stress in the FMS group, higher levels of parent-child dysfunctional interaction, and difficult child scores, as well as many more scores in the 'danger zone', meaning children were at a higher risk of neglect or abuse. Higher scores of parenting distress was found in the RA group, but this was due to one very high score in the 99th percentile, which elevated the overall score. A content analysis was performed on the PPQ findings and indicated more family related illness in the FMS group, more child and sibling mental, emotional, and behavioural issues, and more instances of reported child and sibling autism related symptoms. None of these were reported in the RA group. Several instances of transgenerational somatoform pain conditions were also found in the FMS group, as well as

maternal comorbid somatoform conditions, such as CFS. RA mums reported depression and fatigue. FMS mums reported they and their child had difficulties in coping with their child's pain, as well as their child's pain affected family relations. Additionally, for FMS mums, talk about their child's pain frequently served to dismiss or minimise, as well as rationalise it away, while both groups reported affect induced child pain. This exploratory questionnaire study promoted an intention to explore further elements of attachment theory in relation to the intergenerational transmission of persistent pain.

Chapter 7 outlined five case studies focusing on AAIs with five mothers with different persistent pain conditions; 3 FMS & 2 RA. This chapter revealed ubiquitous adverse child experiences of unresolved loss, abandonment, emotional and physical neglect, and trauma from a very young age across both groups. All the mums with FMS gave accounts of childhood illness being rewarded with nurturing and attention, these memories were often evocative and rich in imagery compared with the rest of their accounts, which often lacked connotative language and/or imagery. For all the mothers in the FMs group there were long family histories of illness, a ubiquity of illness and pain talk, and evidence of transgenerational FMS. The attachment classifications showed that all mothers used dismissive strategies as their first line of defence. FMS mothers were classified as using insecure dismissive (Type A) strategies of compulsive caregiving or compliant/self-reliant, whilst both RA mothers' attachment classifications were reorganising from insecure dismissive compulsive compliant/self-reliant strategies to a reserved secure Type B1/2. This seemed, in some part, to support Kozłowska's (2009) hypothesis that a subset of Type A attachment strategists use pain as the only allowable negative affect in their coping repertoires.

Chapter 8 was a key chapter in this thesis. PDIs were conducted and analysed using the MotC analysis, which allows a sophisticated examination of dispositional representations,

or systems of beliefs and attitudes the parent has towards their child and their relationship. The MotC analysis indicated that 4 of the 5 mothers displayed a system of child oriented meanings involving complex, mixed representations of their child, including attempting to control the child's demands, and attempting to emotionally withdraw from them. However, one mother, in the RA group, displayed a sensitive orientation towards her child. The PDI/MotC analysis was linked to the AAI analysis, suggesting that the mothers' predominant dismissive strategies may have been challenged by their children's demands, which in turn were exacerbated by their continuing pain. This appeared to lead some of them to also employ more overt displays of control and some hostility towards their children. The findings were of some surprise, and also clinically important, since three of the mother-child relationships were rated as 'high risk', and one at 'some risk' regarding the children's future development.

Mothers' responses to their child's pain predominantly took variations of two different paths;

1. As a result of their own experience of pain mothers are more empathetic to their child's experience and expression of pain, and indicate a willingness to respond sensitively and fully to relieve their child's distress
2. Because the mothers are constantly in pain they are distracted and therefore have less capacity to consider their child's pain and distress.
3. Oscillation between Path1 and 2.

Those taking variations of path 1 were Zia (from the RA group) and Linda (from the FMS group), with Linda taking an intense, controlling/enmeshed, over-protective form of path 1, meaning that due to her own pain experiences, including the transgenerational form which manifests within her family, she became hypervigilant and over-estimated the threat of her son's pain complaints, resulting in an anxious over-reaction, and placing over-importance

on seemingly everyday child pain niggles. Mothers taking path 2 included; Carrie (from the FSM group) and Analie (from the RA group). Both mothers experienced their pain and parenting as overwhelming, and subsequently had few resources left to take their child's acute pain seriously, leading both children to over-exaggerate pain and illness experiences in an attempt to force mum to attend to their needs. However, one mother, Karys (from the FMS group) took a form of path 3 which hypothesised that mothers may oscillate between these two paths. Whilst Karys was unable to acknowledge the affects her condition had on her child, she was able to provide comfort and care when her daughter complained of pain. However, Karys managed this in a way that avoided Luna's pain associated distress, with the result that Luna did not seem to look to her mum for emotional comfort. Linda's response to her child's pain suggested a fourth path; one of hypervigilance due to parental health anxiety, precipitated by their own pain experiences. A key finding of this study was that the analysis indicated some considerable level of risk for some of the children in these relationships.

The mothers also seemed to use other discourses to manage the interviewer's perception of them as a 'good' mother, and to lessen the psychological impact of not meeting the socially constructed ideas of what a good mother is. They did this either through using wider discourses of 'the bad child' or 'the angel child', or by constructing alternative identities through their study, work, talents, and skills.

Chapter 9 looked at four CAIs, two from the FMS group and two from the RA group. All the children indicated use of dismissive strategies. In relation to illness it was striking that although all the children reported receiving physical care when poorly, there was no mention of nurturing or comfort during illness, which could cause some children to increase their pain signals, as seen with Ellen's illness behaviour, thus heightening the risk of perpetuating the cycle of transgenerational contested pain. As such, there was a discernible lack of connotative language, meaning they were possibly unable to express their emotions, conceivably due to

not having learnt or not been taught to (Kozłowska, 2009). Notably, children in the FMS group did not allude to their mothers' illness at all, which was in direct contrast to the children in the RA group who displayed much anxious concern over their mothers' pain, and specifically expressed the wish that they not develop RA themselves in later years.

### **10.3 Summary of findings**

The findings showed mothers with FMS tended to display more parenting stress and difficulties in coping with their maternal roles and pain conditions, compared to mothers with RA. Contrary to what was expected, differences in aetiology of the pain conditions did not influence attachment styles, or the expression of either maternal or, subsequently, child pain. For the women in this sample, it was unresolved childhood trauma and loss that influenced how maternal pain was experienced, irrespective of pain condition, and this became manifest through talk.

This is where the findings showed mothers seemed to use talk as a performative action, as a way of trying to organise an action in the relationship between themselves and the interviewer, managing the identity of the self, ostensibly of looking to the interview for regulation through the way they described their difficulties and distress, but of also managing the interviewer/interviewee relationship. Some sense of shame seemed to be felt by the mothers, shame of possibly not always meeting their child's needs, and the socially constructed ideas of what a good mother is. There seemed an intolerance of, and/or lack of capacity with, elements of reflective thinking regarding the possibility that their pain may be adding to their child's distress. Initially, there was an almost universal wariness of ideas or concepts that questioned the self-protective discourse they had constructed to protect themselves. It appeared that being given the chance to be listened to in a sympathetic way, without feeling blamed, was like a catharsis. Once a relationship had been built up with the

mothers, and they trusted there would be no blame or judgement, that the interviewer would not think they were crazy, but believed they were in fact in pain, and acknowledged they had other issues feeding into their experience of pain, they found they could actually talk through their stories. For most women in this research, this was the first time they had had the opportunity to do this. So, whatever narrative they used to describe their experience, the mothers seemed to be looking for a reflection of that experience in the interviewer, that there was a true understanding of what they were struggling with.

The AAI findings revealed that for the mothers with FMS in this sample, pain was the only display of negative affect that was attended to by their own childhood attachment figures, which supports Kozłowska's (2009) work. Where this body of research furthers Kozłowska's ideas is through the use of the MotC. This is the first time the MotC analysis has been used to investigate how mothers with persistent pain understand their child, and it provided evidence that the children in this sample are at risk of developing attachment issues and developing somatic pain in later life. In fact, this research, through the MotC, showed that this sample was proliferate with problematic relationships, that there are issues with these mother-child relationships and the children are at risk. In actuality, the MotC threshold for sensitive parenting is reasonably low, if the parent is able to show some ability to mentalise and reflect on their child's experience, then some level of sensitivity is achieved, meaning that failing one's child in tolerable ways is not necessarily detrimental to their development (Winnicott, 1953). The MotC looks for strengths in parenting, so the fact that the parenting of 4 out of 5 mothers in this research essentially puts their children at risk indicates this group of mothers are struggling and are in need of some help.

It initially appeared that the language of the MotC (like much of attachment theory based assessments) can sound pejorative, this is because it was devised within a child protection setting. So, the combination of difficult childhood, attachment experiences, and

coping with persistent pain, offered a wider perspective on why the mothers predominantly adopted more controlling/unresponsive strategies with their children. This wider perspective suggests the mothers' intentions towards their children were benign, but were compromised by their own embodied attachment experiences, including childhood traumas and the distraction of their own pain conditions. Specifically, the findings suggest these traumas emerged in their implicit emotional and sensory representations of their children, and served to block them from achieving the kind of parenting they would ideally like to achieve. Furthermore, at times these traumas seemed to prevent them from being able to mentalise their own behaviour, causing them to become preoccupied with regulation of their own feeling states to have capacity for their child's. However, a dilemma with this research is how these findings could be presented to mothers in a way that would not be experienced as blaming, confirming what they feared, namely that they do not meet the socially constructed ideas of what good mothers are. Yet, there is a validity about the analysis, in that they *were* at times unable to be empathetic due to their pain and unresolved traumas crowding in, they were not always able to mentalise for their child, to the extent that some mother-child relationships in this research are harmful, and these children are unfortunately at risk developmentally, no matter how unintentionally.

The analysis in this research, therefore, attempts the avoidance of blame through a social constructionist perspective, using the mothers' experiences and narratives to understand and explain their position, thereby situating it within the context of challenged experiences of emotional regulation and attunement, by which the attachment system was constantly activated without resolution. They, in turn, seemed to use the research as a way of seeking validation of their parenting through the relationship with the interviewer, thus allowing the research to align with their experience as a mother. Their very seeking of validation suggests there is a part of them that wants to fit the socially constructed idea of

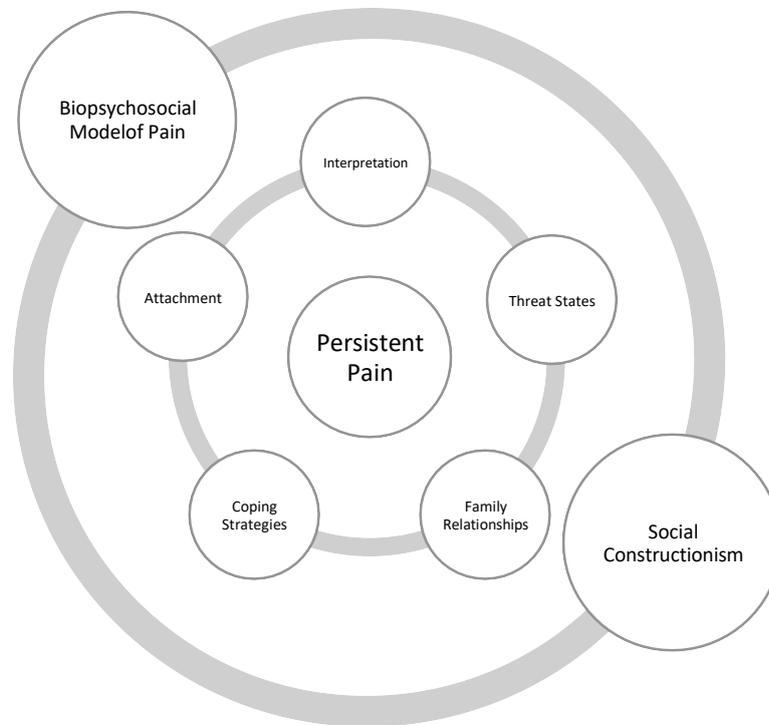
what a good mother is, and that allows for a positive thread to be woven into the analysis, and through their narratives. For example, for some, their performative action through language says ‘Look, I’ve done my very best with a difficult child, and with all my pain’.

There are two different functions in this kind of performative action. 1 – is how they manage blame and their own sense of responsibility in their child’s behaviour, and 2 – is how they are able to manage feelings of being disturbed and distressed, and of being unable to find ways of containing their feelings. Those two things alongside each other means they sometimes formulate an extreme representation of how they manage their child’s behaviour.

In addition, an important finding was that contrary to the clinical view, the pain of RA is really not as well managed as clinicians claim. Mothers with RA were found to be struggling considerably with their pain, as found in the exploratory study, questionnaire study, and interviews. It may well be that because the biomedical model views the mind and body as separate, it is not fully considering the mental and emotional toll of the pain of RA, not providing care in this respect, and not taking attachments and unresolved trauma/loss into consideration. Arguably, this is a failing of the biomedical model and therefore it is failing these women. A better way to understand persistent pain would be with the application of the conceptual framework devised in this research.

A greater understanding of individual persistent pain can be gained by taking into consideration the mother’s attachment strategies, including how she has learnt to channel distress, how language is used to make sense of pain and construct a protective reality, how she interprets perceived dangers, and how this affects her sense of control over internal and external states. The findings have been summarised and developed into a formulation, which is discussed in greater detail in Chapter 2 (Conceptual Framework Chapter), and is shown schematically in Fig.1 below. The wider cultural context is represented by the biopsychosocial model of pain and social constructionism, which influence, and are

influenced by, the more individual persistent pain sufferer's attachment strategies. These then influence and are influenced by the interpretation of threat states and coping strategies.



*Figure 11: Attachment Integrated Model of Persistent Pain - Cultural Context*

In application, for example, Carrie's AAI indicated that she learnt to use a dismissing strategy as a child, meaning she was unable to make overt requests for care, and instead learning to get her needs met indirectly through pain and illness. However, her traumatic experiences in childhood means she overestimates, and has become hypervigilant to, feelings of threat. These overestimated threat states often intrude, and break through her defensive strategy when triggered by demands and conflict with Ellen, meaning Carrie's unconscious emotional interpretation and experience of her child is one of threat. The unbearable anxiety and distress this caused her, led to a rejection and withdrawal from Ellen, and a cognitive rationalisation where she uses the narrative of Ellen as 'the difficult child'. This seemingly instigated a reduction in her sense of responsibility for Ellen's behaviour, displaced some of

her pain, frustration, anger, and placed blame on her child. For Carrie, this may be some way of attempting to gain some sense of control over her relentless experience of pain, and a way of coping with what she experiences as the overwhelming demands of her child. Carrie’s experience appears to be of having little control over Ellen’s behaviour and no control of the all-encompassing pain she experiences.

Added to this is a wider normative discourse of failing to be a ‘good mother’, heightening her fear of not meeting these standards, which in turn leads to a sense of increased threat of being judged and not believed. This cocktail of factors appears to create untenable internal stress, and her dismissive strategies fragment, meaning she is assailed by burgeoning negative affect she has not learnt to manage, thus channelling her distress through the only negative affect she has learnt; that of pain. Additionally, Ellen, unable to get her needs met through open bids for care, has learnt that dramatic incidences of illness behaviour (overdose of pain meds) finally gets her mum’s attention, increasing the likelihood of perpetuating pain cycles.

The wider context of the Attachment Integrated Persistent Pain model can be illustrated on a more individual level in Fig. 2 below:

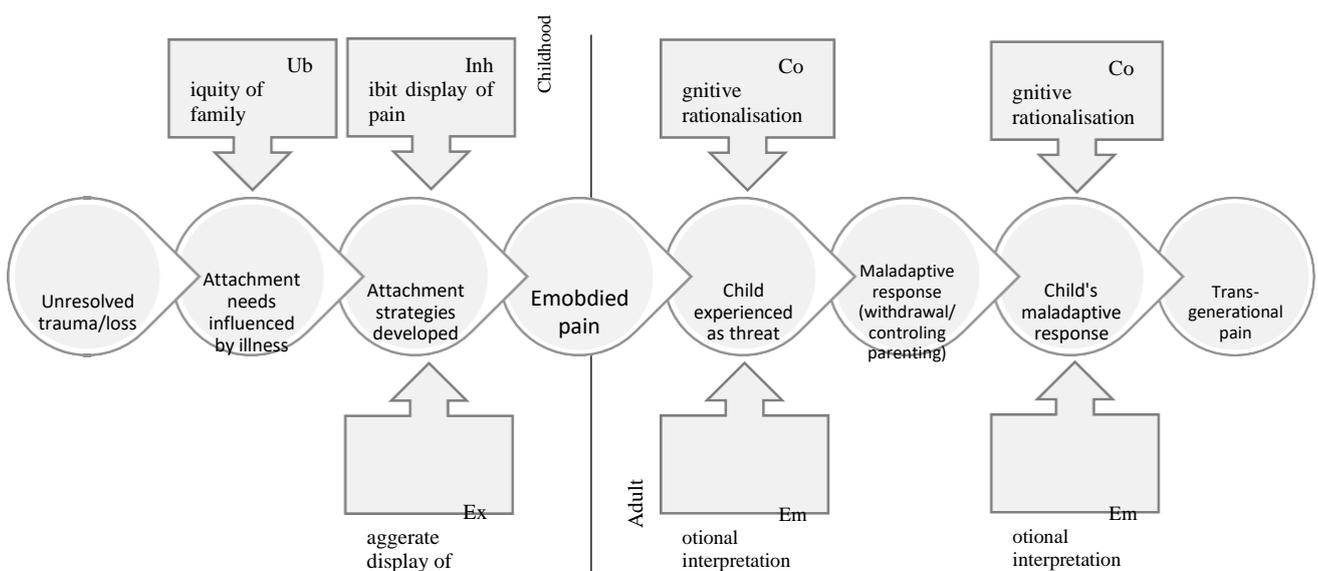


Figure 12: Transgenerational contested pain

However, not all mothers with persistent pain will have trauma, nevertheless the conceptual framework devised in this research can still help to understand their pain experience. The biomedical model does not account for how pain impacts a patient psychologically, emotionally, how it affects a patient's interpersonal relationships, attachment strategies, social engagement, identity, or their sense of control. The Attachment Integrated Persistent Pain model helps to integrate these explanatory strands and, as this research has shown, when mothers with persistent pain feel they are fully understood it can help them to begin to process their feelings, integrate better, and possibly start to reflect.

For example, Zia's AAI indicated a stable, loving childhood, with emotionally available parents, no wider family persistent illness, and she was able to get her needs met through open requests for care, assured in the knowledge that those needs would be adequately and appropriately met. Although experiencing maternal abandonment in early adolescence, it may be that her stable childhood negated some of the adverse effects of this. The lack of trauma in Zia's childhood appears indicative of her pain as not being experienced as overwhelming and is seemingly adequately managed, meaning she has more resources to allow her to be empathetic to Tania's experience and expression of pain, and seemingly more well-disposed to respond sensitively to her distress.

So, possibly in line with some elements of trauma theory, the mothers in this research, particularly the FMS mums, and some in the RA group, find themselves in perpetual flight or fight mode due to various unresolved trauma and loss experiences. This is consistent with the embodied somatising formulation of FMS, and as such, it was found that the mothers' predominant defence was a dismissing one. However, there were episodes in the AAIs where this defence was not functioning adequately enough. In effect, these defences appeared to be failing. Broadly, it is suggested that Attachment Theory does not yet quite explain specific DRs which are not proving to be effective, and how they become fragmented and morph into

symptoms. The findings in this study suggested that due to the intensity of their unresolved trauma and loss, the mothers' attachment strategies start to breakdown and other painful information and experiences start to leak into their dismissing strategy, which then acts like a block or gets inundated, so a solution to this is symptomology. So, for this group of mothers, their embodied distress becomes channelled through what they know, what has been their experience; the ubiquity of family pain/illness, consequently their symptomology is one of pain. There may be some relative transferability here, for example, for others with a family history of using food as comfort, distress may be embodied by obesity, or other eating disorders. For others it might be drugs and alcoholism if drinking, smoking, and/or taking drugs are the family norm, and for others still their distress may become manifest in psychiatric symptomology such as schizophrenia, or personality disorders.

#### **10.4 Conclusions**

This research also highlights the clinical importance of the intergenerational aspect of FMS, in particular, that it is not being properly addressed in pain clinics, partly because of the way services are commissioned around the individual rather than looking at systems as a whole, and the systemic nature of pain and pain/illness transmission, meaning that these repeating cycles are sadly not being addressed. Current services might give enough benefit that parenting may subsequently be less driven by patient's own attachment needs, due to being met in some part during clinic, but services are not organised around this, and data has not been gathered to monitor this. If services were organised around the family rather than the individual, which therapeutically would be very powerful, it could serve to break some of the transgenerational cycles found in this research.

##### ***10.4.1 Clinical Implications***

The implications of the research fall into two parts: Firstly, what the findings reveal about these two populations of mothers experiencing pain. This offers ideas about what may be helpful in terms of support and clinical interventions for them. Secondly, taking part in the research could in itself have some benefits for the participants, such that the research process of being given a chance to talk about their experience in a non-judgemental manner was in itself experienced as helpful.

**1. The Research Findings.** The findings indicate that both groups may benefit from support and therapeutic input, both at an individual and family level. All the women described how their pain condition had been an emotional and practical challenge for them. They all had childhood histories and adult attachment relationships which posed challenges for them in dealing with their lives and their pain. In turn, these impacted on their parenting and the well-being of their children. In four of the five cases there were considerable risks to the well-being and future development of their children. This clearly suggests that these mothers might benefit from an attachment oriented family therapy, and also therapeutic support for themselves on an individual basis. The individual work could focus on the traumatic events they had experienced in their childhoods, how this was compromising their abilities to manage their pain, and in turn to offer empathetic and supportive parenting for their children. Instead, the most common form of intervention for these groups is medication, which can offer some benefit, though long-term usage can become unhelpful. Rather than a reliance on medication, a combination of individual and family therapy could help the women to develop wider repertoires of coping for themselves and their children.

**2. The Potential Clinical Benefits of the Process of the Research.** Although not part of the formal research aims of the study, an important finding was that participants found being given the chance to talk and tell their stories a positive and valuable experience. More broadly, it reinforces findings from clinical practice in the importance patients place on being

heard. In this study it also suggests that this may largely relate to their unmet attachment needs, and specifically their experience of invalidation some encountered through contested illness, but more generally the compassion fatigue that may result in families where pain is a chronic and unrelenting part of their lives. Once participants were able to go beyond the potential sense of threat they may have felt, of feeling ‘not good enough’ as a parent, a failure for not being able to manage their pain better, and instead were able to experience a feeling of safety with the interviewer, participants found the experience helpful. Being invited, in a non-judgemental way, to talk about difficulties in parenting, their pain experience, being overwhelmed, and recognising their struggle was experienced as beneficial. It allowed them to organise their thoughts in ways they may not have done before, and helped them make sense of the situation they find themselves in. This could be vastly helpful in supporting them to manage their pain and the relationship with their child, as well as improving our understanding of the context for these women. However, our understanding of this does not mean the fact their relationships with their children are problematic can be ignored. It indicates a clinical need, not just for individual but also for family based therapies for these women and their families.

This research also revealed that mothers found sitting in on their child’s CAI helpful to their parent-child relationship. The interview gave them a different context to hear and discuss subjects they had not heard or discussed before. The interviewer helped them to maintain a calm stance by not responding, normalised some of the things being said, allowed a space where each were able to talk calmly, and both mother and child realised they were able to do more semantic reflection than they otherwise normally would. This reinforces the importance of understanding family systems, working within the family context, and the potential for transgenerational patterns of unmet needs. The clinical implication is that allowing children to discuss how their mothers’ pain condition affects them, how they feel,

how they see their parents reacting to them, could potentially be useful in managing and mending relationships, conceivably assisting parents in mentalising their child's experience through the process, and in potentially immobilising the transgenerational effects of pain.

The issue here is that this suggests resolution of attachment trauma may be one way to progress towards some form of recovery, however within highly pressured, poorly resourced Pain Clinics there may not be sufficient time to support this. Researchers and clinicians may need to be creative about how this can be achieved. Initially, small research projects could focus on investigating the usefulness of therapeutic strategies for families around attachment and persistent pain using the Attachment Integrated Model of Persistent Pain. The findings from these studies could investigate ways it might be possible to bring this to Pain Clinic settings. One suggestion could involve a multi or group workshop format for mothers, or families with maternal persistent pain, showing video clips of families/mothers discussing various aspects of coping with maternal pain. The group could be asked to comment on what they saw, what they thought was done well in the clip, what was not done so well, how things could be done differently, and how it resonates with their experience, thus making them the experts. This builds upon multi-family therapy approaches (McKenzie, Dallos, Stedmon, *et al.*, 2019), and would be especially useful for this group due to feelings of exclusion, guilt, etc. This approach would give mothers some distance, viewing from the outside might release the exhausting need for defence, allowing them some objectivity and space for reflection. Mothers from this research project could be involved in developing the video clips, in a form of appreciative enquiry. Additionally, the development of a series of simply written books following a family through their life coping with aspects of maternal persistent pain, could potentially provide an accessible way to help families start to mentalise each other's experience. Another suggestion could involve the development of a series of animated shorts

following the same family, which could be used alongside the books in Pain Clinic or family sessions.

### ***10.4.2 Limitations***

There were a number of significant limitations to the study. Some of these have already been documented, especially the extreme difficulties in recruitment of participants for the study. More participants in each group would have highlighted differences in coping, attachment, and trauma. Particularly, more participants would help to elucidate coping and attachment strategy variability within the RA group. Qualitative and idiographic studies do not emphasise normative statements or statistical generalisations but nevertheless, a greater sample size allows a greater range of experiences to be examined by the research thereby promoting greater transferability so that readers are more likely to be able to identify with cases that resemble their own clinical and research experiences.

All of the participants were from the same ethnic background; white, with white partners and children. Having participants from different ethnic and cultural backgrounds, including mixed-race and other BAME backgrounds, would broaden our understanding of the pain experience, and of the possible different transgenerational pathways of maternal persistent pain.

There were a range of limitations in relation to the research methodologies and instruments employed:

1. The Meaning of the Child (MotC) analysis. This is a relatively new method which involves an analysis of interviews based on the Parent Development Interview. The analysis of this interview to date has largely been used with at risk families where there are safe-guarding issues. Hence the scales available for assessing risk are not yet widely applied to other populations, such as health and clinical populations. The intention of using the MotC in this study was not to

make normative comparisons to other populations but to use it to elicit the attachment related meanings that the mothers held towards their children. Nevertheless, this study has used concepts from the MotC such as ‘controlling’ and ‘unresponsive’ and it is important to state that the validity of these is evolving and consequently has to be noted as a limitation. However, the MotC is based on the DMM model which has been applied to a wide range of populations and also the core concepts of the MotC sensitivity and control can be seen as derived from Ainsworth’s seminal work with Bowlby.

2. It is acknowledged that the attachment measures utilised in this study are sophisticated and require extensive training. Part of the reason for using them was that they ask interesting and important questions which are valuable for elaborating and enriching a qualitative analysis. However, they also provide indications of what is more implicit in people’s accounts and this was deemed to be an important avenue to explore. The decision was therefore made to try to utilise attachment measures whilst recognising the potential difficulties in this. The author is not trained in the AAI analysis which is costly in terms of time and financially. Training was provided by her supervisors, but this was not adequate to offer the level of reliability required in standard AAI analyses. It is also strongly advised in AAI analysis that researchers and clinicians do not analyse their own clinical or research cases. So even with the advantage of full training and reliability in the AAI, independent coding is a requirement. Although the AAI was used qualitatively to offer an idiographic description of the mothers’ attachment strategies, nevertheless the discussion of the findings moved into suggested classificatory descriptions of the mothers’ strategies. Hence ideally the study should have included inter-rater independent codings of the mothers’ AAIs to indicate, at least qualitatively the reliability of the classifications. In future research it would be desired that such independent coding would be employed.

3. The author became impressed by the sophistication of the DMM model of attachment during the time of the research study but was less versed in how this differed from other attachment approaches, in particular the ABC-D (Mary Main) model of attachment. Hence in the thesis there is some variation and possibly confusion regarding terms such as attachment styles, representation, strategy and so on. The preference is to use the term strategy which is employed in DMM to emphasise that people attempt the best they can to attain self -protection as the traditional attachment label of secure and insecure from the ABC-D did not do justice to the challenges the mothers in this study faced in managing both adverse childhood circumstances and the distress and discomfort of their chronic pain conditions.
4. Difficulties of using different attachment models. In the study the Child Attachment Interview, PDI, MotC, Adult Attachment Interview were employed. The reasons for these choices were partly pragmatic in that the supervisors had training in these models and they were relevant to the aims of the study. However, they come from different attachment perspectives. Both the CAI and PDI derive from the ABC-D models of attachment and employ some different concepts, especially the notion of disorganised attachment and the role of traumatic events in childhood, It would have been preferable to employ consistently ABC-D or DMM based assessments but the time nor the funding was available to gain training in a DMM version. However, to the author's knowledge there was not a similar interview to the CAI available in DMM. It was important that the study was able to access representations that the child held about the parent not more general attachment representations as in Story Stem based assessment available in DMM. However, dealing with the different terminologies was a challenge and is a limitation of the thesis.

## Final Reflections

There were a number of surprises that emerged in the study. These should occur in research but sometimes the source of the surprises does not always come from the initial research questions:

1. Recruitment proved very difficult. It was assumed initially that this might be particularly a problem for the fibromyalgia group because the condition is more ‘contested’ and sufferers often feel blamed and misunderstood, that the condition is somehow a form of what used to be called ‘hysteria’. However, recruitment was difficult for both groups. It became apparent that women in the rheumatoid arthritis group also appeared to feel some guilt and shame about their condition and did not wish to discuss it. Furthermore, and linking with some clinical observations, reflection on the traumas and challenges experienced by both groups of women was typically viewed as a source of shame rather than a way of helping them to make sense of some of their difficult experiences.
2. Related to the above a surprising observation arose in the nature of the discourse of the women in the support groups. For the fibromyalgia groups the postings on the sites suggested an attachment discourse reminiscent of C or pre-occupied patterns. This is only based on posts but suggest considerable expressed anger and hostility and lack of support for others and a focus on the self. Surprisingly though the AAI of the others in the sample suggested that they were employing inhibiting A – dismissing strategies. It is difficult to pursue credible answers to this since it may be that coding of the women’s AAIs was incorrect since inter-rater reliability was lacking. More broadly this represents a dilemma in attempting to make some generalisations from very small populations. This could be a focus for another study with larger populations.
3. A significant learning point was that the mothers’ attachment strategies as indicated by their AAIs did not simply map onto their representations of their relationships with their children. This is an important contribution of DMM which emphasises the possibility of change and

discontinuity across the generations. This is in contrast to the ABC-D model which emphasises continuity. The mothers in some cases appeared to express some anger towards their children in a way which was more inhibited in their account of their early childhoods with their own parents. Further, in this sample of mothers they were continually distracted by their own pain which perhaps offered a level of negative arousal which impeded their ability to mentalise and be sympathetic towards their children. The MotC analysis of the PDIs attempted to capture how the parents' own childhood experiences influence their relationship with their child. But it was a surprise to see how sharp some discontinuities could appear.

4. One significant point of reflection was that despite some clear examples of negativity towards their children, others also displayed positive intentions to be good parents and do some things better for them than had been their own experiences. In DMM analysis (and the MotC) these intentions are sometimes described as 'semantic' statements which belie hostility towards the child. In this sample it did appear that there was a genuine desire by the mothers to be connected more positively with their child. Of course, it is contentious to argue about whether this 'really' is a genuine intention but clinically it seemed to offer a more hopeful way of seeing these parents and their children. As reflected in the findings chapters, aspects of attachment analyses could appear at times to be disparaging and overly negative. The MotC, for example could appear to provide a catalogue of the mother's failing and negativity towards their child.
5. Despite the drawbacks stated in the limitations section relating to the use of attachment measures without formal training or adequate inter-rater reliability the author concludes that, although challenging, these analyses added considerably to the study which would have been much less if it had only utilised standard qualitative methods, such as thematic analysis or standard discourse analysis.

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## Appendix 7

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PISM/Version6 - 23/05/17

Phase 1

# Research Study Information Sheet - Mothers

## Attachment as a protector in the relationship between maternal chronic pain and child pain complaints

- Are you a mother suffering from rheumatoid arthritis or fibromyalgia?
- Are your children between the ages of 5 years old and 16 years old?
- Do your children sometimes complain of pain or display pain-like behaviour?

### **Invitation and brief summary**

We would like to invite you to take part in a research study exploring the family relationships of mothers who suffer with either rheumatoid arthritis or fibromyalgia.

This study will form part of the requirements for a PhD research project. The lead researcher, Movita Chapman-Moyle, is a PhD student in clinical psychology at Plymouth University.

Research shows that children growing up with parents with a chronic pain condition are more likely to experience pain themselves, compared to children whose parents do not experience regular pain. Yet little is known about what causes this happens, and why it happens for some children whose parents experience chronic pain, but not others. We are interested in whether elements of the parent-child relationship can help to protect children from going on to develop medically unexplained pain in later years. We have chosen to look at mothers with chronic pain, because the mother-child relationship is often so influential.

[This study has been reviewed by the South West – Cornwall and Plymouth Research Ethics Committee \(REC\)](#)

**How can I get involved?**

If you would like to become involved please complete the consent forms &/or questionnaires given to you by your healthcare clinician and use the accompanying envelope to send it to the research team. Alternatively, please contact the lead researcher at the email address given below (Movita Chapman-Moyle).

**What would taking part involve?**

If you decide to take part in this study we will ask you to complete two questionnaires. Completing the questionnaires will take about half an hour or so, and will require you to use the self-addressed envelope to return them to the research team. The questionnaires include questions about your child's pain and things you find stressful about being a parent. When completing the questionnaire about your child's pain, please indicate which questions do not apply.

There are further phases to this study that requests family involvement. If you would like more information regarding these phases, please indicate your interest on the consent form and information will be sent to you.

**Will my information be kept confidential?**

We will collect data from many families, and each mother and family taking part will be given an ID number. We will record the responses that you give, but we will not refer to you or your child's names in any reports or publications. We will not show your named data to people outside of the research team unless any significant welfare or safeguarding issue regarding you or your child emerges. In such instances, we will discuss these with you and signpost you to your GP, and/or inform relevant agencies in the unlikely event that this be necessary.

[This study has been reviewed by the South West – Cornwall and Plymouth Research Ethics Committee \(REC\)](#)

**What will happen to my personal data?**

Your personal data, which will include your consent form & completed questionnaires, will be securely stored for a period of 3 months after the study has ended. This means your consent form & completed questionnaires will be kept in a locked cabinet, accessed only by the research team. After the study has been completed, all data has been analysed & collated, & the study has been written up, all your data (your consent form & completed questionnaires) will be securely destroyed.

**How long will I have to be involved?**

The questionnaires will take around half an hour to complete, longer for some depending on the information that you give. However, should you wish to participate in any further study phases then your involvement will be necessarily longer. There are 3 further phases, which will occur during the next year or so. However, if you only wish to be involved in the questionnaire phase then this is fine. Or, if you would like to be involved in only one or two of the further then phases, then this is also fine. Information about the further phases can be sent to you by contacting the research team (details below), or on the study webpage (details below). Please feel free to request information; this will not indicate a commitment to taking part.

**What are the possible benefits of taking part?**

There are no known physical or psychological benefits to taking part in this study, however, many people find taking part in a research study means they may be contributing towards the advancement of science, and the development of future health interventions, which some may find beneficial.

[This study has been reviewed by the South West – Cornwall and Plymouth Research Ethics Committee \(REC\)](#)

### **What are the possible disadvantages and risks of taking part?**

There are no known disadvantages or risks in taking part in this study, however, although this is a low risk study there is always the chance that some people may find some questionnaire questions upsetting. If this proves to be the case you have the right to withdraw your data or contact the research team to discuss this. Contact details can be found below.

### **What will happen if I don't want to carry on with the study?**

Taking part in this study is entirely voluntary, and you do not have to take part at all if you do not want to. If you decide that you do want to take part and then change your mind, then this is OK. You have the right to withdraw at any time. Should you change your minds at any time before, during or after the study, this is perfectly OK. All you would need to do is to contact the lead researcher, Movita Chapman-Moyle, at the email address below and we will withdraw your data from the study. Any information gathered will be securely destroyed. You do not have to provide any reason for changing your mind, and no questions will be asked.

### **How can I find out what the study found?**

The study website will be updated after each phase so that you can be informed about the findings, details of which can be found below. The results of this study will form part of a PhD thesis, and individual phases may also be published in academic journals.

### **What if I am unhappy about how the study was handled?**

Plymouth University is committed to investigating any allegations of research misconduct. Please contact Dr John Martin, Secretary of the University Research Ethics Committee by telephone

[This study has been reviewed by the South West – Cornwall and Plymouth Research Ethics Committee \(REC\)](#)

on 1752588931 or by email at [J.Martin-2@plymouth.ac.uk](mailto:J.Martin-2@plymouth.ac.uk); or Professor Judy Edworthy, Chair of the Faculty of Psychology Ethics Committee by telephone on 01752 584818 or by email at [J.Edworthy@plymouth.ac.uk](mailto:J.Edworthy@plymouth.ac.uk), if you have any complaints about how this research study has been handled.

### **Further information**

This study is being organised through Plymouth University as part of a PhD student project.

The data collected from this study will be reviewed by a research team which includes family therapists with over 30 years' experience. Your data will be reviewed with the utmost respect, understanding, and confidentiality.

The purpose of this research is to improve our understanding of what contributes to some children developing similar pain to their mothers, but not others. Ultimately, we hope that this work will also contribute to a family support leaflet.

Further information about this and further phases of the study can be found on the study website: [www.painstudy.uk](http://www.painstudy.uk)

Alternatively, please feel free to contact a member of the research team:

Movita Chapman-Moyle (PhD researcher): [movita.chapman-moyle@plymouth.ac.uk](mailto:movita.chapman-moyle@plymouth.ac.uk)

Dr Jacqui Stedmon (research team): [j.stedmon@plymouth.ac.uk](mailto:j.stedmon@plymouth.ac.uk)

Professor Rudi Dallos (research team): [r.dallos@plymouth.ac.uk](mailto:r.dallos@plymouth.ac.uk)

[This study has been reviewed by the South West – Cornwall and Plymouth Research Ethics Committee \(REC\)](#)

Dr Doug Crix (research team): [dcrix@nhs.net](mailto:dcrix@nhs.net)

[Thank you for your time and cooperation.](#)

IRAS Ref No: 195347  
PISM/Version 6 -18/06/2018  
Phase 2 and 3

## **Research Study Information Sheet - Mothers**

### **Attachment as a protector in the relationship between maternal chronic pain and child pain complaints**

- Are you a mother suffering from rheumatoid arthritis or fibromyalgia?
- Are your children between the ages of 5 years old and 16 years old?
- Do your children sometimes complain of pain or display pain-like behaviour?

#### **Invitation and brief summary**

We would like to invite you to take part in a research study exploring the family relationships of mothers who suffer with either rheumatoid arthritis or fibromyalgia.

This study will form part of the requirements for a PhD research project. The lead researcher, Movita Chapman-Moyle, is a PhD student in clinical psychology at Plymouth University.

Research has shown that children growing up with parents with a chronic pain condition are more likely to experience pain themselves, than children whose parents do not experience regular pain. Yet little is known about what causes this happens, and why it happens for some children whose parents experience chronic pain, but not others. We are interested in whether elements of the parent-child relationship can help to protect children from going on to develop medically unexplained pain in later years. We have chosen to look at mothers with chronic pain because the mother-child relationship is often so influential.

#### **What would taking part involve?**

[This study has been reviewed by the South West – Cornwall and Plymouth Research Ethics Committee \(REC\)](#)

If you decide to take part in this study we would like to invite you to take part in two audio recorded interviews. Should you decide that you would like to be involved in the interviews your child will also be asked to take part in a play-based task , if they are younger (aged 5-7), or an informal interview about their experience of being in a family if they are older (aged 8-16).

During the first interview you will be asked questions about your own early life, and relationships when you were growing up. In the second interview you will be asked questions about your experience of being a parent. Each interview will last up to 90 minutes and will be both interviews will be either audio recorded on a small handheld device, or video recorded online via Skype or Messenger.

During the play-based task/story-based chat (for children aged 5-7) your child will be told the beginning of stories about everyday family situations and will be asked to finish the stories off using dolls, or toy animals. The play-based task/story-based chat will be video recorded. You will be able to sit with your child and will be able to stop the task/chat at any time if you feel your child no longer wants to continue. You will also be given time to ask questions before and at the end of the interviews and the child task/chat.

During the informal interview (for children aged 8-16) your child will be asked to describe and think about their experiences of being part of a family. Again, the interview will be recorded, and you will be able to sit with your child, should you wish, and either of you will be able to stop the interview at any time. You and your child will also be given time to ask questions before and at the end of the interviews.

If you would like to take part, we would like you to visit us at Plymouth University to interview you. There will be reimbursement of travel expenses at 20p per mile for each visit. There will be another visit to the university for your child's play-based task. Alternatively, researchers will be able to visit you at your home, if you live within Devon or Cornwall, or we can conduct these over Skype or Messenger, should you prefer or if you live beyond the South West.

### **Will my information be kept confidential?**

We will collect data from many families, and each mother and child taking part will be given an ID number. We will record the responses that you give during the interviews using a voice recorder, and we will video record the task/chat with your child, but we will not refer to you or your child by name in any reports or publications.

We will not show your named data to people outside of the research team unless any significant welfare or safeguarding issue regarding you or your child emerges. In such instances, we will discuss these with you and signpost you to your GP, and/or inform relevant agencies in the unlikely event that this be necessary.

### **What will happen to my personal data?**

Your personal data will be securely stored on an encrypted device for a period of 3 months after the study has ended. This means your consent forms will be kept in a locked cabinet, & your audio recorded interviews, & your child's video recorded play-task will be stored in a double passworded file on a computer accessed only by the research team. After the study has been completed, all data has been analysed & collated, & the study has been written up, all your data

(your consent forms, audio recorded interviews, & your child's video recorded play-task or interview) will be securely destroyed.

**How long will I have to be involved?**

If you wish to participate, the interview phase will happen at a time convenient to you sometime during the coming year. The play-based task and children's interview will also happen at a time convenient to you and your child during the coming year. There is another phase to this study, which will involve the whole family, however, if you only wish to be involved in this phase, then this is OK.

Information about the further phases can be sent to you by contacting the research team (details below), or on the study webpage (details below).

Please feel free to request information; this will not indicate a commitment to taking part.

**What are the possible benefits of taking part?**

Many people find the act of talking about childhood experiences during their interviews often have a therapeutic effect, which some may find beneficial.

**What are the possible disadvantages and risks of taking part?**

The interviews may involve talking about emotional issues such as times when you were separated from your parents or experienced loss as a child. If you want to stop at any time or do not wish to answer a question, then this is fine.

**What will happen if I don't want to carry on with the study?**

Taking part in this study is entirely voluntary, and you do not have to take part at all if you do not want to. If you decide that you do want to take part and then change your mind, then this is OK. Everyone has a right to withdraw at any time. Should you or your family change your minds at any time before, during or after the study, this is perfectly OK. All you would need to do is to contact the lead researcher, Movita Chapman-Moyle, at the email address below and we will withdraw your data from the study. Any recordings and information gathered will be securely destroyed. You do not have to provide any reason for changing your mind, and no questions will be asked.

**How can I find out what the study found?**

The study webpage will be updated after each phase so that you can be informed about the findings, details of which can be found below. The results of this study will form part of a PhD thesis, and individual phases may also be published in academic journals.

**What if I am unhappy about how the study was handled?**

Plymouth University is committed to investigating any allegations of research misconduct. Please contact Dr John Martin, Secretary of the University Research Ethics Committee by telephone on 1752588931 or by email at [J.Martin-2@plymouth.ac.uk](mailto:J.Martin-2@plymouth.ac.uk); or Professor Yaniv Hanoch, Chair of the Faculty of Psychology Ethics Committee by telephone on 01752 584830, or by email at [yaniv.hanoch@plymouth.ac.uk](mailto:yaniv.hanoch@plymouth.ac.uk), if you have any complaints about how this research study has been handled.

**Further information**

[This study has been reviewed by the South West – Cornwall and Plymouth Research Ethics Committee \(REC\)](#)

This study is being organised through Plymouth University as part of a PhD student project.

The data collected from these studies will be reviewed by a research team which includes family therapists with over 30 years' experience. Your data will be reviewed with the utmost respect, understanding, and confidentiality. If you wish, you will also be able to have copies of all audio and video recordings of interviews and play-based tasks that you and your child are involved in.

The purpose of this research is to improve our understanding of what contributes to some children developing similar pain to their mothers, but not others. Ultimately, we hope that this work will also contribute to a family support leaflet.

Further information about the study can be found on the study webpage [www.painstudy.uk](http://www.painstudy.uk). Alternatively, please feel free to ask your pain management team for further details, or by contacting a member of the research team:

Movita Chapman-Moyle (PhD researcher): [movita.chapman-moyle@plymouth.ac.uk](mailto:movita.chapman-moyle@plymouth.ac.uk)

Dr Jacqui Stedmon (research team): [j.stedmon@plymouth.ac.uk](mailto:j.stedmon@plymouth.ac.uk)

Professor Rudi Dallos (research team): [r.dallos@plymouth.ac.uk](mailto:r.dallos@plymouth.ac.uk)

Dr Doug Crix (research team): [dcrix@nhs.net](mailto:dcrix@nhs.net)

Thank you for your time and cooperation.

IRAS Ref No: 195347  
PISM/Version 4 -04/10/16  
Phase 4

## **Research Study Information Sheet - Mothers**

### **Attachment as a protector in the relationship between maternal chronic pain and child pain complaints**

- Are you a mother suffering from rheumatoid arthritis or fibromyalgia?
- Are your children between the ages of 5 years old and 16 years old?
- Do your children sometimes complain of pain or display pain-like behaviour?

#### **Invitation and brief summary**

We would like to invite you to take part in a research study exploring the family relationships of mothers who suffer with either rheumatoid arthritis or fibromyalgia.

This study will form part of the requirements for a PhD research project. The lead researcher, Movita Chapman-Moyle, is a PhD student in clinical psychology at Plymouth University.

Research has shown that children growing up with parents with a chronic pain condition are more likely to experience pain themselves, than children whose parents do not experience regular pain. Yet little is known about what causes this happens, and why it happens for some children whose parents experience chronic pain, but not others. We are interested in whether elements of the parent-child relationship can help to protect children from going on to develop medically unexplained pain in later years. We have chosen to look at mothers with chronic pain because the mother-child relationship is often so influential.

#### **What would taking part involve?**

[This study has been reviewed by the South West – Cornwall and Plymouth Research Ethics Committee \(REC\)](#)

If you decide to take part in this study we will invite you to video record some family-time at home.

For the family-time home recordings, should you and your family wish to take part, you will be provided with a webcam and asked to video half an hour of family time when you are feeling well, and half an hour of family time when you are experiencing more pain than usual. Plymouth University will send you a secure link into which you will be able to drag and drop the recordings that you choose to submit. Which family-time recordings you choose to send to us is entirely your choice.

### **Will my information be kept confidential?**

We will collect data from many families, and each family taking part will be given an ID number. We will not refer to you or any family members taking part in the home recordings by name in any reports or publications.

We will not show your named data to people outside of the research team unless any significant welfare or safeguarding issue regarding you or a family member emerges. In such instances, we will discuss these with you and signpost you to your GP, and/or inform relevant agencies in the unlikely event that this be necessary.

### **What will happen to my personal data?**

Your personal data will be securely stored on an encrypted device for a period of 3 months after the study has ended. This means your consent forms will be kept in a locked cabinet, & both

[This study has been reviewed by the South West – Cornwall and Plymouth Research Ethics Committee \(REC\)](#)

home video recordings will be stored in a double passworded file on a computer accessed only by the research team. After the study has been completed, all data has been analysed & collated, & the study has been written up, all your data (your consent forms & both home video recordings) will be securely destroyed.

**How long will I have to be involved?**

This study will occur at a time convenient to you and your family during the coming year.

**What are the possible benefits of taking part?**

There are no known physical or psychological benefits to taking part in this study, however, many people find taking part in a research study means they may be contributing towards the advancement of science, and the development of future health interventions, which some may find beneficial.

**What are the possible disadvantages and risks of taking part?**

There is the risk that some of your family members may not wish to be video recorded at home, and may feel that the camera is an intrusion. You and your family will be able to discuss when recordings take place so that unwilling family members do not have to be involved in this phase. You and your family will have complete control over what is submitted for the study and what isn't, so that if an unwilling family member is accidentally recorded, or you are unhappy with the recording, you do not have to submit it as part of the research study.

**What will happen if I don't want to carry on with the study?**

Taking part in this study is entirely voluntary, and you do not have to take part at all if you do not want to. If you or your family decide that you do want to take part and then change your mind, then this is OK. Everyone has a right to withdraw at any time. Should you or your family change your minds at any time before, during or after the study, this is perfectly OK. All you would need to do is to contact the lead researcher, Movita Chapman-Moyle, at the email address below and we will withdraw your data from the study. Any recordings and information gathered will be securely destroyed. You do not have to provide any reason for changing your mind, and no questions will be asked.

### **How can I find out what the study found?**

The study webpage will be updated after each phase so that you can be informed about the findings (Details below). The results of this study will form part of a PhD thesis, and individual phases may also be published in academic journals.

### **What if I am unhappy about how the study was handled?**

Plymouth University is committed to investigating any allegations of research misconduct. Please contact Dr John Martin, Secretary of the University Research Ethics Committee by telephone on 1752588931 or by email at [J.Martin-2@plymouth.ac.uk](mailto:J.Martin-2@plymouth.ac.uk); or Professor Judy Edworthy, Chair of the Faculty of Psychology Ethics Committee by telephone on 01752 584818 or by email at [J.Edworthy@plymouth.ac.uk](mailto:J.Edworthy@plymouth.ac.uk), if you have any complaints about how this research study has been handled.

### **Further information**

This study is being organised through Plymouth University as part of a PhD student project.

[This study has been reviewed by the South West – Cornwall and Plymouth Research Ethics Committee \(REC\)](#)

We will collect data from several families, and each family taking part will be given an ID number. You can ask to have your data withdrawn from the study at any time. The data collected from this study will be reviewed by a research team which includes family therapists with over 30 years' experience. Your data will be reviewed with the utmost respect, understanding, and confidentiality.

The purpose of this research is to improve our understanding of what contributes to some children developing similar pain to their mothers, but not others. Ultimately, we hope that this work will also contribute to a family support leaflet.

Further information about the study can be found on the study webpage [www.painstudy.uk](http://www.painstudy.uk). Alternatively, please feel free to ask your pain management team for further details, or by contacting a member of the research team:

Movita Chapman-Moyle (PhD researcher): [movita.chapman-moyle@plymouth.ac.uk](mailto:movita.chapman-moyle@plymouth.ac.uk)

Dr Jacqui Stedmon (research team): [j.stedmon@plymouth.ac.uk](mailto:j.stedmon@plymouth.ac.uk)

Professor Rudi Dallos (research team): [r.dallos@plymouth.ac.uk](mailto:r.dallos@plymouth.ac.uk)

Dr Doug Crix (research team): [dcrix@nhs.net](mailto:dcrix@nhs.net)

Thank you for your time and cooperation.

## Appendix 8

# Why children and mummies sometimes feel pain

### Our study

Hello. My name is Movita and I go to a school for grown-ups.



This school for grown-ups is called Plymouth University.



This is Plymouth University

I am learning about how some mummy's bodies can hurt.  
I am learning about how some children's bodies can hurt too.



Your mummy has said it is ok to talk with you, but I would still like to ask you if it is ok with you.

Some children find that there are times when somewhere on their body hurts.



I would like to find out about some of the things that can make this happen.  
Sometimes, children can't talk about how they feel.



Feeling like this can sometimes make parts  
of their body hurt.



I would like to find out about why this happens to children, and to try to find ways to help.

Would you like to help me find out?

You and mummy can come to see me at Plymouth University. We can do some play activities together.

First of all, we would like you to talk about it with your parents to see whether you would like to come along to see us.

### **What will happen if you come to see me?**

When you and your mummy come to see me at Plymouth University I will ask you to do some play activities with me.



I will tell you the start of a story and you can finish the story off.

You can use some little play figures and other toys to show me what happens in the story too. Mummy can stay with us while we do the play activity.

If it is ok, we would like to do more than one story with



you.

This could take up to an hour or less. An hour takes as long as watching 3 Something Special programmes on the television.



long

A video camera will record us doing the play activity together, so that I can give you time to see how you would like the story go.

### **What if I decide I don't want to do the play activity?**

If you don't want to do the play activity that is OK.



Even if you come to see me, start to play with me, and then change your mind and want to stop, then this is OK too.

You can ask me as many questions as you like, as well.

I want you to feel as comfortable and happy as possible when you are doing the play activity, so if that means stopping when you have had enough, then I am very happy to stop.

I hope to see you soon and thank you for reading this.

Bye bye

From Movita



# **Why children and mums sometimes feel pain in their bodies**

## **Our study**



Hello. My name is Movita and I am a student at Plymouth University. I am learning about how some children can feel pain in different areas of their bodies from time to time.

Your mum has said it is ok to talk with you, but I would still like to ask you if it is ok with you.

I know there are times when somewhere on your body hurts, and sometimes it doesn't, and I would like to find out about some of the things that can make this happen. Sometimes, children don't feel able to talk about how they feel, I know that feeling like this can sometimes make parts of their body hurt. I would like to find out about why this happens to children, and to try to find ways to help.



I am asking you whether you would like to help me with my study. To do this I would like to talk to you through the webcam on your computer. First of all, I would like you to talk about it with your parents to find out whether you would like to talk to me.



## **What will happen if you say you want to take part?**

When we have our chat over the webcam I will ask you some questions about your family, questions like who is in your family, and what your bedtime routine is. If you prefer, your mum can be present during our chat. Our chat will take about half an hour. I will record us talking; this is so I can look at the activity later on. Researchers call this data analysis.

### **What if I decide I don't want to talk to you?**

If you don't want to talk to me that is OK. Even if we start talking, and then change your mind and want to stop, then this is OK too, and you can ask us as many questions as you like. I want you to feel as comfortable and happy as possible when you are talking to me, so if that means stopping when you have had enough, then I am very happy to stop.



I hope to see you soon, and thank you for reading this.

From Movita, Jacqui, Rudi, and Doug  
(The research team)

## **Looking for a link between mums' chronic pain & child pain complaints**



### **Invitation and brief summary**

Hello. My name is Movita, and I am a research student at Plymouth University. I am conducting research about how some children, whose mum's have chronic pain, can also occasionally complain of having pain themselves. I am doing this because previous research tells us that children growing up with parents with a chronic pain condition often experience pain themselves, and we would like to find out about why this happens, in order to try to find ways to help.

I would like to ask you to help with my research study. To be involved I will ask you to have a chat with me over Skype. However, I would like you to talk it over with your parents first, to make sure you are completely happy to take part.

### **What would taking part involve?**

If you do decide to take part, I will ask you some questions about your family. For example, some of the questions will be who is in your family, and what your bedtime routine was when you were little. If you prefer, your mum can be present during the activities. If you are happy to be involved, the whole chat will take about half an hour. I will record our chat; this is so I can look at what we discussed later on. Researchers call this data analysis.

### **Will my information be kept confidential?**

We will collect data from lots of different children, and everyone will be given their own ID number. That way, your personal information, like your name and age, will be kept confidential.

### **What will happen to my personal data?**

Your personal information, like your name, age & address, will be kept on a password protected computer on Plymouth University's own secure server. Your consent form will be kept in a locked cabinet, in a locked office at the University. All of your personal information will be destroyed 3 months after the completion of my PhD studies.

**How long will I have to be involved?**

The whole chat will take around an half an hour to complete.

**What are the possible benefits of taking part?**

Some people find taking part in a research study and furthering scientific knowledge interesting, and make them feel as if they are helping to move science forward.

**What are the possible disadvantages and risks of taking part?**

The questions will be about family life, which some children might find uncomfortable. If you want to stop at any time, or do not wish to answer a particular question, then this is fine.

**What will happen if I don't want to carry on with the study?**

If you don't want to have a talk with me, that is OK. Even if we start talking, and then change your mind and want to stop, then this is OK too. You can ask as many questions as you like, before, during and after our chat. I want you to feel as comfortable and happy as possible whilst doing the activity, so if that means stopping when you have had enough, then I am very happy to do so.

**How can I find out what the study found?**

The study webpage will be updated after each phase so that you can be informed about the findings, details of which can be found below.

**Further information**

This study is being organised through Plymouth University as part of my PhD student project. If you wish, you will be able to have copies of the interview video recording you took part in.

The purpose of this research is to improve our understanding of what contributes to some children developing similar pain to their mothers, but not others. Ultimately, I hope that this work will also contribute to a family support leaflet.

Further information about the study can be found on the study webpage [www.painstudy.uk](http://www.painstudy.uk).

We hope to see you soon, and thank you for reading this.

From Movita, Jacqui, Rudi, and Doug  
(The research team)

## **Appendix 9**

### **Carrie – Representational Systems**

#### **Procedural**

##### *False Positive Affect*

‘Yeah, so, like obviously, like I said we lived in a cull de sac so, you know, those kids they were horrible (smiling, laughing).’

##### *Dysfluency*

‘It was horrible, really, because I just, I felt like...(two second pause) you know, that I wasn’t, um...(sighs) how can you say, like...(five second pause)’

##### *Hesitation*

‘Hmm...(eleven second pause). It’s really hard this one...Um...(twelve second pause) Hmm. I’m just-just wondering what type of, you know, about the actual relationship...(eight second pause)’

##### *Passive, Flat Affect*

**‘Can you remember how you felt?’**

C: ‘I think at first it was sort of, um...(four second pause) I kind of thought “oh”, you know, should we be doing it?’

#### **Sensory**

##### *Lack of Images*

‘...Um, and I just, kind of, almost shut off any, sort of, feelings I had about my nan. Um...(three second pause) Because I didn’t, I didn’t feel like I could grieve. And, yeah, I just felt like I had to step up, really’

##### *Auditory Imaged ‘Bloody’ = Trauma*

‘...my mum walked in on it one day and, sort of, said, “what the bloody hell you doing?”. And I can remember “what the bloody hell you doing?”’

#### **Semantic**

##### *Idealisation*

**‘Can you remember an occasion where you felt loved with your mum? Where the relationship was loving’**

C: ‘...I dunno how to explain it but, like, the fact that she, sort of, always come and picked me up from nursery.’

*Minimisation*

‘...because my dad was more, more like that than my mum. My mum was, like, as mums are, busy, aren’t we?...’

*Nominalisation*

‘...she made me give it to the person next to me which I wasn’t very happy with, but you know what it’s like when you’re a kid, as soon as it’s all over that’s that...’

*Analytic/irrelevant details*

‘...we always used to bath on a Sunday before school and um, it was teatime um, and we always used to have...(laughs) it’s mad, have banana crunch(Laughs) it was like a banana custard with, like, a crunchy topping so I can remember, um, being sat (inaudible) in with my dad and having this bowl of, like, banana crunch and we used to watch, I think it was um, there’s something on the tele. The borrowers or something small ...’

**Episodic**

*Memory loss*

‘Um... (six second pause). Just tryna think if I can think of something different um, it’s really weird because I... (four second pause) um, hmm... (four second pause) Comfort. I’m just thinking... (seven second pause) um.. (seven second pause) it’s weird, I can’t-I can’t even remember...(three second pause)’

*Cut off*

‘I can remember, like, my mum sitting, I can’t really remember, I can remember seeing her like that and she was, I think she was like...I can’t remember whether she was talking at that point or not’

**Integrative**

*Failed reflection*

**‘Are there any aspects of your childhood that you think were a setback or hindered your development?’**

C: ‘Um...(five second pause) no, I don’t think it’s hindered my development um, there’s nothing really, um, that’s done that um, I mean obviously the deaths, they were a massive factor, but, you know, I still went on and, sort of, done my GCSE’s and stuff like that’

*Lack of integration*

**‘Has your relationship with your parents changed since you’ve got older?’**

C: ‘Yeah, I would say me and my mum, um, you know, are so much closer now than we ever were, and, um, like I said, we’re always together, you know, specially, like, mum has fibro was well, so, um, you know, we, sort of, go to a lot of (inaudible) together and confide in each other’

## Appendix 10

### Linda – Representational Systems

#### Procedural

##### *False positive affect*

At many points during the interview there was laughter at pain and hurts, and while at times there was some arousal, her tone was somewhat subdued given some of the content

‘...I was fourteen when he died and he took his own life. So, um, we, he took his own life. He hanged himself and I found him (Smile and laugh)’

‘...he just chucked me in me bedroom and locked the door

#### **Right. And were you physically hurt?**

L: Oh yeah, yeah, definitely, and I was pregnant (smiles) as well’

##### *Dysfluence*

While there was some dysfluence, she never lost control, and despite some difficult content remained co-operative with the interviewer

‘No, I didn’t, no, I-I, a, ugh, I just did as I was told’

‘I remember that-that’s when my feelings changed with mum, they ha-it’s like a-it’s actually like a-feels like two different mothers’

‘L:He hanged himself and I found him (Smile and laugh)

#### **At fourteen? Right. And how, well, so you ...**

L: It’s alright, go on (laughs)’

##### *Sensory*

There were few instances of rich visual images, but Linda relayed many auditory images of some of her more difficult memories

‘I must’ve said oh something along the lines of ‘What’s the matter with my brother’ and my dad said ‘your mum’s gone, she’s not coming back’

‘she was never me mum’s best er friend really um she used to say ‘Well, your mum’s your mum, she’s a selfish cow’ (laughs) and she’d say ‘and your dad’s’ you know ‘the way he is’ and that’s kinda what I got’

‘cause I was shouting ‘Don’t hurt him, don’t hurt him, get off him’ and then he’d be like ‘Don’t get involved, sit there and don’t get involved’

### *Semantic*

At times Linda idealised both parents, none more so in describing her father as safe and dependable, yet who, it later transpires, banished her to live with her mother four months after that mother had abandoned her. Additionally, after her boyfriend died, her father suddenly left the country for 20 years. Throughout the interview there were instances of exoneration and minimisation, and while she repeatedly referred to the negative events, she did not engage in blame.

### *Idealisation*

Of her mother:

‘she’s always been there, so, even through that horrific time she was with me all the way, I cried myself to sleep at night, she was a-she really was-she was my rock’

Of her father:

‘...where dad’s concerned, it’s that fact that he’s never, ever, he’s just always, I-I’ve always known if I pick up the phone even now, um, and he’s seventy years of age, if I picked up the phone and went “Dad, I need you” h-he’d, it, it didn’t no matter where he was in the world, he’d be there with us as soon as he could’

### *Exoneration*

‘They’re both highly strung people, and I think they were actually really bad for each other, I also don’t think back then, in the eighties, there was a lot of thought about the kids, n-now, when divorce happens now, it’s a lot about child welfare and what’s right, mental health for the child and what’re they’re experiencing and what they’re seeing, they just, I think they just were firefighting in, in the best way they knew how, really’

### **Episodic**

There is some memory loss apart from where she describes traumatic events. Many episodes are general and fail to support positive statements. However, these are relatively clear most of the time. Throughout the interview there were instances of her taking her parent’s perspective.

#### *Memory loss and cut off*

‘Yeah really yeah...I never really told her how I felt, I told her what she wanted...(5 second pause) uh it’s hard you think of how it is now don’t you, I know-I don’t (looks away from camera & becomes inaudible)...’

#### *Parental perspective*

When discussing her father dragging her down the stairs by her hair:

‘I just felt like I was a big disappointment...I wasn’t angry at him, I felt like-I felt it was deserved...cos I’d let them down’

### **Integrative**

Linda showed evidence of integration

#### *Corrective script*

‘I never, up until these last few years, I’ve never questioned...whether his reactions were-were right or not...it’s only these last few years I’ve thought ‘hang on a minute, I’ve

got my own children, now how would I handle things', it certainly wouldn't be like that'

*Awareness of mixed feeling*

'Erm...I-I just felt awful...part of me wants to say angry, I was angry that they were saying this to me, and part of me was so scared at the thought of losing them'

*Impression on the interviewer*

**'And can you tell me how you know this?'**

L: Because they told me so (laughs) um, yeah, sorry, that was a bit facetious, wasn't it?'

*Awareness of role of illness*

'I've done a lot of self-awareness, I'm thinking 'if I'm ill, somebody's going to look after me', yeah, definitely, and, and, and I used to do that when I little, yeah.'

*Reflecting on her mother*

'I think worse since she's got diagnosed with fibro. It's affected her pain. Because she drank for the pain. Or she used the drink as an excuse for the pain, to drink more. And then it became, it went from habitual to addiction, really'

## **Appendix 11**

### **Representational systems - Karys**

#### **Procedural**

##### *False positive affect*

Karys repeatedly displayed false positive affect when talking about the losses she'd experienced.

'& he just rapidly deteriorated overnight...he was drifting in & out of consciousness...so...(laughs) you gotta laugh now, it-its crazy'

'Oh...you're making me fill up now...(wipes eyes with tissue & smiles)'

##### *Dysfluence*

Some dysfluence would enter Karys's discourse when remembering the circumstances around her nan and father-in-law's deaths, as she seemingly fought the burgeoning negative affect.

'...I can remember walking, walking down the corridor, and they was coming towards us, an...they were qui-quite-quite blank, you know, so they wasn't, you know, y', it's, you're too late, she, she's already gone...'

##### *Intrusion of affect*

During some parts of the interview, especially regarding loss, her narrative style changed and showed intrusions of affect

'K (takes off glasses) Oh...you're making me fill up now...(wipes eyes with tissue & smiles)'

#### **Oh I'm sorry**

K (continued smiling, wiping eyes) It's alright, carry on (continues to wipe eyes)'

'So when they're away I do think 'Please don't let anything happen to them when they're away'...you know, if I wasn't there it'd be even worse...having been through it twice (takes glasses off & wipes eyes)'

## **Sensory**

### *Positive imagery*

There was some positive imagery, especially regarding her Nan

‘I remember having a grey pram for Christmas and a doll, and that was my world...it was, it was exactly what I wanted as a child, it was a grey corduroy and it was just perfect you know...it still stays with me now’

‘...on the Saturday then the whole family would come so we’d have all the cousins...and there’d be my nan, would be doing the Hotdogs and she’d make apple tarts, you know, it was very, very busy Saturday...you know, and all the aunts and uncles would catch up with each other and it was nice...’

### *Auditory imagery*

Karys often used auditory imagery, and while this was relatively mild and contained, it generally only occurred when relating difficult memories.

‘...I remember listening to the teacher saying ‘she’s only a bit homesick she’ll be fine after’, and I just thought ‘oh I’ll give up and just stay there’s not a lot I can do’

‘...it was the day of my cousin's...wedding, & I'd already said 'Look he's not going to be here by the weekend, we can't come', & he died the time my cousin got married’

## **Semantic**

### *Idealisation*

There was some idealisation of both parents, especially her father, who seems to have had a minimal presence. She described her mother as warm and loving, but the examples, though often positive, portrayed a practical rather than a demonstratively tactile mother.

Of her mother:

‘...you know she taught me how to cook, she used to let me help with polishing and hoovering from the age of like three, you know, helping out around the house and things like that...she taught me how to be a good mum to my own children...in, in that way, you know...’

‘...cos my mother wouldn't let us do anything...so everything I do in my house, I'm self-taught, you know...she's a bloody clean freak, you know (laughs)...’

Of her father:

‘I would worship my Dad, my Dad's my world, as much as I'm close to my Mum, I'm a proper Daddy's girl, you know’

*Analytic/irrelevant details*

Karys would veer off into analytical or irrelevant detail as a way of avoiding discussing difficult memories.

‘...we were still in the A&E, they put us in a-in a private cubicle then, they were trying to get him a private room, you know, & they said 'Now go & grab a coffee, we'll keep the curtains open' he was opposite the desk 'We'll look after him'...so he rang his sister, we had the quickest coffee, it goes down in gulps, dun it?’

## **Episodic**

*Memory loss*

**‘Can you remember a specific incident when you were upset about something, a fight with your brother, or something happened at school**

K: No not really...I can't really think’

‘it was Christmas time as well...and I had two, two little kids at home (pause) um, you know we had to be happy & jolly, an (pause, shaking head, smiling) I couldn't tell you what they had that year, what we, you know...what we did’

*Parental perspective*

Karys takes her father's perspective when remembering her and her brother's impatience to see their nan.

‘he just, like, the Saturdays come home from work around 12:30...and he'd always take us up to my Nan's because she lived about...about eight to nine miles away, an...we'd be nagging and nagging him, as an adult you can appreciate how difficult that must have been for him (smiles), can't you?’

*Integrative*

There was not much evidence of integrative thinking, and what was there was rather vague and general, there was a tentative replicative script to take her children on holidays as their parents did, but nothing in-depth, however, Karys attempts to explicate a corrective script by vocalising a determination to ensure her children were more independent.

#### Replicative script

‘We had...caravan holidays by the seaside, we had a touring caravan, my mother & father did, we got a touring caravan now, & you know, we always did the same holidays...that-that proper family orientated, playing games, & out swimming, & bike rides & stuff, we-we-we think we-we done with our children what our parents did with us, you know?’

#### Corrective script

‘...but I always wanted my kids to know, you know, how to go out & look after themselves...& I don't-I wouldn't worry at all, you know, yeah I've always tried to do that with each one, you know’

## Appendix 12

### Representational systems - Analie

#### Procedural

##### *Co-operative with the interviewer*

Analie was very cooperative with the interviewer, she gave full and detailed answers to every question, & every subsidiary probing question, making it an extremely data rich interview

**‘It’s up to you whether you want to answer, I don’t want to push too much.’**

A: Yes, the answer is yes ...’

##### *False positive affect*

There were several instances of false positive affect

‘...that for me was a huge betrayal when she went, because there’s leaving you, then there’s bugging off to another country with another man...and that was like a real...left you once, now I’m gonna leave you again (laughs)’

‘... she left when I was 13 umm and I was brought up by my father at that point ummm... so-so that was when life starts to get a bit...(laughs) more unstable...’

**‘Have your feelings about his death changed over time, do you think?’**

A: Yeah, I think so, I think...I’m not angry about it anymore...erm I wrote some god awful poetry at the time (laughs)...’

##### *Coherent discourse*

There was minimal dysfluency through the interview, the discourse throughout being coherent, thoughtful, and articulate

‘...so much happened, between the ages of 13 and going to university, it’s like somebody crammed five novels into that period of time, and saw how much happened to one individual, and actually...that now I’ve shut a door on it really...’

## Sensory

Analie used a wide range of both visual and auditory imagery that closely related to the semantic content, and was consistent with the episodes being recounted. This was for positive images of comfort, and for some distressing ones

‘...I can remember saying it felt like swimming pool life because it just felt like...like noise underwater...umm that you can hear background noise but nothings getting through to you and it felt like that...’

**‘You described your relationship with your dad as indulgent, can you describe a specific occasion or event when your relationship was indulgent**

A : (laugh) yeah...(sighs)...I had mumps and...the only thing that I wanted was ice cream...I remember him bundling me up in the car, we didn’t have any ice cream at home, bundling me up in the car wrapping me up and driving miles to go and find ice cream...because it couldn’t just be ordinary ice cream, I wanted mango flavour ice cream...oh yes!...(laughs)’

## Semantic

### *Idealisation*

Especially of her father as loving

‘I remember...there was (stuttering) a blanket around my shoulders and it was pink scratchy blanket one of those old horrible things...I remember it being slightly, you know, uncomfortable, but I didn’t want to move because I didn’t want to break that kind of spell to break that (stutter) cuddle’

‘I know full well that if I was in trouble or if I ever needed him he would move...the universe to make that right...when I was younger’

but she also offers a reflection of his shortcomings

‘...his first response to anything was irritation or anger, but it was a blow over thing, it was like his brain couldn’t stop

that irritation coming out first, and then it was hugs and don't worry I'll fix it, but first of all it was irritation...'

The accounts were usually told in a relatively matter-of-fact way, but she also included her feelings

'...she pulled down my pants and she smacked me in the middle of the street in front of Vicky Percy, and...I've never been more mortified in all my life...'

### *Exoneration*

There was some exoneration of her parents, but this was usually done with a balanced view which included her parent's perspective alongside her own feelings.

On discovering her sister's baby book was filled with photos and mementos, and hers was virtually empty:

### **'Why do you think your parents did that?'**

A: Time (laughs) I don't think it came down to anything other than she was the first...my sister was dying, you know, she died, and I think they were in such a bad place mentally that the thought of taking a photograph, sticking it in a book, and remembering wasn't...something that they could do'

She recounted some criticism especially of her mother, and three of the five adjectives describing her relationship with her mother were negative

### **'I'd like you to use 5 words or phrase that describe your relationship with your mother when you were young'**

A: Distant umm...is definitely one ... ummm ... showroom...ummm ...which is...there was always a necessity...to...be the perfect family...and to look...everything...to look right...and that feel of not being able to be myself...be what was expected...ummm...caring...educational...and tempestuous...we fought a lot'

'...she...decided to emigrate to Greece, as you do, and she went to live in Greece for a year and it was at that point I killed her off because I...that for me was a huge betrayal'

## **Episodic**

The episodes recounted by Analie supported the semantic labels, they were coherent, contained both sensory and semantic content, there was rarely any memory loss, and the episodes generally stayed on topic

### **‘can you describe a specific occasion when your father was loving**

A: So I had a teddy bear...pink ted and he-he came with me everywhere and I just had a memory of sitting on a beach...sitting with pink ted and my dad on his lap, and he’s got his arms wrapped around me and...I just remember thinking that that was the safest, nicest, warmest place to be in the world, and just that feeling of complete peace’

### **‘So, have any of these things we’ve discussed here, have they changed any relationship with family members?’**

A: Umm sort of umm...sort of...my father...I love him very much...but I realise he has flaws...and I realise that he’s not...that he is a human being and that he’s not the all-conquering hero that I thought he was, which is fair enough you know, that’s life...mum...well you know (laughs) it was never gonna end well, but at the same time...she’s now the most amazing grandmother that you could hope for...’

## **Integrative**

There were repeated examples of reflections weaved throughout the discourse, which include an awareness of how her perspective now differs from that of the past.

On her parents losing her sister:

‘...neither of them, if you talk to them, remember when I first walked...because their heads weren’t there, and now that I have children of my own I can entirely understand that, because um, but at the time, you know, at four or five, it felt like rejection, it really did...’

## *Reflection*

‘erm with my mum...there are things we cannot talk about, full stop, that do not get talked about, erm, but now I have respect for her, and I don’t think I did before, I didn’t understand why she’d done these whole series of things, I don’t think I necessarily blamed myself, I don’t think I was that person, but I didn’t get it, I didn’t...now that I’m a parent myself, and know how that type of love feels, then I can begin to understand, and the thought of losing one of them in that way...just...I-I don’t know how I would pick myself up from it, and I’m in a happy, loving relationship, and for her to pick herself up from it when, actually, they were in a completely dysfunctional relationship, even at that stage...all power to the woman, dear god, you know, well done, ‘cause I don’t think I coulda done it’

*Corrective script*

‘They were strict as parents, and I am, I think...I’m not...I-I-I don’t-I’ve never needed to hit my children, erm, in terms of spanking, erm, and I don’t think I ever would’

‘I think I am always conscious with my own children of being present, erm...and I’m conscious of listening to them, ‘cause I felt, health-wise, that I wasn’t listened to, erm...and that’s, that’s hard, it’s very hard...erm, yeah, so there’s-it’s that being listened to, being present, erm...a hug, a kiss, there’s a lot of physical, you know...and it’s a very tactile...different sort of approach’

## Appendix 13

### Representational systems - Zia

#### Procedural

*Co-operative with and acknowledges the interviewer*

‘Erm...I don’t know if this demonstrates it particularly well, but...’

*False positive affect*

Zia frequently used false positive affect, especially when recounting some of the more dangerous events in her life.

‘...so I think that was quite a strong feeling that erm you know that this isn’t how I thought it would end, you know (laughs) you know, this isn’t how I thought it would be (laughs) you know, I thought it was a good thing I was doing...so yeah, and shock probably, shock at the speed and the noise of them coming in, you know, probably that (laughs)’

‘...that really did impact because I just didn’t know what to do, I just did not know what to do, so I-I remember that till the day I die...but (laughs)’

**‘So when your marriage ended were they supportive?’**

Z: Erm...I think my mum had a bit of a er...er “Well, I could’ve told you that in the first place, I don’t know why you married him”, so that for me is like the “GRRRR!” (laughs) “Well, ok thanks for that” (laughs)’

*Dysfluency*

There was a lot of dysfluency within Zia’s narrative

‘...i-it was just accepted that you were gonna have this conversation, ‘cause she’d said we were going to have it, a-and not a drea-you know, a feeling of “Urgh, gonna be in trouble”, just...you know...er-er I think I knew I’d done something wrong’

‘...I just...in my head I er-er you know, for that split second it seemed like a goo-so “I don’t know, don’t know”...erm...er...so now, er-er, and I’m making this up, but now erm...’

*Analytic*

Zia could be quite analytic, where she was able to stand back to discuss herself and her relationships from a distance

‘...so, it-it was probably the first recognition of dependable, but not really knowing...that that was...you know, it was because he was dependable that was why he did it erm yeah’

‘...again, whether they were doing this...erm...consciously or not, you always got a job, you always had to hold the...tissue on the thing, you know that kind of distracting thing...’

### **Sensory**

Zia used an array of both visual and auditory images that were connected to the episodes and the semantic label, some were disparaging of herself.

#### *Visual imagery*

‘I’d go into screaming tantrum rages, erm and I’ve got quite a clear mem-and I would’ve been about two and a half/three, of...screaming into my mirror, looking at my own face in the mirror, you know, absolute (laughs) hissy...’

#### *Auditory imagery*

‘...my dad being really cross “What are you doing up there, absolute, you don’t do the washing up without us being, that’s it straight back in your bedroom and I will come and get you when...I...you know, erm when I’ve decided you’ve erm”...’

There were images of comfort and connection, but may have held elements of exaggeration

‘...in this particular pack there was a toy called a Sunny Jim...er...and it-it’s like a sailor, but not-not really a sailor, it’s quite an odd (laughs) as toys were in those days, Sunny Jim...it was my life that I’d got one of these Sunny Jims, and my mum just being really happy that, you know, I was so happy’

‘... so we picked up all these pine cones and they went in the shopping bag, and they came all the way shopping with us, and all the way back again, and then that afternoon we made little pinecone hedgehog people (laughs)’

## Self-derogating images

‘...I don’t think at that age my face would’ve (laughs) have covered any emotion that was going thro-you know, erm er-er-er the bottom lip was probably stuck out about two foot, y-you know, erm probably was humphing about like you do when you’re...you’re little’

## Semantic

There was a good mixture of adjectives throughout the narrative, which were mainly positive for her parents, and some of the episodes suggest some idealisation of her mother.

### *Exoneration of her mother*

Despite her mother leaving the family, Zia emphatically excused her mother’s sudden departure, believing she and her 8 year old sister had been prepared for it, and that at 12 years old she was mature enough to cope with without her mum

‘Well, my mum left when I was 12...so erm...but again, oddly at the ti-er...er I don’t think it had much of an impact by then, and in hindsight I think she’d prepared us quite...well, in a way...’

‘I think really the only adversity was my mu-my mum leaving, but by then I think I had enough...strategies to cope, and erm, and I had enough in my life to cope as well, so it wasn’t, I-I did have a job, I had school, I had quite a lot of friends at school...erm, I had me little sister...so, yeah, I think we had the techniques to...to cope, really’

### *Idealisation of her mother*

Although not emphatic, some of the reported episodes suggested an element of idealisation

‘...but my mum was always...you know, all the usual sickness things got wheeled out, so you know, warm Ribena, and...erm duvet on the settee, and erm...it was the only time I was allowed ice cream as well, the only time, so that was really significant...we didn’t have frivolities like ice cream, erm so...fizzy drinks I was allowed as well, Tizer, which you would never be allowed a-you know, I don’t know if they still make it,

that-that was always a poorly thing, so if you were poorly you could have Tizer...erm...and that's the, you know, as mums do, that sort of trying to tempt you to have something to eat even though you really didn't feel like it, so again, the only time there would be more than one offer (laughs) for what-what er what you can have'

### *Minimisation*

'it was almost my mum has thought "Right, my work sort of here is done" you know "I've got them secure, I've got them..." you-this-er my sister would've been eight/nine, erm...and...she then felt the time was right, that she could sort of...leave us'

**'OK, so when your mum left did you feel that as a rejection?'**

Z: Not really, er-er, like I say, it was more a relief that they were going to be happier...erm and that we weren't living in that slightly toxic...so it was better...for...them to separate...I think it softened me dad actually in a way, erm, and I think me mother was much, much happier...much happier...so, it was a positive more than a...negative, yeah'

### *Analytic*

Some of the episodes were slightly analytic

'Erm...uh... my dad was different, and I again I think that was a generational thing, so I think for his time he was fairly hands on...erm er wasn't that hands on 'cause he wasn't there really, he was at work, so I mean he worked quite long hours...er...but, you know, when he was there we had a good time...'

'I think the older I got there was...disapproval, but I think that was...generally, I think wa-er you know, was meant in the kindest way, you know, as a sort of learning curve to it, you know, about choices you make about your, but I don't really remember it as a young...child, erm...we were great ones for talking it through, you know, "Can you understand why that might not have been a great thing to do?, you've done it, but actually I'm not very happy about that" but I can't think of anything specific...'

### **Episodic**

The narrative throughout the interview was clear and coherent and fit with the semantic labels. Zia was able to integrate her parent's perspective with her own, she used plenty of detail, sometimes with a slight balance towards details and objects, but always connected to the adjectives. However, there was a tendency to move to the parental perspective, with some examples of cut off.

#### *Parental perspective*

‘...it got a bit like that, where, you know, er “Hmm” (laughing) and I probably was being very dramatic for something that just had, you know, probably like the 90th time they’d gone through why I had to have it done’

‘...I can remember this quite distinct-and sort of thinking “Actually perhaps I am being a bit of a drama queen” (laughs) “I won’t admit it, but I’ve, yeah, and er actually they are sort of right”...’

‘...and she moved in with a chap down in...and knew the physical size of the property she couldn’t have taken us with herself-with her anyway...’

#### *Cut off*

‘...thinking about my first day at school, I just went in and...went, which my children didn’t, they howled (laugh) a long time, erm...so I don’t...really...remember (3 second pause) a time (2 second pause) I ca-er can’t actually remember a time, I don’t think that I did go and seek it, I think it was...yeah...yeah, nothing that springs to mind’

### **Integrative**

#### *Integration and reflection*

Zia offered many examples of spontaneous reflection, an understanding of her parent's perspectives, and her own developmental understanding – as a child vs now, past and present reflection

‘I think if there was any kind of feeling it was that er...er...a feeling of...(3 second pause) and again, this is coming from an adult perspective so it probably wasn’t quite as...erm...but that...the feeling of er I should be good, and I should eat them, so but actually on this occasion I’m not going to be good (laughs)’

## Appendix 14

### Detailed Analysis of the Interview - Carrie

There is little positivity and warmth in this account, as Carrie evidently finds Ellen difficult to parent, and appeared to have trouble finding positive things to say about her. This was evident from the very first comment in the interview

‘... I’ve been having lots of problems with my eldest. She’s 13, umm, so at the moment, it’s kind of, she’s up with her Dad, but it’s... (three seconds) The tensions are high ...’

Even when explicitly asked to say something positive about Ellen, the comments seemed almost immediately undermined with a negative, either obvious or hinted

#### ‘What do you like most about her?’

C: Um... (five second pause) Hmm, never thought about that one before, um... (four second pause) I guess, when she’s, um... (three second pause) like, um, parts of her personality is quite, can be quite, you know, quite fun, and, um, cheeky, you know, it’s part of her personality, I guess, um, you know, but there’s only certain times when she’s like it’

And

‘I dunno where we really clicked, um ... there’s so much that goes on with her that’s negative, it’s hard to think of any positive, you know, m, uh... (16 second pause) It’s a tough one, that is, it’s really tough’

She struggled to find three adjectives to describe Ellen, which all had undermining or slightly negative connotations, if subtly so ('character', 'old beyond her years', and a 'drama queen'), and the episodes to illustrate them seemed undercut with elements of negativity.

'Character' seemed to be used to dismiss what she may see as her daughter's boldness, while 'old beyond her years' used the words of a mental health professional to seemingly voice her own feeling that Ellen may be too clever and possibly manipulative, although this is hinted at, and would be referred to as 'ventriloquism' by the MotC

‘... a professional actually said to me, that was working with her. He was sort of working on emotional issues and stuff like that with her, and he said “sometimes you really have to step back”, and she’s only 10, at the time, he said “you really have to step back because you don’t, you almost forget that you’re speaking to a child and not an adult”.

And

‘I dunno whether it’ll shock you or not, really, she’s like, um, she’s made up things to create drama, like, um, like being pregnant for one ... um, she’s done it twice, I believe, 12, maybe the first time, no, 11. 12. 12. 12. She was 12 and she’s done it recently as well, this year, and um, gone right the way through even as far as sort of getting photos from, I don’t know where, scan photos and stuff off the internet. And photos of babies and really like, following through ... so, yeah, real drama queen, she likes to create drama and she just thrives on it’

Carrie did not appear to be able to mentalise on Ellen’s behalf in this episode, nor did she appear to show any curiosity as to why Ellen might repeatedly engage in such extreme behaviour, or what might have pushed her to that point. However, there was less hesitation, in comparison, in choosing adjectives to describe herself, all of which were positive

‘I would say strong. Um... (two second pause) Selfless. Um, and one more, um... (two second pause) Um, one more... (six second pause). Um... (six second pause). Caring, I guess’

There were several instances where Carrie reported needing help with Ellen’s behaviour

‘She made out to them that I basically used to, like, beat her and all sorts, um, and... which was untrue, obviously ... and here she is saying that about me, um, which was quite, you know, quite traumatic as well for me ... because, you know, as much as I loved her, I just didn’t like her ... so there was a period she stayed with my sister ...’

And

‘... with Ellen, obviously, I’ve had lots of issues, um, and... (two second pause) I had to call the police on her, um, for attacking me, basically, um, so... I made that choice to call the police and have them come out, um, and they told her that if she did it again, she would be in the cell’

The relentlessness of Ellen’s seemingly ‘bad’ behaviour is obviously overwhelming for Carrie, and she sends Ellen to live with her sister for a while or calls the police to help,

rather than tackle the issues that are driving the behaviour. The MotC refers to this as abdicating parental responsibility. Looking at Carrie's AAI and the model of parenting she had from her parents, it is unsurprising attempting to avoid the issue has been Carrie's strategy, she was not given the skills by her parents to deal with the situation head on. On top of this, the unremitting, intense pain and fatigue associated with FMS, coupled with her depression is likely to mean she just does not have the resources to cope, and, when faced with the discourse of what good mothering is and her inability to meet it, her only recourse is to avoid the situation.

Despite all of the tension and trauma, there were moments where glimpses of joy could be gleaned

'C: ... in the car, for instance, um, a lot of the time we'll have like a giggle and, um, she loves singing, so, like, usually when we're in the car and there's music on and we'll have a bit of a giggle, sort of, you know, singing along and she'll be like "Oh mum!", you know, that kind of thing, because she knows she's like, she loves singing and goes, you know, over the queen drama queen style. (Laughs) And I'll just pretend I can't sing and stuff like that ...

**How do you think Ellen felt?**

C: Um, I think she was happy too, um, he loves to have a giggle and, you know, there's, she always likes there to be laughter and whatever, so, um, yeah, so when she's laughing, you know, proper laughing you know that she's, she's content then as well, she's happy'

Ellen's love of music and singing could be a medium to bring them together, a common ground on which to build closeness and although not explicitly stated this may have been the case.

There were possible indications which highlight why Ellen may have to resort to extreme action to get Carrie's attention

'...It's like the other day she couldn't, she thinks she can't draw, she can, but in her head she can't draw, she had to draw this beast for English and she was like "draw this for me, mum", and I was like "no" and ... and she's like "you can draw,

I can't", and I'm like, "no, I'm not doing it", you have to draw the line somewhere, and, you know, she was getting right thing about it, that, you know, I wouldn't help, and made out then that I'm some awful mother because I won't help her with her homework and I'm just like "no, I'm not doing it".

Although a compromise might have been arrived at, with Carrie possibly showing Ellen how to draw a beast, instead there was an outright 'No'. However, Carrie showed some guilt at not helping with her homework

'I was just tired, I was so tired, just thought, no, it's her homework and I'm not bailing her out ... I felt a bit, like, bad that I had, sort of, told her no when she was actually doing her homework for once, which, you know, so maybe, you know, in a sense I should've maybe, you know, been a little bit more helpful, but at the same time'

There seems to be the sense that helping with homework is 'bailing her out' and asking for assistance outright does not seem to get the help Ellen needs. An answer as to why that might be is found elsewhere in the account

'if I have got to go out and she's in the house she's more than happy, then, to go and make herself food...she's more than capable of, you know...but the minute I walk back in that house I become her slave...when I walk in and I see, like, for example, she's, you know, she's cooked herself some chips...I suppose I should be glad, really, that she's showing that independence but part of me...the frustration is if you can do this when you're on your own, why can't you do it sometimes, you know, if I'm not well or whatever, why can't you do it then?...it's very frustrating and deflating'

Rather than receiving praise for independent behaviour, for Ellen, it only seems to end in more conflict and disappointment. She gets in trouble for not making her own food, but also gets in trouble when she does.

When Ellen is at her dad's it feels like respite from an interminable crisis for Carrie, but she also feels as if she's losing her, which she finds difficult to deal with

'Like now when she's with her dad, um...I do feel like, um, I'm losing her, to be honest, umm, it's difficult'

The difficulty comes when Carrie feels Ellen takes her dad's side against her

‘...her dad, um, you know, there was domestic violence in the relationship and he’s very, um, narcissistic and, I think, um, he lies about stuff, and the problem is when she’s around him she absorbs everything that he, um, that he says and does’

The DV Carrie suffered at the hands of her ex-husband continues to cause disharmony and conflict between them, and Ellen seems to have been brought in as an arbitrator

‘In the heat of the moment I disclosed to Ellen that there was domestic violence in the relationship between me and her dad, she was a child, she may remember, to a degree, um, but, he basically told Ellen that I was a liar and the whole of his family did, actually. Um, and...he knew that it was the truth, but he like, he didn’t want to take the heat, and how she would look at him, so, um, he plays the bad guy, so that he would have the better relationship’

Both parents seem to want to prove to Ellen that they are the innocent party, the passive partner to whom these bad things have been done, and the other is the source of the on-going conflict. Neither appear to consider the effect on their daughter, exonerating themselves from blame seems to be the main goal, resulting in some heavy triangulation for Ellen.

Carrie’s difficulty in parenting Ellen is summed up by this comment:

‘Even though sometimes you feel you’re so consumed and overwhelmed that you just want to give up ... there are times where it’s so hard to show her and continue... showing that love towards her’

## Appendix 15

### Detailed Analysis of the Interview - Linda

Initially, Linda seemed to show some idealisation of Jago and a sense of her needing him to nurture her, and almost straight off her pain was brought to the fore

‘...he’s loving on a regular basis with myself, especially if I’m struggling, if I’m having a bad pain day, he will love and he will hug me or he will ask me if I need anything, any support or ... he’ll just say are, ‘Are you in pain today, mum’, and I’ll say ‘Yeah, why’ and he’ll say ‘Yeah, I can tell, is there anything you need me to do’, you know, he, yeah, and he’s like that with his sister as well, he’s, if she’s not great’

It may be that Jago giving her love and comfort when she is poorly is reminiscent of her childhood, where she reports being ill was the only time she received nurturing from her mother.

There seemed to be a heavy emphasis on Jago’s schoolwork and achieving, something she seemed very proud of

‘...he’s just going into year nine at the moment and he wants to, um, take one of the subjects, um, one of the highest subjects of triple science’

And

‘You can see he’s passionate about Physics and he gets very excited talking about it (Nods) and um, you can just see it in his face’

And

‘He wants to work in some kind of um, computing but he’s thinking about aerospace engineering as well, so working like, doing all the, the programming and satellites and that’

Linda tended convey quite strong feelings about being a parent, and it sometimes seemed difficult for her to distinguish her own intense feelings from Jago’s perspective

‘if I step back from it, I try to put myself in his shoes, I’d be happy that one, my mum was aware of it and two, she was interested’

She could hardly speak about him without an intrusion of herself, almost as if she cannot see him without seeing herself reflected back at her

‘Um, he’ll have a cry, instantly, he’ll go straight to tears if it’s really upsetting, m, or he’ll go quiet and he’ll, just like his mum (laughs), I’ve just said that out loud, I do both of those things as well (laughs)’

When asked how her anger affects him:

‘it gets him angry I would say, because he’s quite defensive...he has said to me, quite recently ‘It’s a lot easier if I do as you ask isn’t it?’, they were his words (laughs), his words, and I just went yeah, it is really’

‘...but he has said that to me already, ‘It’s just easier if I do as you ask’, my, my response to that was ‘Well, I don’t ask you to do that much really in comparison to maybe my own childhood, or his friends, you know’, and he’ll go ‘Yeah, I know really’

Linda seems to have lost his perspective completely here, there is no sense of what he actually might be feeling, just as long as he complies, it appears, all will be well. A lot of her inability to take Jago’s perspective sometimes appeared to come from an ostensible need to self-justify

‘I, I, I really have to almost take part of my head out, and just become a parent and stop, because ...while I’m talking to him I get these, where I think ‘ok, am I doing the right things socially and emotionally here, am I affecting his confidence?’ and I really, it’s like a second voice in my head, but no, I’ve just got to be a parent and trust my parenting instincts’

The ‘second voice’ may well be her actual feelings, not her ‘parent-voice’. It appears that the ‘parent’ is the first voice that she is talking down, so this commentary appears self-justifying, as if she is attempting to exonerate herself for not taking his perspective. However, at times Linda does try to see things from Jago’s perspective, but it seems a very hard take for her

### **‘What was his argument for playing Fortnite?’**

L: Um, it’s a social aspect for him, he said it’s his social outlet so it helps him relax, however, in my opinion we are going to find other ways of channeling that, so, yeah, keep a balance, but he

did a pretty good argument actually, I was quite impressed (laughs)'

Occasionally, Linda seeks advice of others to help anchor her sense of being a parent, and to check her responses are correct

'I usually talk them through with my partner, um, I usually find he's a really good sounding board, or I'll talk them through with my best friend, she's a really good sounding board ...so, we tend to batt it back for a bit of a 'Are you doing alright' sort of thing (laughs) um, and sometimes just to check in that it's normal to feel like that, just like, you know, am I going crazy and I'll talk to my friend or my husband and they'll go 'Nah, I feel like that too', I think that's, as soon as I hear that I think it's not just me then'

And

'when he started seeing his school and I was like 'I'm gonna run him to school every day' and my husband stepped in and he went 'No, he needs to walk to school, he needs to learn to walk on his own', and that took a lot of my head getting round, but, and it's the best thing, it grew his confidence and he wouldn't, I very much unless it was throwing it down that he would have me dropping him off now'

Checking in with other parents to ensure she's on the right track seems a healthy practice, and seems to help confirm her feelings are natural, or will help her adjust her thinking where needed. She is aware there may be problems with her parenting

'...he tells me I'm over-protective and that, that manner of me feels like um, sometimes I, I, I get the impression that I'm stifling his growth a little bit emotionally, maybe emotionally'

'I constantly worry that I'm screwing them up, all the time...so I will, as in my parenting choices I will second guess what I'm doing and I will look deeper and look at the, what I might be doing on an emotional level more than just a parenting level which is a curse now (laughs) it is, it really is a curse...'

Linda seems able to access cognitive information as to how she should parent, but her anxious 'second voice once again undermines her parenting choices. If we link this back to her childhood, how frightening and comfortless and lonely and insecure it was, her behaviour begins to make more sense. It may be that she is terrified of doing the same things to her

children, and possibly noticing herself occasionally doing similar things as her parents, albeit on a much lower scale, and this may trigger those memories and cause her anxiety. This sense of parenting anxiety appears to have been present from Jago's birth

'I would try and be less neurotic when he was little (laughs), if I had the time again when he was little, I just wish I'd of paid...less time about the floor being clean that he was crawling on and more time enjoying watching him crawl...I was quite neurotic with him'

Considering her upbringing and her corrective script, it is possibly unsurprising she is constantly worried she may be repeating her mistakes her parents made.

Linda's pain-condition is a theme that repeatedly emerges throughout her account, and there is the sense that she fights hard to stop it overwhelming her completely

'...going to university and doing this degree, while I'm, while I've got this condition, um, it's been really, really hard, um, but the drive is a lot stronger than, than any of the physical element'

And

'...doing the final exam possibly, was, was stressful, um, I'd do a lot of revision for it and like on the day of the actual exam, I was pretty much burnt out and I could quite have easily, in fact I know I could have easily got it postponed due to my condition under the, the medical terms but I just, and that's just in my head most mornings when I just don't want to take the day on, but the drive will kick in and it will be and I was like no, I'm gonna do this, I'm gonna go and I'm gonna pass it and I did'

Linda shows the same resilience against the devastating effects of her FMS that she needed to get past her childhood and adolescence. Her counselling degree seems to afford her some social leverage against the negative social aspects of her condition, as if it negates some of her disabilities, especially in this current political climate where disabled people are not seen as socially viable. If she has a degree, then she holds some social worth. It is obvious the FMS is a mountain she has to climb each day

**'And what gives you the most pain or difficulty from being a parent?'**

L: Um. (3 second pause) I would say it, it's physical again actually, I would say it's, it's exhaustion, I'm shattered, I'm absolutely shattered, um, and there are times when I just don't want to do it. but you don't have the choice, do you, it's not an option, it's not an option'

Talk about pain seems to be quite ubiquitous within the family, it is not hidden or glossed over in any way

'...cause I'm quite open about my health with him, I don't, I've never hid it from him and, and if I'm not happy, if I'm feeling down or sad...'

There appears to be no real thought to what it might be like for a child to see their mum crying, or in pain, or distressed, what would that feel like for a small child, or how would that affect their sense of security and safety.

Linda recalls how her FMS caused great difficulties during pregnancy, some of which have stayed with her, but it appears the flare ups and physical damage were worth it

'I have, I've got long term, um, serious health conditions with my back, serious conditions with my back because of it and my hips and stuff, so, that's irreversible, so, um, and then emotionally, with Jago, I would say, I would go so far as to say he gave me, he gave me meaning out of no surprise...I found my meaning really. I felt like I had purpose when I had him'

Initially from this excerpt, it seems as if Linda needs Jago, indicating a possible risk of role-reversal, however, when you consider her childhood/adolescence; the abandonments, the child sexual abuse, the loss, the trauma, the suicide attempts, the violently abusive relationships, the drugs, the chaos, etc, she was lost on a stormy sea for the vast majority of her life, and it sounds like on his arrival Jago became her anchor. She had to stop and be responsible, or risk perpetuating the cycle of her own childhood, and as we know she has a corrective script, this would be of great importance to her. So rather than Jago, per se, it was possibly having to be responsible that finally gave her purpose and routine, and ultimately some meaning emerged from the chaos.

## **Appendix 16**

### **Detailed Analysis of the Interview - Karys**

Reminiscent of her AAI, Karys repeatedly described family life as happy and close, and as having a very loving and intimate relationship with her daughter. When asked to consider difficulties, Karys appeared to find it difficult to consider negative aspects of their relationship. Overall, the interview created an impression in me that Karys had a strong wish to depict family life as outwardly conflict free.

#### **‘Can you describe a time when you and Luna weren’t clicking or didn’t click?’**

K: (Five second pause) No, not in the last week. (Three second pause). No. Can’t

**No?**

K: No (shakes head)

#### **Nothing at all where -**

K: She’s not like, you know, I don’t have to shout at her or tell her off and stuff, and I’ll say to her “right here are your jobs for today”, she’ll-she, I say “they don’t have to be done now, but within the next hour”, she- she’ll do them, I don’t have to keep on to her. So’

She uses the phrase ‘She’s not like [that]’, which seems to imply that, for Karys, Luna does not possess the ability to behave unhelpfully. However, she did hint at mild issues, but these were presented in a jokey way, which appeared to minimise the negativity of them.

#### **‘Okay, what do you like least about Luna?’**

K: Her short temper.

**Oh okay**

K: (Laughing) That was quick

**Yes, it was wasn’t it?**

K: (Laughs) Yeah'

And

**'What do you like most about Luna?**

K: See, I could say when she goes up my mother's couldn't I? (Laughs), when she's in bed (laughs) ...'

On the surface this appears somewhat mocking, or derogatory, but the jokey tone seems to soften and neutralise this.

Karys often described Luna as a perfect child, seemingly implying she has no faults. This is referred to in the MotC as imaginary idealisation.

'Oh, she is. She's a darling'

And

'Aw she's amazing, she really is'

And

'She gets up fine in the morning, she goes to bed and, you know, she sets her own alarm to get up, we don't have to get her up in the morning, yeah, she's, she's fab ... but, you know, if I'm not well she'll get up and get herself off to school ... but um, yeah, she's-she's fantastic she is, and like I'll get up and there's a glass and my tablets on the side ready for me and yeah, she's really good, I know (rolls eyes), make you wanna cry, don't she?'

Karys may be influenced here by wider ideas about what it is to be a 'good mother', & the fact her pain condition prevents her from fulfilling this role, or living up to the social discourse around being a good mother, she possibly over-compensates by praising Luna as an 'angel child'.

She describes their relationship as very close, and the examples she gives for these all involve Luna's caregiving. There is a particularly strong theme of role-reversal throughout

the interview, of Luna being Karys's carer, and while it may seem as if Luna's value is based on her caregiving role, Karys expresses appreciation for all that Luna does for her

'Basically every time I-I-I-I'm, I'm unwell, but I try not to be, you know, when I think, oh you know, I don't want her to see this, and she comes in from school and it's a case of "you're not well today mam, I can see it in your face" and it's, you know, "come on come to bed" she'll-she'll get me into bed, she'll get my medication for me, she's, aw, she's-she'll help me dress, aw, she's amazing, she really is (nodding)'

And

**'So, can you think of a incident or a memory that comes to mind with respect to the relationship with Luna being close? So, something specific**

K: I'm trying to think of one specifically, because it's, it's quite difficult, you know, she does do so much. Um.

**Just illustrates the closeness of the relationship**

K: Ah (sighs), back um, about probably March/April time I would say, I wasn't very good at the beginning of the year. January/February I wasn't very good. I remember going down to town with her and I was *really* wobbly on my feet, and she made me go on the inside, not to fall into the road like, you know, like you would do with a child, like I used to do with her when she was little and she held my hand all the way down to, to town. And I think for a thirteen-year-old girl to do that, in in public, you know? You don't do that, do you (shakes head)? You don't hold your parents' hand, and she literally held my hand all the way down, yeah, she 11 made me go on the inside, so I was safe, and I did go into the wall at one point and she was like "see! That could've been a car" (laughs). It's a bit of a role-reversal with me and Luna sometimes'

Although Karys identifies the term for their relationship, 'role reversal', from a MotC point of view she does not seem able to fully mentalise further on behalf of her daughter.

However, from a social constructionist position, for Karys, her reality may be that she's failed to live up to the socially constructed view of a mother, and her young daughter has

almost given up her life to care for her, which seems a difficult position for her. This can be seen where she shakes her head after saying ‘You don’t do that, do you?’

All of Karys’s episodes focus on Luna’s actions as opposed to her feelings. When she was asked to imagine how Luna might have been feeling, Karys appeared to find this difficult, and relied on Luna’s outward displays of laughter as the gauge

**‘How do you think Luna felt?’**

K: Well she was laughing like hell, so I think she was enjoying herself’

Karys sometimes appeared to find it hard to recognise Luna’s needs and put them before her own, which the MotC calls abdication of parental responsibility. For example, when asked how Luna feels when she sees her mum in pain and feeling sorry for herself, Karys struggled to mentalise on behalf of her daughter, and she uses the fact that Luna does not outwardly seem upset to mean she was content with the situation. Again, the MotC calls this refused mentalisation

**‘When you feel like that and if Luna is around, what sort of effect do you think that might have on her?’**

K: (3 second pause) Err, I don’t worry about that ...’

From a social constructionist position, this may be an example of Karys constructing an environment where she does not have to confront a reality that impinges on the safe, happy one she has built for herself and her family.

As she continues the discourse it appeared as if Karys needs Luna to help regulate her emotions, and soothe her. She does not appear to be aware of the possibility that Luna might find seeing her mum in pain upsetting, and there is the underlying sense that Luna is may be left to navigate difficult emotional territory alone

‘I think, you know, she sees me like it a lot, and I don’t want her to pick up on-on things as well ... and like I say, she’ll come in and put her arm ‘come on’ she’ll say

‘Cwuchth in’ and I’m cwutched into her on the settee and she’s stroking my hair or my arm ...you know, ‘Do you want a cup of tea’ and ...and just look after, she’ll just sit there, you know, and say ‘Shall we watch a bit of TV’, she’ll try and distract me then, you know?’

There are moments of genuine warmth and sincere affection that shine through the narrative, with glimmers of Karys being able to reflect, but currently it appears that it may be too difficult for her to think that the situation might be a problem for her daughter

‘Um ... She’s got a lot more on her shoulders than a lot of 13 year olds have (4 second pause) you know? (2 second pause) but, she says “I’ll do this” and I say “Lune, you, you know, shouldn’t be doing it, leav-I’ll manage” and she’s like “No mam, I’ll-I’ll help”’

What emerges from Karys’s interview is that Luna is committed to caregiving for her mum. This drive for caregiving seemed to be present from a young age, as can be seen from the example of Luna being described as being an ‘extra member of staff’ at pre-school

‘Yeah ... they always said in-in nursery she was like another member of staff (laughs)’

Throughout the interview Karys emphasised the point Luna is very independent, and ‘old for her years’.

‘Um, well, she’s, she’s very strong. And independent’

And

‘...in general she’s way too independent for that (laughs) she is...you know?’

And

‘She’s so old for her years you know (smiling), she really is’

And

‘Like I said you know she’s, she’s safe and secure, and she is mature for her years, and she’ll have a conversation with an adult’

## Appendix 17

### Detailed Analysis of the Interview - Analie

Throughout the interview there was an underlying sense that Analie wished to impress her value on the interviewer, and to show herself in a positive light. This was evident in the passages where she was asked to provide adjectives to describe herself, and Analie seemed, quite rightly, very proud of her accomplishments.

#### **‘OK, so again then, can you give me a specific incident, or memory that could illustrate your artistic side?’**

A: That’s difficult because it’s so much a core of what I am ... and who I am. So, it, it’s a ... to find one example is quite hard but ... I designed costumes for the opening of the Olympics, ... um... and ... yeah that’s kind of ... one of the big things I did so (laughter)’

‘I’m a passionate feminist and ... a ... a student got in touch with me, um, and ... er, to say thank you, um saying that, um, it was, I, that I’d always talked to her and talked to the class about why it was so important as a women to vote, um, and why it was important to be politically active ... and she’s now, um, running for, um, for office, um, and that actually she’d never seen herself in that frame ... um, until I drummed it in her head that she could be in that frame (laughs) ... um, and showed her ... e, y’y’know, she said i’d showed her how important it was as a women to b, to be heard ... so’

‘I write to a chap on death row ... who ... is the only standing criminal to um to have been convicted and ... given the death row penalty twice ... so yep I write to him, um ... because I believe that he’s still a human being ... I, similarly, I will always talk to, um people who are homeless, or struggling on the street, and I will encourage my children to the same because ... they’re still human beings ... um and sometimes if you talk to them, they’ll find, they’ll say to you that actually the thing they want most is for somebody to say hello and somebody to interact

She uses rather evocative, often intense language to recount the episodes, which the MotC would view as controlling markers. From a social constructionist perspective, however,

although seeming to be ‘humble-bragging’, considering she has all but lost the life she wanted for herself to debilitating illness, this could be seen as Analie craving to be seen as alive, with talent, and as holding a useful place in the world, disguising the physical things she is unable to do, and not just a mum, or a woman in pain to be pitied. Analie comes from a middle-class, relatively wealthy, privileged position, so her talk of Olympics, ballet, and writing to double murderers on death-row can be viewed as discourses of entitlement. On the one hand she is the product of her class, bringing discourses of achievement, but on the other her life is flawed and failed, because she cannot physically do things herself due to pain, bringing with it the reality of her body.

There was a tendency to mask what seemed like an underlying anger/frustration towards Chico, as seen in the next passage, and elsewhere in the interview

**‘What do you like least about your child?’**

A: Um, (laughter) it’s that ... yeah, I, pffft ... that inability to listen ... drives me ... to distraction ...that ... single-minded belief that he knows best ... um ... when he doesn’t (laughter) he-he ju ... yeah you can’t get past it and that ... I find, yeah winds me up. Um ... I ... don’t like ... um (7 second pause) he’s very competitive, really competitive, um and sometimes ... too much so. He has to win, has to have the last word has to, yeah ... (laughs) um yeah, I, I, I find that difficult (2 second pause) and I find his reaction to pain very hard’

Negative comments about Chico would often be sandwiched between laughs. The initial laugh may signal her anxiety regarding her anger, almost as a method to avert the interviewer from seeing her in too negative a light. Analie’s subsequent laughter could be viewed as a way of neutralising the negativity of them

‘I was really frus ... really frustrated, really sort of ... It- it was unnecessary, if he'd have just (laughs) slowed down or listened to me the first time when I took time, I think it was the fact that I'd taken so much time to explain to him why it was important to me and why he needed not to do that,

for him to then go and do it straight away was uh just made my blood boil (laughs)'

And

'I know I'm strict ... and ... sometimes ... it has also led to sort of ... um ... hiding things? ... 'cause he'll do stuff that he knows is wrong ... and th-then he'll hide it ... um ... because he knows that I won't-he knows there is consequences to actions as far I'm concerned ... um so, if he eats all the biscuits in the biscuit barrel (laughs) he will be in trouble for it, so he hides the biscuit barrel (laughs) (5 second pause) which then gets him in trouble twice (laughs)'

Analie's expectations of a nine-year-old child seemed high, and she often appeared frustrated when he could not meet them and behaved like a child

'I think he-er tying his shoe laces, he can't do ... but he will, he'll try, and then he'll get it wrong, and then he'll ask um ... sometimes he'll try and he'll try, and he'll make a complete mess and hide the situation ... um ... so he will put on a another pair of shoes (laughs) ... and then I'll find yeah a shoe with five million knots in it in the shoe cupboard'

Whilst in the quote above Analie showed some awareness of Chico's needs, she did not develop this further to reflect on how he might have felt emotionally, whether embarrassed or ashamed, nor how she might have helped him. Instead, the talk repeatedly took a turn towards Analie and her needs, as if she struggled to focus on him when talking about a memory or episode. She would veer off to talk about her needs or her pain condition. At times the episode or memory seemed to be used as a vehicle to demonstrate to the interviewer that despite her physical limitations, she could conform to the discourses around what constitutes being a good mother

**'A learning relationship, that's a really interesting one ... can you give me a specific memory that illustrates that?'**

A: ... um (3 second pause) but (3 second pause) he (2 second pause) I'm a teacher ... it's what I do ... um ... and ... I can't-I can't turn that off ... um ... so ... the summer that he went to school ... um ... we ... spent the whole summer doing what I christened the alphabet challenge.

So, each day we did a new letter of the alphabet and we did activities relating to that letter. So, on C day we went to the canal uh we baked a cake uh we made a giant 'C' out of cars uh (laughing) that sort of stuff um ... and a lot of what I do with him ... is revolves around learning something ... um ... and ... I will always try and explain to him why he has to do something, or why he doesn't have to do something ... or what the-the route is ... um ... so that he understands he's being yelled at ... because (laughs)

The episode above was meant to be about their relationship, yet there is very little sense of Chico in it, it is more about Analie and her competence in combining her skills as a teacher with being a mother.

'So ... he has friends over ... kids always do, um but I have a no screen time policy when that happens ... um partially because he goes over to friend's houses and they y'know go on Minecraft, they sit in front of a tv for hours, um f-I don't consider that necessarily to be spending time with each other ... so anyway uh we don't do it um we always make something um and whether it's a cake or biscuits or ... um ... slime or do some kind of crazy science experiment ... and ... the result is he has a waiting list (laughs) ... he has a friend's waiting list err because they want to come and they want to-do they want to do ... something ... creative and finding out he had the friend's waiting list was (laughs)'

Analie mentions punishments for minor misdemeanours and solutions for issues Chico might be struggling with, both of which tended to be quite cognitive in nature. This makes sense when it is remembered that Analie's attachment pattern is reorganising from an A+, which relies heavily on cognitive information and ignores or distorts affective information. However, the use of dismissing strategy may be threatened by a child who offers some challenges and raises the mother's emotional arousal. This coupled with either the experience of pain and/or a wider sense of unfairness and victimisation by her condition may result in a dismissive strategy, absorbing some more punitive and controlling aspects towards her child. For example, she described her the 'naughty step' procedure

'he went through the typical three-year-old pushing boundaries...push, push, push, push, push...and... he'd spent a

whole day pushing buttons, and we out with um both sets of grandparents, we were out at a big stately home um and he'd been y'know being naughty, and he'd been told...a stick... Put it down, put it down, put it down' and he hadn't, and I'd given him the warning of you know 'If you don't put that down you will go on the naughty step'...so I responded by picking him up and putting him on a naughty step and telling everybody else to ignore him for 4 minutes'

Here rather than trying to understand what her child might have needed, how he felt, for example, bored, frustrated, wanting her care, she instead focusses on a strategy to control his 'pushing the boundaries', which is a semantic and psychological/professional construing of the child. She refers to this again:

'...but there was an instance where...uh I put him on the naughty step which for an nine year old boy is 'WHAHA' as I'm sure you know...um...y'know there's that kind of 'well I'm too big for a naughty step' and...'I'm on the naughty step' the whole confirmation...'

In the example above she indicates some awareness of what may be appropriate for a nine year old, but difficulty in connecting with how he might have felt about this punishment.

There were times when Analie appeared frustrated and angry at Chico's inability to fulfil the chores she set him.

'um so he-he comes down in the mornings his breakfast is on the table ... and his job is to eat his breakfast, pack his school bag, make sure everything's ready, get his pack lunch out of the fridge ... and make sur-get dressed, make sure everything is done ... he went through ... a stage of deciding actually what he was going to do was ... get dressed, come down stairs and sit in front of the television, and watch the television because I was upstairs dealing with Alanah, dealing with my joints'

And

'... and low and behold the next morning ... he was sat down here watching the television, consequently I removed the PlayStation for the week um and he went to school in tears um ... and ... but from my perspective I feel that it was fair in that I-I-I'd... talked to him about why and what was going on I'd given him a warning that said what was going to happen if you

do this again and then I followed through... I consider that to be fair'

From a MotC perspective, Analie shows no apparent awareness of Chico's zone of proximal development, there is possible abdication of parental responsibility - in that she has given a nine year old a very large amount of responsibility with no adult supervision, and projected mentalising - in that she believes he deliberately ignored her instructions not to watch television. A social constructionist position might take in her mention of her joints. For example, elsewhere in her account she explains how stiff and painful her joints are in the morning, and how it takes a while for her painkillers to kick in. Remembering how much pain Analie is in each morning, her frustration at Chico's apparent disregard for her instructions becomes more explicable.

Her account indicated an oscillation between seeing her son as deliberately being difficult and oblivious to her pain and needs, and, in contrast, seeing him as enjoying activities which could possibly be construed as his attempting to please her

'He's a dancer, so erm he, he, he's a, is training to be a ballet dancer ... and he just doesn't stop. So ... we do erm three hours' worth of class, erm ballet class, on a Sunday ...'

And

'so the ballet the thing ... um ... so, he started it in September ... and part of the reason he started was because he knew it's what I did, he knew that I trained as a dancer, and that it-it was something that I cared a lot about ...the first session he came-he finished he came back with the biggest smile on his face and said he could see why I loved it and asked if he could do more, and I said of course, and then ... since then, every night he's been practising, and he practices with me, so um I do some of the exercises because I know they help with my-with my ... strength and ... um ... with my joints ...'

It is conceivable that Chico chooses to take ballet not only for his own enjoyment, but also as a way of being close to his mum, to spend time in a joint pursuit, and to please her.

Analie sometimes appears to lack reflective integration. During the interview she described a time that would have been very difficult for the Chico, but later talks about nothing being a setback for him and that he has had a 'charmed' life.

**'Do you think there are any experiences in your child's life that you believe to be a setback for him?'**

A: (4 second pause) Not really um he's been lucky so far um there's not...he's not really (2 second pause) he's led a pretty charmed life so far which is all I could ever ask for him um I think there are...me being me um that impact[s] upon it...'

And

**'Do you think Chico ever feels rejected?'**

A: (4 second pause) Sometimes, yes...but I think considerably that comes from-would come from him not understanding the word [rejection] in ent-in its entirety, I mean I think... he might say he feel rejected, but I don't think he necessarily...h-I don't think he necessarily...does...does that make any sense whatsoever?'

Although she is able to mentalise for Chico and understand that there may be times when he has felt rejection, she does not seem to spend much time thinking about the possibility. It seems too painful for her to think he may have had many setbacks. When asked if her son feels rejected, she oscillates between saying he does, and then he doesn't. Again, it seems it is too hard to think of her child feeling rejected by his parents, possibly because she internalised the rejection she experienced from her own parents whilst they were in deep mourning after the death of her older sister.

However, whilst warm moments and genuine affection do shine through the narrative, Analie seems like an anxious mum. However, an answer to Analie's ostensible anger, frustration, and inability to cope with Chico's childlike behaviour eventually becomes clear

'I know there-there are times when I know ... I'm being ... too strict, or I know ... I am (2 second pause) I know that he

desperately wants to share something with me, but I just can't ... see beyond ... I can't go beyond the pain I am in and I can't engage with him at that point in time and I hate that (2 second pause) because I-I know I've done it five minutes later when he's disappeared and (2 second pause) yeah that's devastating'

And

'... on Sunday um I ... was really sore ... and ... we'd had lunch and um I couldn't ... it was so bad that I couldn't eat ... I just-I was feeling really ... I was not coping um and the kids had wanted to go to the park and they'd wanted to go out but ... um but I knew I couldn't I-I-I just I just couldn't ... and ... I knew that ... um I was getting short and I was snapping at people um so I just took myself off to bed ...'

The effect of her intense pain on her children seems a heavy burden for Analie to carry, and she seems acutely aware of the role reversal, and while Chico's deep empathy for her when she's struggling with her pain evokes feelings of pride, it is a double edged sword, also bringing feelings of shame

'Chico ... um ... will ... say that he-he-he needs to look after me ... or that he wants to look after me um and silly things like sometimes when I'm sore ... he'll mimic Stephen's behaviour um ... so he'll ... he'll put himself in the same place that Stephen would put-to give me-to give me help and to ... um and I know I can't lean on him, he's 9 ... uh but yeah ... he'll-he'll do that um'

And

**'So how does that make you feel when he wants to look after you?'**

A: In many ways I'm so proud, I'm so proud that he, that he recognises that, he sees that and then he wants to care ... in other ways I am deeply ashamed of it ... because he shouldn't ... he shouldn't have to (voice breaks) (2 second break) it sucks (broken voice) (5 second break) um yeah ... he shouldn't have to (sniffing)'

## Appendix 18

### Detailed Analysis of the Interview - Zia

Zia seemed to take a little while to settle into the interview. From the outset, Zia's description of Tania is of a child who struggles to regulate her emotions. Her first adjective in describing her daughter was 'dynamite', immediately evoking images of explosions

'... and it escalated to the point that she took her seatbelt off and tried to open the car door as we were going alo-you know, really dangerous sort of things to do, erm and ... it was probably ten minutes, erm until she'd sort of come back down again, and she was in a place where she was upset ...'

Although she did palliate this with descriptions of Tania's empathy and sensitivity, initially, when viewed through a MotC lens, she seemed to use conflict laden and evocative language when discussing Tania's anger; language such as, 'red mist'; 'dynamite'; and 'throw herself out of a moving car'

'... I wouldn't say she's the least volatile child I know, but she really can go whoosh in an instant, and it's ... you can see you're beyond any point where ... erm, you can sort of negotiate with er, you know when y-d-d that sort of red mist, that sort of, y-you know, absolute she's gone whoosh and you're just gonna have to wait for the (laughs) the coming down'

Zia explained a lot of effort had been put into helping Tania regulate her big emotions, yet it sometimes seemed as if Zia's language was somewhat passive, and distancing. As if she watches her child regulate herself, and that she has trouble in actively supporting Tania in managing her difficult feelings

'... we've done a lot of work and-both me with her and PSA at school, around emotional regulation, so-and she is much mu-you know, d-different child these days ... but that's not to say she doesn't still have moments where-she's better at regulating it, and know-we've got strategies now and put in place, but erm ... i-i-you know th-the things are less dangerous these days and less impa-you know, she can't

get her own way, there are ... moments now where the dynamite will go o-and she just can't ... cope (laughs)'

Zia seemed to find Tania's negative affect and angry behaviour difficult to cope with, and this may have its roots in her abusive marriage and the fallout from the subsequent, extremely acrimonious separation

'... was I at a place in my head when she was born that erm ... I was going through absolute ... my ex-husband was i-y'know, he'd never hit me or anything like that, but he was real-really hard to live wi-er-er you know, you-er ... you never really knew which way the wind was gonna blo-so there was a lot of that sort of (sighs) static tension all the time ... then you've got all that in your mind about, you know "I've just had two young children, how can I have got this so wrong" (laughs) ... and so my mind probably wasn't solely on my new baby and I had a 20 month old as well, so they were quite small ... erm ... so ... d-did she feel rejected emotionally, may-y-maybe there was-I just wasn't there for her at times emotionally, 'cause I was too busy trying to deal with myself ...'

In the episode above, Zia is able to reflect on how her difficult marriage may have affected Tania and seems to be able to integrate and mentalise on her behalf.

Zia works in as a project lead for an organisation that develops research projects and training around adverse childhood experiences (ACES), and during the interview she had a penchant for using what attachment theory would refer to as 'borrowed language', or statements that involve specialist words or expressions, possibly either used by the professionals Tania has been involved with, or from her work environment

'... she will tell me she can't get to sleep, but um I think it's more that 'mind chatter', where her-she can't settle to get to sleep ...'

And

'... so, we've done a lot of work and-both me with her and PSA at school around 'emotional regulation''

And

‘... this isn’t one word, but it’s a phrase more that I would-she is ‘the fearless-fearful child’ ...’

And

‘... we were just totally there in that moment, almost like erm (3 second pause) (mutters under breath – inaudible) Dweck talks about it a lot, but it-er, yeah ‘in the flow’ ...’

It might be that Zia uses these phrases as a way of better expressing what she is thinking or feeling, but possibly may not have the vocabulary for. Or It may be to demonstrate competence, to show the interviewer that she has a greater understanding of and connection to what is happening with Tania, in effect using jargon to demonstrate that she is connecting with her daughter, or even possibly to establish a knowledge parity and connection with the interviewer.

Yet as she settles into the interview her reflectiveness and openness become clearer, and she is able to reflect on her own strong feelings and reactions to Tania’s difficult behaviour

‘... I’m trying to keep really calm and tau-sort of talk my way out of this and be diplomatic, and get her to make the right choice, but there is the erm chimp on the shoulder that’s saying “She ain’t listening to you (laughing) and she ain’t gonna listen to you in a month of Sunda-you know, you can try and be (laughs)” and she wouldn’t listen if I shouted either, so it-it-it’s not really the answer, but ... it’s that inner turmoil that puts me in that ... what do I do? What actually do I do now, because I ... in a way you’ve beaten me ‘cause I can’t-I dunno what I do with you (laughing) to make this situation any better, so I d-I-I feel frustrated ...’

And

‘... so all of that is inside, that real ... and despair sometimes where I just think “Oh I just don’t know what ... to do, I don’t kno-y’know, dunno where to go with this”, erm ... and, but knowing ... er walking away or doing nothing ... and I don’t mean by doing nothing there has to be a consequence or anything like that, but that kind of ... (3 second pause) i-if e-even if I only do the ... “I hear what you’re saying Tania”, I he-you know, the broken er-er the broken record that-so-that-I’m doing something to try to-to bring that situation back’

and to see things from her daughter's perspective

'... so one of the things she used to get really ... violently cross, so she'd kick me and bite me, and she'd be really explosive ... and getting some advice from the expert, and the expert said, you know, y-you need to d-my thing would be "Go and sit over there until you've calmed down" sort of thing, and that counterintuitive thing, well it was to me, "No, get hold of her and keep her close, 'cause she will calm down in the end, and actually, what she needs is for you to be close", so we did a lo-you know, loads of that, and really that's what the bed thing was about, and the clingy baby thing, actually what she wanted was me, that's what she wanted, erm and she needed me more than my other daughter had ever needed me for whatever reason that-that was, so .. yeah, erm when I'd got to that point when I realised, actually this is as much about me as it is about her, that-that was the point that ... sort of things changed really, erm, and it's a different relationship then, isn't it, 'cause you're understanding that it's not-it's not bad behaviour, it's not 'cause she can't do it, it's-it's because there's something in her that doesn't want to do it'

Yet it is apparent just how difficult the struggle is for Zia

'... and the chin goes down, and the face goes down, and the shoulders go down, and the you know "Urgh it's not fair" and I find that really hard (laughs) to cope with, you know, because mostly it's things we've gone over a thousand times before, so it's tha-so it probably says more about me than it does about her, and she knows the little switch to flick too to get the reaction'

The image of Tania's anger evoked by Zia would be referred to by the MotC as evocative and distancing; '*the chin*', '*the shoulders*'. It can seem as if she is personalising the interaction and positioning Tania as the protagonist, misbehaving in order to make her mother feel bad, rather than out of her own frustration; 'she knows the little switch to flick'. However, when it is remembered that Zia is parenting a child with emotional and behavioural difficulties entirely on her own, whilst ostensibly still suffering from the effects of an abusive relationship, her difficulties in coping with Tania's behaviour become understandable. That said, Zia is able to acknowledge it is her reaction, that her feelings are

her own responsibility, not Tania's; '... it probably says more about me than it does about her'

Although lone-parenting two children, whilst working full-time, and running a home, and doing all of this while managing a pain condition, is hard, she still has the capacity to enjoy her children, and some warm images of connection, as well as balanced and real episodes emerge

'... there'd been some b-er something had been delivered that week, so there was some bubble wrap in the kitche- "Oh, and I'm going to show you this, mummy, how-how you do special pictures with bubble wrap", and we just sat there in the sunshine for probably hour and a half, erm with the paints and she was showing me this, and chattering away as she was doing it, and er-er you know, going through all the things we could create in the future (laughs) and it was just a l-really lovely, precious time where we were both doing the same thing, both connected ... we were as much absorbed in the task as each other, and erm just er really... calm, lovely time'

Zia shows moments of teasing and affectionate humour when she talks about her girls and their relationship

'... and I keep saying "Even when you're grown up and married I'm going to have to come around your house and clean your ears, 'cause (laughs) nobody else can do it, you know, (laughing) it's going to be odd explaining to your future husband why I'm in there cleaning your ears" (laughs)'

However, it is evident that past issues with the father still impact both Zia and Tania. In an attachment sense, Zia appears to still be somewhat 'preoccupied' with the abuse she suffered within marriage and the consequent separation and custody court case, and her own lack of resolution may be impacting Tania, despite her very real desire to hide it

**'Do you think there are experiences in Tania's life that you feel have been a setback for her?'**

Z: Clearly with the separation of me and her dad it wa- and it was er just about as horrific as it could possibly

b-you know, even as a grown-up it was horrific, so we moved out, because he wouldn't agree to move out, so and we had a two year court process, we were in holiday accommoda-it was just horrific ... he was taking them out of school and I didn't know, and then I wouldn't get them back at the right ti-you know, and it-it was a horrific me-a-absolute mess, absolute mess ...'

And

'... so that I think has been massive ... for a child who was already quite erm ... you know, in turmoil herself before all that happened, you know ... how much of that previous turmoil was how to do with how you were liv-you know, so you don't know do you, but it certainly would've impacted greatly on-on her, and again, you know the two children just coped an-well, Tania didn't cope, she didn't-she couldn't cope with it, and Kelly she just coped ... while Tania was just like this (laughs) dynamo'

There may be some trace of triangulation for Tania occurring, and this emerges when talking about the girls' overnight visits to their father's home

'... there's been an element of me ... overthinking how awful she feels not being w-with me, so ... that-my perspective of that sort of ebbs and flows depending on ... where I am on the emotional scale, but overall now, my perception of how she feels was always on the ... (stutters) worst, extreme end of things ...'

And

'...there'll be instances that'll happen while she's away that she'll come back and tell me about ... erm, she find the long times away, so like there's a fortnight in the summer ... and quite a long one in the er the Easter time, and Christmas time, she finds those long ones, I do think she finds hard ... she'll say to me "I don't like going there blah blah blah, this thing happened, and that thing happened, I don't like going there" it's quite hard to unpick how much is "I don't like going there" and how much is "I don't like that particular thing that happened while I was there" ...'

And

'Kelly will report "She's fine mummy, she's fine when she's there, she doesn't, you know" so it's really hard to know ... you know'

Kelly reports all is fine when at their father's, and Zia acknowledges her possible projection of negative feeling, so any resultant triangulation would possibly put Tania in an difficult position, causing some internal conflict for her, wanting to be sympathetic to each parent in the face of possible hostility from each toward the other, and this conflict may well be displayed as 'difficult' behaviour. It is unclear how much of Tania's upset is unconsciously perpetuated by Zia's palpable distress over the court process and her obvious unease over the result, but there appears to be some unresolved guilt for Zia that she was unable to protect her girls from what might possibly have been her own fears

'I think if she was given the choice, and I can't give her that choice, 'cause we've got a court order in place, I don't think she would be separate from me as much as she is ... I tried my best when I had the opportunity going through court to, y-you know, say's not what she wanted, but of course the other side said I was just doing that because I didn't want to be on my own and y-you know, i-it-so, y-you know, it's be-i-er-er-tha-and ... I-I think the court lost sight of the child in that, because what she was saying was "I do want to go, I don't want to st-I-I want to go, but I don't want to stay overnight" and that was fine really, that's absolutely fine with me, but they deemed (mutters inaudibly)'

Zia's desire to protect her girls extends to shielding them from her pain, and despite her accounts of Tania's sometimes challenging behaviour, she also portrays Tania as sensitive and empathetic, particularly concerned with her mother's pain

'I will say, you know "I'm nowhere near as bad as lots of other people, I'm really lucky because it's only one side, erm, once the tablets kick in, once my pain killers kick in I'll be fine" ... erm ... so I hope I've made it OK for them, that they don't constantly worry'

And

'... so I kinda get outta bed and I ...go into their room and then I get their blind open, erm ... and Tania will say "How are you mummy, how's your knee this morning? It looks a bit sore" ...'

And

‘... when I had a recent flare up, I, you know, I couldn't kneel to do anything ... and Kelly had asked me to get something for her, and Tania was immediately in "How do you think mummy's going to be able to do that, Kelly" you know "You need to go and get that yourself" ...’

As the interview progresses, Zia appears to be truly reflecting, and she ruminates more on Tania's perspective and her own feelings and their impact. She takes time to think, there are long pauses, and by doing so she can then relay full episodes from both their perspectives, with both rupture and repair

‘Erm ... erm (9 second pause) so (5 second pause) it's really hard to tangibly (10 second pause) I'm going through a sub-set of questions in my head, so how do I know I-that-that you know there is a erm a loving element to it, so erm (4 second pause) ...’

And

‘I went back into her and I said er-y-by then she was ... absolutely heartbroken ... an-and er me trying to explain to her, you know "I'm really so-I am really sorry I shouted at you, but it-I was so scared, and I thought you were going to get [burnt]\*"... and I sa-must've said something like "I'm such a bad mummy, I shouldn't have spoken to you like that, that's an awful way to speak to you, you know, and I'm really sorry"... and um a bit later on that evening, she came back with er she'd cut out a piece of paper in the shape of a leaf, and coloured it in, and she wrote on it ... it said something like "Don't ever think you're a bad mum, you're always a good mum" (laughs) and in that moment I thought "God, you know what, whatever each of us does, we do both know that ... recognising of um, so loving isn't always about it being happy and wonderous all the time, it's about that acknowledgement that actually when things go wrong ... you can only sort of build the bridges again if ... there is love there’

## Appendix 19

### CAI Interview - Ellen

The first few sentences set the tone for the rest of the interview.

**‘Can you tell me about your family, so who lives together with you in your house?’**

E: My mum, my sister, and at the moment my mum’s boyfriend

**OK, do you have any other family that you see regularly ... that you’re close to?’**

E: Erm ...my father, maybe? ... Erm’

Ellen’s dry and amusing comments reveal a somewhat indifferent attitude frequently seen as typical of teenagers; *‘at the moment my mum’s boyfriend’*, implying it is probably a temporary thing, and *‘my father, maybe’*. Her account was peppered with similarly pithy comments.

An insight into how Ellen may feel about her mum’s pain condition was highlighted when she reported her mum had asked her to make the family dinner the previous night. Ellen replied she ‘can’t be bothered’, which seems like a slightly derogatory comment, and not unusual confrontational teenage behaviour. Mum was likely to have asked for help with making dinner because she was in pain, but Ellen seemed unwilling or unable to take mum’s point of view in this instance. In the end, mum’s boyfriend made dinner, adding weight to the impression that mum was too poorly to do it.

*‘Last night she asked me to make tea and I said ‘Nah, I’m lazy, goodbye’, and I just left (giggles)’*

However, the use of word ‘lazy’ to describe herself could be questioned here. It is unlikely ‘lazy’ is a word a child would choose to describe themselves unless they had heard it directed at them before. It is possible that Ellen has previously been told she is lazy, and this

was the repetition of an internalised script. In view of mum's PDI, Ellen's response may not be so unthoughtful considering Carrie described how Ellen gets in trouble for not making her own food, but, conversely, also gets in trouble for making a mess when she does make her own food. This seeming lack of willingness to help with dinner might actually be Ellen's avoidance of entering a conflict filled domain. This is a pitfall parents often unwittingly fall into; focussing on negative behaviour and forgetting to praise positive behaviour, thus inadvertently encouraging unwanted behaviour.

There were several instances of underlying anger, which were then either masked by laughter, or dismissed with an 'I don't care anyway'

**'OK, do your parents sometimes argue**

E: Pffft, yeah! (short humourless snort) they argue over anything'

And

'... Yesterday, innit, with the whole dad thing, probably the most recent one ... after mum pressured me for about ... hours and hours about my dad, I finally came out and told her and I was just, like, crying my eyes out ... (shrugs shoulder) but it's ok, 'cause I don't care anymore (laughs)'

There are several descriptions of fallings out with her parents

'Cause me and my father are arguing at the moment, because he wants another baby, and I, I don't want a baby ...so mum's sticking up for him, and I, I sort of, like, shouted and was like 'Stop sticking up for him' ... and then'

Ellen's descriptions of her relationship with her father paint him almost as a boyfriend rather than a father. Her language around the argument about her father's wish to have a baby with his new wife seem to blur the line between her and the wife; 'because he wants another baby, and I, I don't want a baby'. She later describes how they can talk about anything but boys

'Yeah ... me and my dad, like, talk about ...everything and anything, so it's like ... so I'd talk to him about things I'd talk

to my best friend about ... I won't talk to him about boys, that's one thing I won't talk about, 'cause he'll freak out ...'

At 15 boys are likely to be the major things she wants/needs to talk about, and dad could give her a male perspective to help her, but her perception is he does not seem able to countenance the thought of Ellen with a boy, or it may be he is having trouble adjusting his view of her from child to woman, and therefore feels she does not have this source of support and guidance.

Ellen's repeated dismissing of feelings of vulnerability with a sense of bravado runs throughout her account, for example in her accounts of separations:

**'So, when you got back and you first saw your mum, what was that like when you first saw her?'**

E: I was just, like 'Hi' ... she was, like 'Come here, hug me' and I was, like 'No! ... don't touch me' ... I was just really sad that I had to come back (laughs)'

And

**'and did you miss your mum and dad while you were away?'**

E: Not really, no (laughs) ... I was with my friend, so I was, like 'yeah, bye'

**'OK, but you felt bad enough to ring your mum and say you wanted to come home?'**

E: Yeah ... (shrugs shoulder)

**and can you remember that conversation?'**

E: I was just like (rests head on the back of the sofa) 'Mum, come and get me, come and get me now'

**'Were you upset when you spoke to her, or was it just a 'Urgh, come and get me'?''**

E: ... I don't know (looks at mum) I don't think I was upset, was I? ... like, I wasn't crying ... I was just, I was just mad, I was just, like, 'Just come and get me, I'm done with this trip' (looks at mum)

C *No, you were a bit upset*

E: Was I, I don't even remember

**How do you think your mum might have felt knowing that you wanted to come home and that you were just so far away?**

E: She was upset, she was upset because she couldn't come and get me, and I was obviously just, like, crying ... apparently'

Ellen keeps the bravado going until her mum reminds her that she was upset while she was away from home, which she initially denies any memory of, but eventually amusingly acknowledges with the reluctant 'apparently'.

Glimpses of old conflicts were observed when asked to describe her relationship with her mother. Out of the three words to describe their relationship two were negative, and one was positive or neutral (Hard, confrontational, and funny). None of the words Ellen chose included words such as caring or loving, or any claims or suggestion of closeness. More conflict seemed to be revealed when she relays what happens when her mum tells her off.

'... I shout back and usually storm off'

In general, arguments in this family do not seem to ever be resolved. In fact, Ellen gave no examples of any conflicts with her parents being resolved through apologies (from child or parent), or through talk. The accounts Ellen gives are of turbulent arguments ending in either separation or laughter. Whilst, there seems little overt indication of danger or menace to the confrontations or arguments, when considering the domestic violence she witnessed as a toddler, accounts of conflict with her father appear to have more dangerous undercurrents. This was evident in the passage where Ellen was relaying an example of when her relationship with her father was funny

'E: Oh god, it was so bad ... yeah, we made a dancing TikTok and then he got so mad that he, he threw my phone

*(Mum laughs)*

**Oh really?**

E: Yeah, he hit, like, I had to stood up and he got so mad that he couldn't do it that he just whacked my phone

**Oh no, so were you able to finish the TikTok?**

E: No ... he was so upset (*Mum laughs*)

**OK, so it started off funny?**

E: Yeah, and then it ended up with him tackling me onto the sofa and then ... me and my dad playfight a lot as well, that's really funny'

Ellen again mentions no conflict resolution, instead the episode ends with a playfight.

It may be that her father is unable to say sorry for his outburst and/or to have a cuddle to make up for her disappointment/upset at the belligerent outcome of something that was meant to be fun, so playfighting may be the usual substitute.

Ellen often reported potentially more dangerous kinds of events in a matter of fact way, minimising any danger she may have felt

'E: So, he'll, like, he'll tell me off and he'll be, like, 'Just get out my sight' and I'll go upstairs and just lay on my bed

**and when he gets cross, how does that make you feel?**

E: (3 second pause) Mmmm (3 second pause) I don't know really, 'cause it doesn't tend to really happen, so, when it does I'm, like, 'O-kay then', I guess a bit shocked that it's actually happened ... (shrugs shoulder)'

We know from her mum's PDI that Ellen witnessed her father's domestic violence against her mum, meaning she would be aware of how dangerous he could be, and although he does not seem to have turned it on her, she may still be frightened when he gets angry. There is likely to be some confusion for her there too, as in the past she had observed that anger equals violence; 'dad is angry with me, will he hit me?'. As Ellen may well have

multiple contradictory DRs of dad, we see this almost freeze and withdraw response when he's angry with her; 'I guess a bit shocked that it's actually happened', compared to the stay and fight response she reports with her mum, and this seems to be minimised with a shrug of the shoulder. It seems as if Ellen is almost delusionally writing out how dangerous her dad can be, and although her dad is presented as flawed, there seems to be an almost covert sense of idealisation of him. We know he was mentally and physically abusive to Ellen's mum, but there is absolutely no indication of this from her, no explicit sense of fear. There was a hesitance when asked if anything big had ever happened to scare or upset her

'(5 second pause) mmmm (6 second pause) (looks at mum)  
What are you looking at me like that for? (laughs)'

She looks at her mother, seemingly to check something, but as her mother is off camera, we are unable to see her facial expression that causes Ellen to question why her mother is looking at her like that. There is no way of telling whether mum was indicating, or warning not to say something, but her father's violence is not mentioned.

Ellen seems heavily triangulated, hints of which appeared early on in the account, but were explicitly conveyed when asked if her parents argued. Typically, Ellen dismisses its effect on her

**'How does it make you feel when they argue?'**

E: I just laugh at them to be honest (*Mum laughs*) they've just, it used to bother me a lot, but now they argue ... sometimes they argue through me, if that makes sense ... like, my dad'll say something

**Right, and how does that feel for you?**

E: Mmm (scrunches her nose up) it's just awkward, 'cause dad'll tell me to tell mum something, and then mum'll tell me to tell dad something, and it, cause they not speaking, and I'm like (rolls eyes, throws hand in the air) ... 'really?' (3 second pause) but, it's ok (short snorty laugh)'

Her frustration is palpable, roll of eyes, exasperated hand gesture and verbal expulsion ‘really?’, but after a short pause this is dismissed with her usual ‘it’s ok’ and a derisive, mirthless laugh.

There seemed to be a level of reasonably good natured banter between Ellen and her mother, with Ellen repeatedly looking to mum for either reassurance or confirmation. At one point the interview seemed to act like a vehicle for family therapy, providing a different context that allowed Ellen to think and talk calmly without the usual escalation, and in that context she seemed to realise she was able to do more semantic reflection than she could normally do with her mum

E: (Look at mum) Where are all these words coming from?  
I don’t, I don’t speak like this!

C: *I know, I’m very impressed, Movita ...she’s not normally (laughs)*

E: I don’t speak like this

**You’re normally different are you?**

C: *Yeah, this is why you can do English, you just hide all these things, don’t you?*

E: I just add a ‘like’ in everything’

Mum noticed Ellen’s expanded vocabulary, engendering a positive reaction from her, giving Ellen a chance to hear praise from her mother, and eliciting another moment of humorous self-reflection in mocking her own use of teen language.

Ellen seemed to have difficulty providing episodes, and she often looked to her mother to help out

**‘OK, can you give me an example of ... the last time you were sarcastic, what happened ... around that?’**

E: ...(looks over at mum) Mum?

C: *Erm (5 second pause)*

E: (mutters inaudibly)

C: *You're sarcastic all the time now ... think about it*

E: Exactly, I'm trying to think about ...'

Whilst Ellen was not overly open when it came to expressing emotions, there seemed to be a focus on more negative and angry emotions when she did, this often tended to be in relation to other's feelings, especially via her mother

C: *'Well, how are you with each other ... Like you said with me 'confrontational', but you're not like that with your father*

E: I'm not like that with dad, no

C: *He'd go nuts (laughs)*

E: Yeah, he'd go nuts with me ...'

Ellen was able to demonstrate some reflection at times, but often stopped short of fully reflecting on her behaviour or the source of her feelings

'(4 second pause) Does-err, doesn't make me feel sort of, like (3 second pause) doesn't make me want to argue with her, I always want to argue with her for some reason'

## Appendix 20

### CAI Interview - Jago

Jago seemed to find it difficult to come up with examples to illustrate some of his answers, and what he did say was often general and limited. Where he appeared to struggle, his mum often tried to supply some for him

**‘So, can you give me an example of when your, or how your relationship with your mum is strong?’**

J: (2 second pause) Um, well, I-I obv-I obviously trust her ... um ... with a lot of stuff ... and, um (coughing) ... I can't-I can't-I can't really think of examples, it's just like overall it's ch-I just like trust her and ... and you just ... just stuff like that and

**I'm trying to think of something that might ...**

*L: What about when you told me about what happened with Hannah? You trusted me with that, didn't you?*

J: Yeah

*L: That's an example, when you had an argument. That's an example of you trusting me. You showed me the messages and stuff. That's an example of trust, that*

J: Oh right (*yeah?*) yeah, I see what you mean now. I thought it was ... okay

*L: So, that's us being strong, isn't it? Our relationship. Felt like you could come to me*

J: Yeah, I do feel like I can-I can come to her for a lot of things ... whe-whether it be my personal life or ... stuff happening elsewhere, at school ... or ... at home, even'

Initially Jago talks about 'trust' rather than 'strong', and mum interjects quite quickly to offer an example of their 'strong relationship', almost without giving him time to think of an example himself. It has the effect of appearing as if she is searching for reassurance that she is experienced as a good mother

**‘And can you think of an example of when you were last told off, or the last time your mum was cross with you, can you tell me what happened? The story of what happened.**

J: (4 second pause)

*L: Do you want one)*

J: Yeah (laughs)

*L: What about the other night when, or last week when I came up and you hadn't done, you were on Fortnight before you'd done your homework?*

J: Oh yeah, um

*L: I sat and talked to you about it, didn't I?'*

As Jago pauses for thought, mum again seems to jump in quite quickly to provide him with an example. The example she suggests is the same event she discussed on several occasions during her PDI, as examples of frustration and anger within the parent-child relationship. Although mentioning it overtly in front of him as something she did, it seems to imply she is trying to resolve this here. She may feel bad about being hard on him, or possibly be trying to exonerate herself, for example she uses the phrase ‘I talked to you about it’ vs ‘told you off’.

Jago did not seem to use connotative language to describe people or events in his life, although more was introduced when he mentioned the death of his paternal grandfather

‘um my dad's dad, um, passed away ... a long time ago, but that was-that was quite saddening for me’

Talking about his grandfather was one of the only times he expressed sensory memories of comfort

‘... he used to always bring me uh a type of biscuit, which I still love today ... so yeah -it-i-it's quite saddening’

He recalls how his father informed him of his grandfather's death, and how he chose an strange time and place to break the news. For Jago there seemed to be no gentle lead up, as if his dad had broken it to him in an insensitive way.

‘There’s one t-I think I do remember my dad telling me, but it was in such a random time and location, and i-it-today I’m starting to think that was just a dream, to be honest, it was such a random time for him to tell me ... I d-(sigh) I was just-we were just ... got out-well I’m assuming we-I’m assuming we got out the car, it was just me and him, and we were walking towards some sort of building, small building, in like ... trees and round me, and stuff, and he just told me ... we-while I was still walking, and I just, and it was so sudden ... that and then that’s all I can remember, ‘cause that’s why is started to think it was just a dream, ‘cause it’s such a random location and time ... and I feel like my dad would’ve sat me down and told me ... if he was going to ... so ... yeah I d-I-er-i-if that is a dream then I don’t have any recolish or recoula-I don’t know how you say it, of when that actually, when I was actually told about (sound breaks up) so, yeah’

Where Jago says ‘I feel like my dad would’ve sat me down and told me’ seems as if he may be struggling with feelings of anger at being told so suddenly. His father, of course, is likely to have been in shock himself and grieving for his father and may not have had the resources at the time to tell Jago in a gentler way. However, the episode seems to have left Jago with some confusion, and seems to lack coherence. It may be that the bereavement was not processed by the family in a way that was understandable and resolved for him.

Jago described how he felt ‘upset’ when his girlfriend was upset, and how he felt unable to help her. From an attachment perspective, his mum’s attempt to offer support seems rather meager with no apparent attempt to help mentalise on behalf of his girlfriend, despite saying it made him feel a bit better

**‘And did that make you feel better afterwards, having spoken to your mum?’**

J: Yeah, because she said herself “Your ... guess is as good as mine” as to why she’s upset and she won’t budge, so it made me feel better that I’m-it’s not something I’m necessarily doing wrong it’s just maybe just her at the time’

From these passages, it appears that he does not expect to be emotionally comforted or guided by his parents, or that they will help him to integrate his emotions, but he does not specifically complain about this.

Jago revealed a hint of idealisation when he described his relationship with his mum

**‘Can you give me an example of when your relationship with your mum was happy?’**

J: Um ... sh-every-more tha-as long-e-every day really, I mean, as long as ... I haven't (slurs words) there isn't anything that's gone on ... like I've-I've ... not done something I should've done then there's obviously, she rollocks me for it but ... um other than that it's-it's-it's-it's generally ... a happy relationship, there's no proper example, if you know what I mean'

The episode becomes the opposite of happy; 'like I've ... not done something I should've done, then ... obviously she rollocks me for it', and he could not come up with any episodic examples of when their relationship was happy, and as such is a powerful example of idealisation

Jago generally had an analytic style of language that seemed to minimise losses and/or separations

‘Erm, there's been times when I've gone away with school, for like the weekend, on a, like a small retreat, like trip thing ... we once went away for an entire week in primary school, that was the best trip I've ever-I've ever had, I still remember it, it was quite-it was really cool ... um ... yeah'

The emphasis is on the fun of the trip, but emotions are not entirely dismissed.

However, when recalling how his parents may have been feeling his memory emphasised discipline, and behaving well vs remembering any feelings

‘I don't-I don't recall any sadness, but I know they were constantly worried about me, and they made sure I needed to behave, and to be safe, they made that very clear (laughs) but err, yeah'

This passage shows his analytic language, which is also distancing, for example when he says 'I don't recall any sadness' has the effect of impersonalising the emotion.

Very few conflicts were mentioned, but there was also no mention of resolutions

**‘Can you remember how you felt when there was a serious argument [between your parents]?’**

J: (3 second pause) I did feel a bit helpless, 'cause I knew I probably couldn't really do anything, I was quite young at the

time, so I couldn't really do anything, but at the same time I-I was just stayed in my room and ... I knew that their relationship was strong enough to not break ... but at the same time I was just-I was just ... getting on with my own life, really'

Jago's language is minimising and distancing here regarding an event that seems to have stayed in his memory, suggesting it possibly had a greater impact on him than he is allowing himself to admit.

Jago reported having a difficult, but strong relationship with his step-father

'I'd still have to say it's-it's a strong relationship, but we don't get on as well as we should do, if that makes sense, it's-it's not ... I-er-we-it-it's-it's the same as my mum i-it's still strong, w-and like, after a while i-it jus' re-it--it comes back but ... we d-I find it like hard to talk to him sometimes just, not because he's my step-dad, just, we just ... never bonded right I guess and that affected the whole relationship, I guess'

And

'... well he-he-he's a bit stricter, should I put it, as my mum, he finds-he ... he just ... well he-he just is, he's just a bit stricter and ... um (2 second pause) he-du-um I don't know, really, but it's just'

It feels as if there may be some underlying issues between Jago and his step-father that are never fully elaborated on. Whether that was because his mother was present at the time is unclear, but he did try to articulate something that gave the impression was unresolved for him

'... I-I have to walk my dog when I come d-when I come home after school ... and when I come home, I just put the lead back where I-where I um, where it was. But he, he didn't, he d- right off the bat he didn't actually believe me that I had walked him out ... simply because of the fact that I'd put it back where it was ... so, I feel like he was just a bit stricter on ... how e-how he should've handled that ... he-he was (slurring words) just a bit forward with it and ... I fee-I felt he didn't ... he didn't need to like ... put it in that way, if that makes sense, he could've handled it a lot better'

Some dysfluency enters his narrative when talking about his step-father's heavy-handedness. This may be because it was an unresolved issue for him, or whether having his

mum present was causing him some internal tension, not wanting to speak badly of him in front of her.

Despite only seeing his dad at weekends each fortnight, and his dad's difficulty in handling the report of his grandfather's death, Jago described having a strong, happy, and humorous relationship with him. The episodes he gave for this, although general, seemed to support his semantic descriptions

'he always likes to send me really bad dad jokes that he's found on twitter or Facebook or something ... which they horribly bad, but they're quite funny as well ... and any time I really go up or he comes down we always try to like um have fun or just have a laugh with stuff'

## Appendix 21

### CAI Interview - Chico

There are several themes that emerge from Chico's interview. One of which is the seeming lack of emotional care that he inadvertently revealed being offered from his parents. Whilst he reports instances of practical care, there is no mention of comfort at all. and instead he seems to initiate the one episode of comfort described after a separation of three days and nights

#### **So, when they came in the door, what happened?**

C: I ran straight to my mum and dad and hugged them'

Chico described being sad while his parents were away, and here he describes how it is him that runs to them, and him that hugs them instead of them hugging him. Roles appear to be reversed. However, whilst he described being offered care, this seemed generally practical and lacked details of any emotions

#### **'Can you tell me about a time when you were really upset and wanted help? And what you did?**

C: (3 second pause and crumples his face up) Well, um, a few months ago I was on a piece for my Grade C Piano and I kept on trying to do it over and over again and I got really frustrated with myself and I got really upset and I just thought stopping would be a good idea, and then mum came down and told me to continue ...'

Chico recalls being frustrated and upset, and wanting to stop, but he was just told him continue. His upset does not seem to have been dealt with, rather he was simply asked to continue. However, he does not recount this as a complaint, but more as compliant acceptance that this was an appropriate response from his mother. This indicates a process of idealisation., Whilst there may well have been soothing words from his mother, they do not seem to have been recalled, and his mother did not interject to correct him. The fact Analie

does not correct him here adds weight to it being factually correct. She did not seem to perceive that she could/should have acted differently, and her MotC indicated that she would be unlikely to have been aware of this. This episode gives weight to the impression that Chico does not seem to ask for help, meaning he appears self-reliant.

**‘Right, ok, so. When you get upset, what do you normally do?’**

C: (2 second pause) Well, I normally give the thing I’m getting upset about if it’s something that I need to try on I try it a few more times, then if I get a bit too overwhelmed I usually just take myself off and do something else’

He does not indicate any attempt at making bids for comfort and uses the phrase ‘I take myself off’, again implying self-reliance.

He also offered a rather limited range of examples, many of which seemed to be recycled. An experience he had at the Grand Prix, Silverstone, seemed an important experience for him, however, because this recycled episode involved ballet, which his mother reported sadly having to give up as a child due to knee pain, it may have been retold as a special event to please his mother

‘Um, last year I danced at Formula One, Formula One Grand-Prix. And like one second or something was put on TV (Laughs) about one second and I did the whole experience with my mother (points to mum)’

And

**‘Can you give me an example of a time when you felt that you were being confident?’**

C: (3 second pause) Again when I was doing my Grand-Prix thing, there was two hundred people, a hundred and ninety- eight girls and two boys (smiles and nods) and one of those boys was me’

And

**‘Can you give me an example of a time when being with**

**your mum was lovely?**

C: Um. Again, to do with the Grand-Prix. I slept two nights alone with her in the hotel'

The Grand Prix episode he offered to illustrate how his relationship with his mum was safe appeared to be almost the opposite

**'What was it about that that made you feel safe that she was there, can you think? ...**

C: (3 second pause) Fact that I had twenty-two cars going past me at (widens eyes) almost a 100 miles an hour, 62 times around, 62, yeah

**So, where were you dancing? In the middle or something?**

C: Um, right before the race started on the very starting grid where they would line up and my feet went to death at the end of it (grins) 'cause it was so hot on the tarmac, it hurts ... (asks mum) wasn't I wearing soft shoes with sort of like slippery insoles and tights because there were only two boys?

*A: Have you said what the temperature was like though? (to interviewer) It was the hottest day of the year. So, it was baking'*

Chico reports the cars going past him at 'almost 100 miles an hour', yet Formula One cars go over double that speed, shredding tyres and entire engines in one race. This may be further evidence of his dismissive strategies, minimising the significant speeds of the Formula one cars around him. Even though this episode was given to illustrate how his relationship with his mum was safe, he mentioned his discomfort 'My feet went to death at the end of it 'cause it was so hot on the tarmac, it hurts'. He uses the present tense 'it hurts', rather than 'it hurt', indicating this may have been experienced as a dangerous event. He did not elaborate on how his mother made him feel safe, and it transpired later that she disappeared during his performance, leaving him feeling anxious and sad

'Again, with the Formula One Grand-Prix ... I was, I was at the start of it and I had no idea where my mum was (2 second pause) so I got really scared and I had no idea where she was (4 second pause) and then the staff came over and helped me

with it and told me that she had just gone off to a meeting ... and I was in the middle of dancing too so I couldn't really stop, just, my eye was just dancing around everywhere looking for mum, darting (shakes head) ... at the end of it, my friend ... came over and realised I was a bit sad and then the staff came over and dealt with it'

Chico recounts a graphic image of his eyes darting around in search of his mother, panic rising, whilst having to continue dancing. She does not seem to have prepared him for her leaving to attend a meeting during his performance, and it is left to friends and staff to reassure and comfort him. His mother's disappearance was not reported as a complaint, but again with compliant acceptance, indicating elements of idealisation.

There appeared to be almost a total absence of expressions of anger. When it was mentioned, it was of his parents' anger towards him, which he described as his own fault and/or responsibility

**'So, how did it make you feel when she found out and told you off?'**

C: It made me feel irritated with myself. Yeah, with myself. Not with mum, but with myself (nods) for doing such a stupid thing'

And when he was explaining when he had felt unloved

'I think it's because I did something, and something happened 'cause of what I did that was bad'

Chico mentions very few conflicts, but when he mentions his parents' anger with him, this does not ever seem to be resolved, which may be the reason he blames himself

**'What happens when your dad gets cross with you or tells you off?'**

C: Well usually it involves a lot of shouting (Mum: Laughs) A lot of shouting and I usually, and same consequence get banned from the iPad, even if it isn't anything to do with the iPad (shakes head and laughs)'

Chico seemed to express anxiety about separations from his parents, but this was often quickly minimised, and when Chico was asked if he had spent any time away from his parents it produced an interesting exchange

‘Nearly a month

A: *(Laughs) No you haven't*

What is the longest time then?

A: *(Laughs) Uh, I think the record is three days*

When you were in hospital, mum

A: *When I was in hospital?*

Yes, I didn't see you

A: *Well that's not quite the same thing and yes you did you came to see me every day*

Did I?

A: *Hmmm ...um, but the longest we've been away was about three days and nights*

Oh yeah, yeah, yeah, wasn't that badminton or tennis?

A: *Yes, badminton at Wimbledon, one or the other*

Badminton, yeah'

For Chico, the separation from his mum felt almost interminable, represented by the, for a young child, exaggerated length of a whole month. Mum possibly does not seem to immediately recognise what a significant separation it was for him, and laughingly, corrects him.

When Chico was asked to describe his feelings about negatively reported events, he often seemed to immediately shut down

**‘Can you remember what made you feel like that?’**

C: Hm, no'

## Appendix 22

### CAI Interview - Tania

Tania's use of examples was very limited, and what there was often lacked any form of detail, even with subsequent probing

**'Do you ever feel your parents don't love you?'**

T: Hmmmmm, sometimes

**What sort of times?**

T: Um, when my sister gets quite a lot of attention

**OK ... do they know you feel that way?**

T: No

**You don't say, you don't tell them?**

T: No

**Why don't you want to tell them?**

T: It might upset them'

The only time Tania offered more detail was when she talked about her cats that died, or when talking about her grandmother

**'So, you also said your dad was bossy?'**

T: Um he make-he's ... he's quite bossy if, um ... like, grandma's coming down, and she's not that kind to us, she's really, and I think that's where our dad gets it from, and he won't let us do stuff without asking her, so

**Oh ok, what kind of things**

T: Like, we were going to go to Sweden, but he said no ...but he asked grandma first before and grandma said no ... and that means we can't go, and not-eh and somehow ... um or she-he must've asked grandma, because ah she le-when we facetimed her um she started saying "You're not going to Sweden, you're not going to Sweden"

**Ah, and how did that make you feel?**

T: Really sad'

There seemed to be some mild criticism and derogation of her grandmother, but stopped short of being overt, even though she showed some arousal in recalling the auditory memory 'You're not going to Sweden, you're not going to Sweden'.

Tania did name emotions, but it was very minimal and never elaborated on. 'Sad' and 'Scared' were oft used terms when describing emotion. Tania did not mention feeling angry, despite it possibly being the more apt emotional term in some instances, and since in the PDI mum often mentioning Tania's escalating temper tantrums

**'And how does that make you feel?**

T: Sad'

And

**'And how did you feel when they [her cats] died?**

T: Sad'

And

**'So, if mum is getting cross with you, how does it make you feel?**

T: Um, scared ... sometimes'

And

**'And how does that make you feel?**

T: Scared'

And

**'OK, and how did you feel when you were there**

T: Um, scared'

Fear seemed to be a theme for her father, and paternal grandmother, and it might be that Tania is learning that anger is related to her father, and so feels unable to relate anger to herself

**‘Can you give me three words that describe your relationship with your dad?’**

T: ... Um ...it’s not really good relationship, because he shouts at us quite a lot ...’

‘Um he starts shouting and tells us off, and if we don’t do what he says, um, he’ll shout at us ...’

**‘What about if you’re at home and you get upset, what do you do?’**

T: Um ... I usually either go to mummy, but when I’m at my dad’s I don’t really go to him

**OK, why do you think that is?**

T: ‘Cause I know he’ll shout

**If you’re upset?**

T: Yeah’

Tania’s parent’s marriage was very abusive which precipitated Tania’s mum to leave with the children, this was followed by an extremely bitter custody battle, the reverberations of which echo through Tania’s account

**‘Can you tell me about a time when you were really upset and needed help?’**

T: Um ... when I was at school, after-when I was about six, after um the fight which’d happened out there (waves towards window to the garden) um it made me scared ... and I was really upset

**OK, and what did you do?**

T: I told a teacher, and they le-um helped me stay calm about things’

And

‘Um w-when our dad was ah quite fight-hard-w-we-against us three ... mum, Kerry, and me’

And

**‘Has anything really big happened to you that upset you, or made you scared, or made you confused?’**

T: Um, when there was a fight round the house, at the house

**Who was the fight with?**

T: Oh, mummy and daddy

**And how old were you?**

T: Six

**Do you want to tell me about that?**

T: Err ... no’

Interestingly, even though she feels able to go to her mother when she is upset, after a quite significant altercation between her parents she sought protection and comfort from teachers at school rather than her mother. She elaborated on this later in the interview when asked if she’d ever felt unloved

**‘OK, so what do you ... do they know you feel that way?’**

T: No

**You don’t say, you don’t tell them?**

T: No

**Why don’t you want to tell them?**

T: It might upset them’

In this instance, Tania appeared to be repressing her own feelings of upset in favour of her parents’. Comfort did not seem lacking, she reported instance of comfort from mum, but very little from dad. There also seems to be elements of quite pronounced idealisation of her mother here too. While there is little evidence of any caring, Tania uses positive adjectives to describe her mum, yet the examples do not support positive terms. Although much less so, there is possibly some evidence of some idealisation towards her father as well

**‘You said your dad was kind, can you think of an example of when your dad was kind**

T: He said he might buy me a surfboard’

Whilst she expresses fear over his anger and talks about how difficult he was with them, she does have positive things to say about him, and expresses happiness at seeing him. It might be that Tania is slightly triangulated, feeling she has to portray him as a little bit scary while her while mum is sat next to her, although she might have said a lot of angry, negative things about dad to please mum, but chooses not to

**‘So, when your dad came back, and you saw him again, how did that make you feel?’**

T: Happy’

There is a sense that she is very enmeshed with her mother and dad is experienced by both of them as frightening, though she still goes to stay with him.

**‘So can you give me an example of when things were hard with your dad?’**

T: Um w-when our dad was ah quite fight-hard-w-we-against us three ... mum, Kerry and me

**And how old were you?’**

T: Um ... (looks across at mum and whispers)

Z: *you would’ve been about ss-five or six*

T: (very quietly) five or ...’

**‘Ok, this is the last question** (T reaches hand out to mum, smiles and holds mum’s hand off camera) ...’

The whispering suggests some possible enmeshment, whilst mum just supplies the age vs any attempt at reassurance or elaboration. So mum sticks to instruction not to interfere with the interview, but supresses any feelings that might arise here to support her daughter.