'If Only I Could Have Said, If Only Somebody Was Listening': **Mothers'**
Experiences of Placing their Child into Care in the Context of Trauma

Thesis submitted in part fulfilment of the degree of Doctorate in Clinical Psychology

University of Leicester

By

Kate Siverns

May 2019

Declaration

I confirm that this thesis is an original piece of my own work. It was written and submitted in part-fulfilment of the degree of Doctorate in Clinical Psychology. It has not been submitted for any other academic award and was checked prior to submission.

Kate Siverns

May 2019

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Kate Siverns

Thesis Abstract

Systematic Literature Review: Eleven papers exploring the experiences of parenting in the context of former childhood trauma were subjected to an interpretive meta-synthesis. Three themes were generated. *Forming a parental identity through the lens of trauma* related to the interpretation of all parenting experiences, especially challenges, in terms of the effects of childhood abuse. *Protecting against perceived threat* related to many parents fearing they would be unable to protect their children, and themselves, from harm. *The need for safe support* was concerned with how parents often felt they needed support but experienced this as unsafe. Results highlighted how professionals should recognize ambivalence as understandable in the context of lived experience and should seek to avoid pathologizing parental difficulties by normalising difficult emotional reactions.

Research Paper: Interpretative Phenomenological Analysis was used to explore the sense-making of three mothers with trauma histories who had made, or come to agree with, the decision for their child to be placed into care. Three superordinate themes were presented: *A fractured sense of motherhood* highlighted the struggle with mothering identities in line with feelings of disconnection and separation; *'I wish I could turn back the clocks': Living with feelings of failure and shame* illuminated the underlying feelings of guilt and shame associated with perceived failings; *'Less than a person': Becoming nothing and no-one'* alluded to the mothers' experiences of isolation and disempowerment, which led to feeling devalued and dehumanised. Themes were discussed in relation to existing theory and literature and highlighted the importance of acknowledging the role of loss and grief as well as the use of therapeutic interventions which are sensitive to the operation of power.

Acknowledgments

Word Count

Thesis Abstract	**299**
Systematic Literature Review	**6930**
Abstract	198
Article Body (excluding tables, figures and references)	6732
Research Paper	**7998**
Abstract	200
Article Body (excluding tables, figures and references)	7798
Mandatory Appendices (excluding figures, images, tables and references)	**4586**
Non-Mandatory Appendices (excluding figures, images, tables and references)	**3475**
Total Word Count (excluding references and mandatory appendices)	**18403**

Table of Contents

'' denotes mandatory appendices*

Addenda

Anonymised[1] transcripts submitted separately

> Transcript One: 'Stacey' (First Interview & Second Interview)
> Transcript Two: 'Nina' (First Interview & Second Interview)
> Transcript Three: 'Claire' (First Interview & Second Interview)

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[1] To preserve confidentiality, pseudonyms for each participant have been assigned and these are used throughout the thesis, including the submitted transcripts. Other parties mentioned by the participants have also been given pseudonyms within the transcriptions and identifiable information has been removed.

List of Tables

List of Figures

List of Abbreviations

Part One: Systematic Literature Review

ASSIA	Applied Social Sciences Index and Abstracts
CASP	Critical Appraisal Skills Programme
CINAHL	Cumulative Index of Nursing and Allied Health Literature
CSA	Childhood Sexual Abuse
GT	Grounded Theory
IPA	Interpretive Phenomenological Analysis
NHS	National Health Service
PRISMA	Preferred Reporting Items for Systemic Reviews and Meta-Analyses
RTA	Reciprocal Translation of Analysis
SPIDER	Sample, Phenomenon of Interest, Design, Evaluation, Research type
UK	United Kingdom
WHO	World Health Organisation

Part Two: Research Paper

BPS	British Psychological Society
CASP	Critical Appraisal Skills Programme
IPA	Interpretive Phenomenological Analysis
NHS	National Health Service
PTMF	Power Threat Meaning Framework

Chapter One: Systematic Literature Review

Understanding the Experiences of Parenting in the Context of Historical Childhood

Trauma: An Interpretive Meta-Synthesis

Prepared for submission to Clinical Psychology Review

(please refer to Appendix A for submission guidelines)

Abstract

2

Introduction: Research has highlighted that individuals with a history of childhood trauma are more likely to experience difficulties in relation to future parenting. The portrayal of these parents within the literature risks pathologizing parenting difficulties as well as overlooking strengths. This review focused on exploring the overall experiences of parenting in the context of former childhood trauma.

Method: An interpretive meta-synthesis was undertaken following a systematic search of five databases. Following quality appraisal, eleven studies were retained for interpretive meta-synthesis.

Results: The meta-synthesis generated three themes: *Forming a parental identity through the lens of trauma; Protecting against perceived threat; and The need for safe support.* All parenting experiences, especially challenges, were viewed through a lens of trauma, to the extent whereby trauma was inextricably linked to parental identity. Many parents feared that their children would be harmed and subsequently strived to offer protection against perceived threat and danger. Furthermore, parents often felt they needed support but experienced this as unsafe

Discussion: The meta-synthesis highlighted the potential need for support for parents with a history of trauma, and how professionals should seek to avoid pathologizing parental difficulties. Ideas from trauma-informed practice were drawn upon when considering clinical implications.

1. Introduction

1.1 Parenting

Within societal narratives, parenting is portrayed as one of the most rewarding experiences concerned with human existence (Bornstein & Bradley, 2012). Parenting, especially for mothers, is often depicted as instinctive and intuitive; and bonding with an infant is perceived as an innate and natural process (Cherry, 2014; Dally, 1982). The prevalent ideals pertaining to what constitutes a 'good parent' are also culturally cemented within white; middle-class; two-parent (heterosexual) families (Warner, 2009). Such dominant narratives are neglectful of the complex and multi-faceted experiences of parenting (Hager, 2011), which can often be challenging, stressful and emotionally turbulent. Nicolson (2001) identified various contradictory paradoxes that new parents simultaneously experience: enjoyment of a child's dependency along with reduced freedom; newly found reciprocal love coinciding with social isolation; a sense of pride and achievement alongside feelings of overwhelming responsibility; developing closer connections with some family and friends whilst feeling disappointed or separated from others; and enjoying the freedom from employment whilst struggling to develop new parental routines.

The transition into parenthood brings about a range of physiological, psychological and psychosocial changes that demand the development of a new parental identity (Stern, 1995). Difficulties adjusting to this role have been linked to the 'post-natal depression' diagnosis (Habel, Feeley, Hayton, Bell & Zelkowitz, 2015), with around 19% of women experiencing a 'depressive episode' between pregnancy and three months post-delivery (Gavin *et al.,* 2005).

1.2 Trauma and Parenting

The terms 'complex-childhood trauma' and 'developmental trauma' have been used to refer to how prolonged and repeated trauma during childhood can have implications for a child's neurological, psychological and social development, that can

3

reach into adulthood (Herman 1992; Van der Kolk, 2014)[2]. It is estimated that one in four children will experience some form of traumatic abuse, which will often be perpetrated by attachment figures (WHO, 2017). The parent-child relationship has significant implications for a child's development, and attachment theory has been a guiding framework in the realm of parenting. Infants are suggested to form an internal working model of attachment through their primary care-givers, which influence expectations and experiences of future relationships (Ainsworth, Blehar, Waters & Wall, 2015; Bowlby, 1969). A fundamental aspect within this attachment experience is providing the infant with a sense of emotional security and safety (Gerhardt, 2004). Secure attachments emerge from a nurturing and safe relationship whereby a care-giver is responsive and attentive to an infant's needs. When an attachment figure abuses a child, the child may develop a disorganised attachment style because they are not able to develop strategies to maximise their safety given that their carer is both a source of threat and someone they rely upon to meet their basic needs (e.g. Hesse & Main, 2000).

The way in which parents experience their relationship with their own children is thought to be shaped by the way they themselves were parented (Siegel & Hartzell, 2014). Fraiberg, Adelson and Shapiro (1975) considered the intergenerational role of trauma and the factors that lead to parents continuing the transmission of trauma with their own children. A parent's inability to meet their child's needs was thought to be due to past trauma experiences not being processed. The psychological defences in place to protect the parent from their unresolved pain was thought to interfere with providing emotional containment and developing a secure attachment with their child. Thus, the repetition of trauma is carried into the next generation, a process that has been referred to as 'the cycle of abuse'. This fits with research which has found that parents who experience trauma in childhood are at risk of inadvertently becoming

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[2] Multiple terms have been used within the literature to define experiences of childhood trauma (e.g. abuse, maltreatment etc). The focus of this review is framed around parental experiences of prolonged and repeated childhood trauma associated with 'developmental' trauma. However, for brevity the term 'trauma' will be used throughout the remainder of the review.

traumatising parents by re-enacting unhealthy attachments or perpetuating abuse (Erdmans & Black, 2008).

Most research concerned with parenting in the context of childhood trauma has been quantitative and has focused on the implications this has upon parenting capabilities. The literature suggests that parents with trauma histories are likely to experience parenting differently to non-traumatised parents and that their capacity to parent may be compromised (Zvara, Mills-Koonce, Carmody & Cox, 2015). Parents who endured childhood trauma have been found to experience increased difficulty in various aspects of parenting including: offering praise (Fujiwara, Okuyama & Izumi, 2012); holding appropriate developmental expectations (Kim, Trickett & Putnam, 2010); and increased anxiety with intimate aspects of care (Douglas, 2000). Research focusing on attachment attributes has indicated that mothers who experienced childhood trauma are more likely to display negatively connotated patterns of engagement with their child including reduced empathy; affection; and consistency (Tarczon, 2012). One review concluded that mothers with a trauma history were generally more 'permissive' in their parenting styles, with them finding it more difficult to set boundaries due to their negative experiences of adults imposing power (DiLillo & Damasheck, 2003). However, contrasting findings have suggested that this group of parents are more likely to engage in harsher parenting practices, with this being linked to parental difficulties in regulating emotions (Banyard, Williams & Siegel, 2003). Studies have also found that mothers with a history of trauma are more likely to be punitive and use physical punishment as a means of discipline (Barrett, 2009).

Other findings have indicated that mothers with a history of childhood sexual abuse (CSA) are more likely to become emotionally dependent upon their child, with the child being placed in the position of meeting the mother's needs (Koren-Karie, Oppenheim & Getzler-Yosef, 2004). This seemed to be more prevalent in circumstances whereby the mother has limited social support (Alexander, Teti & Anderson, 2000). In contrast, one review found fathers with sexual abuse histories were more likely to be physically and emotionally distant from their children, which correlated with self-reported fears of becoming an abusive parent (Wark & Vis, 2016).

One qualitative review of direct relevance was found which synthesized research to consider how mothers with a CSA history are depicted within the literature (Breckenridge, 2006). It was found that these mothers were frequently portrayed within a negative light with research questions focusing on the investigation of difficulties and challenges which were then attributed solely to their trauma histories. This critique is in keeping with research which has observed that the evidence supporting intergenerational transmission of abuse could be skewed by surveillance bias (Widom, Cazaja & DuMont, 2015). The ways in which 'cycle of abuse' discourses have permeated into professional spheres have also been critiqued, by professionals, as resulting in assumptions being made that parents will be unable to appropriately care for their children and for being overly focussed upon individual parents (typically mothers) whilst neglecting wider socio-political factors that impact upon child-rearing (Croghan & Miell, 1999).

1.3 Rationale and Aims of Present Review

Reviews in the area of trauma and parenting have typically been concerned with quantitative studies comparing differences at group levels on traits and constructs researchers have deemed important. Subsequently, research has focused on the deficits or increased problems that parents with a trauma history might face, in comparison with a control parent group. The portrayal of parents with trauma histories within the literature risks pathologizing parenting behaviours and difficulties, as well as overlooking factors pertaining to strength and resilience. Therefore, the focus of this qualitative review was centred around exploring the overall experiences of parenting in the context of former childhood trauma. It was hoped that a greater understanding of the lived experiences of such parents could be generated which could offer new insights and help to inform guidance and intervention.

2. Method

2.1 Search Strategy

A systematic search was undertaken to capture qualitative literature pertaining to experiences of parenting in the context of childhood trauma. Search terms (Table 1) were refined through scoping searches to ensure search strategies returned previously identified relevant papers. For the purpose of this review, it was considered important to capture multiple experiences of childhood trauma, as opposed to exclusively focusing on a specific form of abuse. Abuse is often overlapping and children who endure repeated trauma are likely to experience multiple forms of abuse. Global definitions of developmental trauma, as outlined by Van der Kolk (2014), and specific abusive experiences were encapsulated within the search terms and refined through scoping searches. Searches were conducted between July and September 2018 using databases concerned with a range of psychological, social care and healthcare literature: PsychINFO; Medline; Scopus; CINAHL and ASSIA.

Table 1: Database Search Terms for Systematic Review

Concept	Search Terms / Variations	Location
Parenting	Parent* *(includes: parent; parenting; parental)* Mother* *(includes: mother; motherhood; mothering)* Maternal Father* *(includes: father; fatherhood; fathering)* Paternal "child-rearing"	Title, Abstract, Keywords
Trauma	Trauma* *(includes: trauma; traumatising; traumatizing traumatised; traumatized)* Surviv* *(includes: survivor; survived, survive; survival)* Victim* *(includes: victim; victimised; victimized)* Abus* *(includes: sexual, physical, emotional and domestic abuse; abusive; abused; abusing)* Maltreat* *(includes: maltreated; maltreatment)* Neglect* *(includes: neglect; neglected; neglectful)* Incest* *(includes: incest; incestual)* Violence *(includes: domestic violence; Interpersonal violence)* Battered "PTSD" "post-traumatic stress disorder" "complex-trauma" "developmental-trauma" "difficult childhood" "difficult past" "adverse childhood experiences"	Title, Abstract, Keywords

Note: The concepts of parenting and trauma were combined using the Boolean strategy "AND", while the variations within the concepts were searched using the Boolean strategy "OR". To help capture all different variations of the keywords, some were truncated (as indicated with *)

2.2 Study Selection

Inclusion criteria were developed with reference to SPIDER (Cooke, Smith & Boothe, 2012) (Appendix B). Due to no other existing reviews being identified on this topic, no date restrictions were set to ensure that all existing papers could be considered for the review.

In total 5288 papers were identified through database searches and exported into RefWorks. Following the removal of duplicates, 3988 papers remained and were screened against the inclusion and exclusion criteria at title and abstract level, resulting in the exclusion of 3958 papers. The remaining 30 papers were then screened at full text level and a further 17 were excluded for not meeting the inclusion criteria. The remaining 13 papers were quality assessed for inclusion. No suitable additional papers were identified through forward citation searches, the reference list of included studies, or a search of the 'grey literature' using Google and Google Scholar. Figure 1 presents a PRISMA flow diagram of the search process (Moher *et al.*, 2009).

2.3 Quality Appraisal

There is a lack of consensus regarding what constitutes as good quality qualitative research (Gough & Madill, 2012; Rolfe, 2006) and as such various approaches to assessing quality have been proposed (CASP, 2018; Dixon-Woods, Shaw, Agarwal & Smith, 2004; Walsh & Downe, 2006). A quality assessment was conducted on the remaining 13 papers using a framework frequently applied within health and social research developed by Caldwell, Henshaw and Taylor (2011) (Appendix C). Although the issue of excluding papers from meta-synthesis is debated (Dixon-Woods *et al.*, 2006), two studies were excluded due to their low quality appraisal scores (Appendix D).

Identification

Database Searches:
PsycINFO, Scopus, CINAHL, ASSIA, Medline

Filtering Process - Inclusion Criteria

English Language
Qualitative Methodology
Peer-Reviewed

Records identified through database searching (n=5265)

Additional records identified through other sources (n=23)

Exported into RefWorks (n=5288)

Screening

Duplicates removed (n=1300)

Records after duplicates removed (n=3988)

Records excluded following title screen (n=3838)

Records for abstract screening (n=150)

Records excluded following abstract screen (n=120)

Eligibility

Records for full paper review (n=30)

Records excluded following full paper review (n=17)

Multiple papers of the same study: (n=2)
Focus on substance misuse: (n=3)
Focus not on parenting experience: (n=9)
Focus on pregnancy: (n=1)
Unclear if all participants had experienced childhood trauma: (n=2)

Included

Studies undergoing quality appraisal (n=13)

Records excluded due to low quality assessment score (n=2)

Studies included in the systematic review (n=11)

Figure 1: PRISMA Flow Chart of the Systematic Search

2.4 Synthesis

Meta-synthesis is an interpretive integration of qualitative findings which allows for a greater depth of knowledge to be generated of the studied phenomenon, reaching beyond the themes within each individual study (Barnett-Page & Thomas, 2009). For this review, I chose an adapted version of Nolbit and Hare's (1988) meta-ethnography, as developed by Sandelowski & Barroso (2007) to guide the synthesis. This approach moves beyond the aggregation of research findings to involve the 'translation' of concepts from individual studies whilst preserving the meaning of experiences explored within the primary research (Britten *et al.,* 2002).

A contextualist epistemological position was adopted (Appendix E), whereby it was presumed there was not one true interpretation of the data from the original sources, and it was recognized that the authors' preunderstandings would inevitably shape the themes generated through the synthesis (Madill, Jordan & Shirley, 2000). Rather than this being regarded as problematic, it has been argued that interpretation is inevitable and occurs to some degree within all research (Gough & Madill, 2012).

Definitions of first, second and third-order constructs (Malpass *et al.*, 2009) were used to form a three-level approach to interpreting research findings (Gomersall, Madill & Summers, 2011), as depicted in Appendix F. I read each study several times before applying line-by-line coding to the results and discussion sections of reviewed papers. Then, I used a process of reciprocal translational analysis (Sandelowski & Barroso, 2007) to integrate findings (Appendix G). This was an iterative and dynamic process which was followed by line-of-argument analysis (Barnett-Page & Thomas, 2009). During this process, I continuously referred to the primary papers in order to ensure interpretations stayed close to the source data. Third-order constructs, representing my interpretations of second-order data, were developed and a meta-synthesis concept map (Appendix H) was created to help determine how the themes 'sat together' (Cahill, Robinson, Pettigrew, Galvin & Stanley, 2017). The quotes from participants (first-order data) were returned to at this stage as a further means of ensuring themes fitted with the data. Themes were cross-checked ensuring they were reflected in the majority, if not all, of the primary studies to enhance validity (Appendix I).

3. Findings

3.1 Overview of Primary Studies

All eleven papers shared the overarching aim of exploring the experiences of parenting in the context of childhood trauma (Aparicio, Pecukonis & O'Neale, 2015; Buchbinder, 2004; Cavanaugh *et al.,* 2015; Hall, 2011; Herland, Hauge & Helgeland, 2015; Kistin *et al.,* 2014; Maxwell, Proctor & Hammond, 2011; O'Dougherty-Wright, Fopma-Loy & Oberle, 2012; Pitre, Kushner & Hegadoren, 2011; Tedgard, Rastam & Wirtberg, 2018; Wood & Esterik, 2010). Although no date restrictions were imposed within the searches, all the papers retrieved exploring this experience were more recent publications. Whilst there has been a body of longstanding research conducted into the impact of trauma on parenting behaviours and the implications for child rearing, it seems that parental experiences are a more recent research interest. This might suggest that the experiences for parents have previously been over-looked or deemed to be less important. The studies retrieved considered the experiences of 176 parents, most of which were mothers (88%). Participants' ages ranged from 18-65 years old. Two studies specifically focused on young or teenage mothers' experiences and therefore had a more limited age range (Aparicio, Pecukonis & O'Neale, 2015; Maxwell, Proctor & Hammond, 2011). Studies varied in relation to the extent of other information provided about participants (Appendix J). Most studies provided specific information pertaining to the trauma experiences of the participants whilst some studies referred more generally to traumatic experiences. Table 2 presents details of the primary study characteristics and further information regarding the design and quality of reviewed studies can be found in Appendix K.

Table 2: Study Characteristics of Papers Included in the Meta-Synthesis

First Author and Date	Aims of Study	Recruitment	Sample	Location	Method and Analysis
Aparicio *et al.* (2015)	To explore the lived experience of motherhood among teen mothers in foster care with a history of maltreatment	No details as to recruitment process	6 teen mothers interviewed three times (18 interviews)	USA	Semi-structured interviews Interpretative phenomenological analysis
Buchbinder (2004)	To explore the experiences of mothers who witnessed and were subjected to domestic violence during childhood	Purposive sampling via a domestic abuse intervention service	20 mothers interviewed three times (60 interviews)	Israel	Semi-structured interview Analysis explained but not defined
Cavanaugh *et al.* (2015)	To understand the needs and experiences of mothers who are childhood sexual abuse survivors	Recruitment via advertisements	44 mothers	USA	Semi-structured interviews Thematic analysis
Hall (2011)	To explore parenting challenges and strategies identified by mothers who have a history of childhood abuse	Purposive sampling via friends and acquaintances	3 mothers	UK	Semi-structured interview Grounded Theory
Herland *et al.* (2015)	To explore how men who had a difficult childhood, experience being a father themselves and relate to their children	Part of a wider longitudinal study with participants originally being recruited through their involvement in a state-initiated welfare programme when they were adolescents.	15 fathers	Norway	Semi-structured interviews Psychoanalytically informed discourse analysis
Kistin *et al.* (2014)	To understand the experiences of parenting in traumatized mothers, specifically in relation to coping strategies and disciplinary approaches	Purposive sampling via advertisement at a paediatric primary care clinic	30 mothers	USA	Semi-structured interviews Grounded theory
Maxwell *et al.* (2011)	To explore the experiences of motherhood and parenting of mothers who were 'looked after' or in care during their own childhood	Recruitment via local authority care teams	6 teen mothers	UK	Written diaries Semi-structured interviews Interpretative phenomenological analysis
O'Dougherty-Wright *et al.* (2012)	To explore women's perspectives on mothering as a survivor of childhood sexual abuse	Recruitment via flyers in community settings, announcements in local newspapers and on internet forums for survivors	15 mothers	USA and Canada	Open-ended questionnaire and semi-structured interviews Grounded theory
Pitre *et al.* (2011)	To explore the experiences of motherhood for mothers who have experienced childhood violence	Recruitment via advertisement via posters and articles	12 mothers	Canada	Semi-structured interview Critical feminist narrative enquiry
Tedgard *et al.* (2018)	To explore the experiences of individuals growing up with substance-abusing parents and how this impacts on their own parenting	Purposive sampling via an infant mental health intervention programme	19 parents (13 mothers and 6 fathers)	Sweden	Semi-structured interview Qualitative content analysis
Wood *et al.* (2010)	To explore women's experiences and decisions around infant feeding in the context of childhood sexual abuse	Purposive sampling via a supportive service for women who experienced CSA	6 mothers interviewed twice (12 interviews)	Canada	Semi-structured interviews Thematic analysis

3.2 Interpretive Meta-Synthesis

Three main conceptual themes resulted from the analysis (Figure 2): *Forming a parental identity through the lens of trauma*; *Protecting against perceived threat;* and *The need for safe support*. Table 3 illustrates the taxonomy of findings.
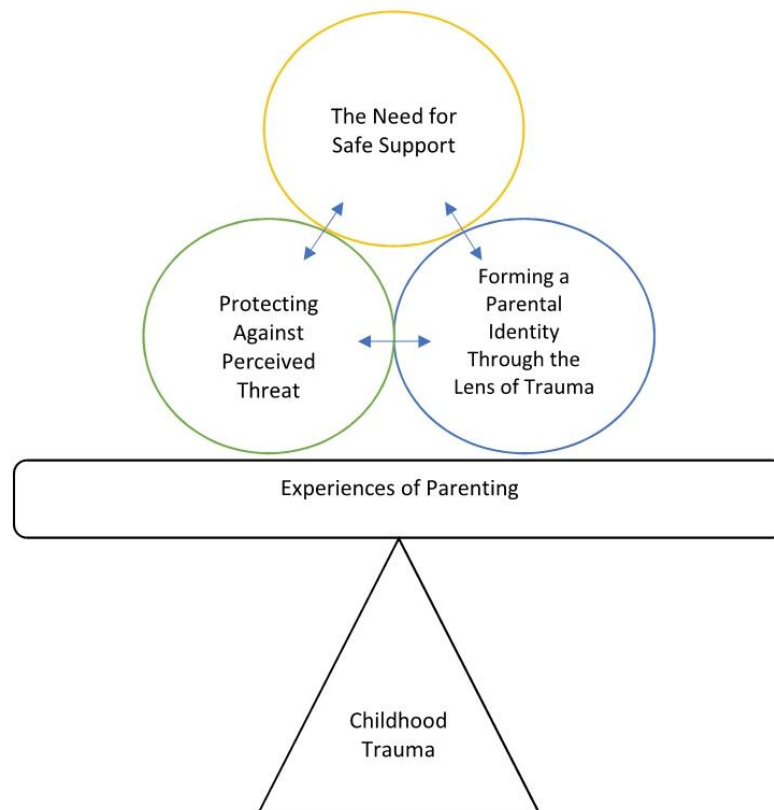
Figure 2: Meta-Synthesis Themes

3.2.1 Forming a Parental Identity through the Lens of Trauma

This conceptual theme pertains to how both the parents and authors of the reviewed papers made sense of parenting experiences and parental identities through the effects of trauma. This theme comprised of two sub-themes: *Breaking free from past abuse*; and *The struggle to meet the emotional demands of parenting.*

Table 3: Taxonomy of Third-Order Constructs

Themes	Sub-Themes	Constructs
Forming a parental identity through the lens of trauma	The struggle to meet the emotional demands of parenting	Attachment not seen as a natural process Enmeshment with child Parent needs vs child needs Feeling overwhelmed Internalised negative perception of self as a parent
	Breaking free from past abuse	Uncertainty of how to be a parent Inadequacy and self-scrutiny Desire, motivation & commitment to doing things differently Surviving & growing (Transmorphis) Absence of positive parental role-models making change difficult Hope for child and for self through parenting Establishing a positive template for parenting Identity and healing through process of parenting Purpose as a parent Learning through child
Protecting against perceived threat		Threat from the external world Efforts to protect child from danger Monitor and surveillance Fear and distrust of self - becoming like own parent (intergenerational abuse) Fear of rejection / abandonment from child Self-preservation and survival Abuse and trauma as inevitable Child as prone to engaging in abusive behaviours
The need for safe support		Dangers of asking for help Desire to seek help Power and threat Barriers to support Parenting with lack of support & resources: emotionally; practically

14

Breaking Free from Past Abuse. This theme relates to how many parents perceived parenthood as a new beginning and a chance to start over, whilst capturing how some parents struggled to break free from their pasts and experienced parenting as reinforcing feelings of inadequacy.

The papers highlighted how parenthood was perceived as a positive experience for many, bringing about a new sense of purpose and an opportunity for parents to break free and develop a new sense of identity to that of victim or survivor:

'Everything changed. Everything was so different…it actually looked a lot better to me. The world looked a lot… it made a little more sense… I always wondered before I had her... like why did god put me in this position… I know why I am here… I need to be a mom' (Aparicio, Pecukonis & O'Neale, 2015 p.51).

For some, parenthood seemed to create a sense of healing and resolution. Parent's spoke about feeling 'free' or at 'peace' with themselves both physically and emotionally, with the parent-child relationship becoming a significant mechanism in parents' adjustment to their traumatic childhood experiences:

'My body changed [after having children] and everything was so new… but in a wonderous way, not in a rejection way… you know how it's like seeing things for the first time?' (Wood & Esterik, 2010 p. 139).

These children are… showing me unconditional love, and I didn't know that before' (Cavanaugh et al., 2015 p.512).

'There's an internal peace that I can actually achieve at times now which is really really lovely… I think I'm also willing to accept a deeper sense of satisfaction in being a parent' (O'Dougherty-Wright, Fopma-Loy & Oberle, 2012 p. 547).

Parenthood seemed to embody a symbol of hope for many parents, something that was missing from their own childhoods. This was reflected in the ideas around a more positive future, where parents were motivated to do things differently for their own children. For some parents, these changes felt plausible and there was a sense that parenthood had helped them to develop a greater level of self-worth and self-belief:

'I just KNEW, If I did the right thing from my heart – put them first. Didn't judge them. Didn't beat them. Didn't call them bad names. THAT – I would have a pretty good chance at raising some decent people… I felt it in my heart' (Pitre, Kushner & Hegadoren, 2011 p.265).

'I learned how to trust myself…. I know myself well enough to know that I want nothing but good for him, and I have to trust that even my mistakes are ok' (Hall, 2011 p.43).

Not all parents shared the optimism of being able to make such changes. For some, attempts to break free from their experiences of being parented and provide a different experience for their own child, often left them holding a tension between knowing what 'not to do' but not knowing what 'to do'. For some of the parents, the absence of a positive parental role model seemed to leave them feeling like they were trying to parent without a template to guide them; which perhaps added to the sense of feeling ill-equipped to make the positive change they envisaged:

'How could I possibly be a good mom? I don't know anything about parenting. I'd never seen it' (Hall, 2011 p.33).

'I felt some relief at least knowing what not to do… but the hard part is not knowing always what to do… and not having that good example' (Pitre, Kushner & Hegadoren, 2011 p.266).

Self-doubt and insecurity often seemed to manifest, and it appeared that some parents struggled with the belief that they were failing as parents in comparison to others. There was a sense that despite their best efforts they would always be 'traumatised parents' and this would inevitably impact upon their ability to parent in the way they wanted:

'I hardly ever feel that I am good enough, I am so preoccupied with everything that I do wrong' (Tedgard, Rastam & Wirtberg, 2018 p.7).

'At some really deep level, I second guess myself… because I just felt like everybody else is … smarter… or more intuitive… or knowledgeable or something when it comes to being a parent than ME' (Pitre, Kushner & Hegadoren, 2011 p.266).

The Struggle to Meet the Emotional Demands of Parenting. This theme embodies the emotional and relational difficulties that parents experienced with their children, which typically were perceived to be a direct consequence of parental trauma. For example, difficulties with physical intimacy were related to surviving abuse and seemed to be particularly prevalent during times of intimate contact (e.g. breast-feeding):

'At 6 weeks he went on the bottle… [stopped breast-feeding] I was touched out and I'd had all the physical contact that I could possibly take in those 6 weeks' (Wood & Esterik, 2010 p. 139).

'It always amazed me as to how beautiful of an experience [breastfeeding] could be, and yet for me it was such a trauma' (Wood & Esterik, 2010 p. 138).

The emotional demands involved with forming healthy attachments was also interpreted through the effects of trauma. Some parents described how, contrary to

their desires, the ability to establish emotional closeness with their child did not develop 'naturally', as presumed. For other parents, there was a sense of increased vulnerability associated with developing 'too close' an emotional attachment, motivated by fear of rejection or harm coming to the child. Whilst some parents seemed to find it harder to emotionally and physically separate from their children, others reported making a conscious effort to emotionally distance themselves as a form of self-preservation:

>*'I have a tough time being affectionate with them, showing them the love they deserve… I couldn't really form a real close bond because there is a child in me that I believe I haven't accepted' (Cavanaugh et al., 2015 p.513).*

>*'I didn't let myself be that much in love with him because I was so scared of what that could do to us…' (Hall, 2011, p.33).*

>*'I have never been away from my children… no, no, I would die… I can hardly breathe if I just think about it' (Tedgard, Rastam & Wirtberg, 2018 p.7).*

For some parents managing their own emotional experiences and managing the emotional needs of their child was a fragile act of balance. When parents found it difficult to contain their own emotional experiences, trying to navigate their child's emotional world was an additional demand placed upon them which they felt they had little capacity to manage. Furthermore, some parents described how they found themselves experiencing heightened distress when their child reached milestones reminiscent of their abusive experiences, with their child then becoming a trigger for emotional pain:

>*'The stress of being a parent is enough for the quote-unquote normal person, but if you've got shit in here it comes out… often I'm being triggered and in the situation of needing to cope… I have the interplay of*

trying to bargain with myself to meet my own need... and meet the need of the child standing in front of me' (O'Dougherty-Wright, Fopma-Loy & Oberle, 2012 p. 542).

'The years that were particularly hard [as a parent] were the years that I had hard years [childhood].... I wanted so badly for him to get to nine... because I was nine and someone set me on fire. I don't know why I thought now I have a kid... something horrible is going to happen at nine' (Hall, 2011, p.37).

For some parents, this seemed to result in a role-reversal whereby the child would become the emotional container and comforting figure for the parent:

'I think that she can tell I'm stressed out... out of nowhere she will come up and start kissing me and hugging me – that is how I know she knows' (Aparicio, Pecukonis & O'Neale, 2015 p.51).

'I was going to take her to preschool... probably she's ready... I'm not ready. I still miss, I still need to be around her' (Pitre, Kushner & Hegadoren, 2011 p.269).

3.2.2 Protecting Against Perceived Threat

This conceptual theme encapsulates the dominant ideas and concerns around perceived levels of threat and danger that was referenced in relation to parenting experiences (Figure 3). For some parents there appeared to be an underlying sense that abuse was somehow inevitable, resulting in fear that they would not be able to protect their child or themselves from harm.
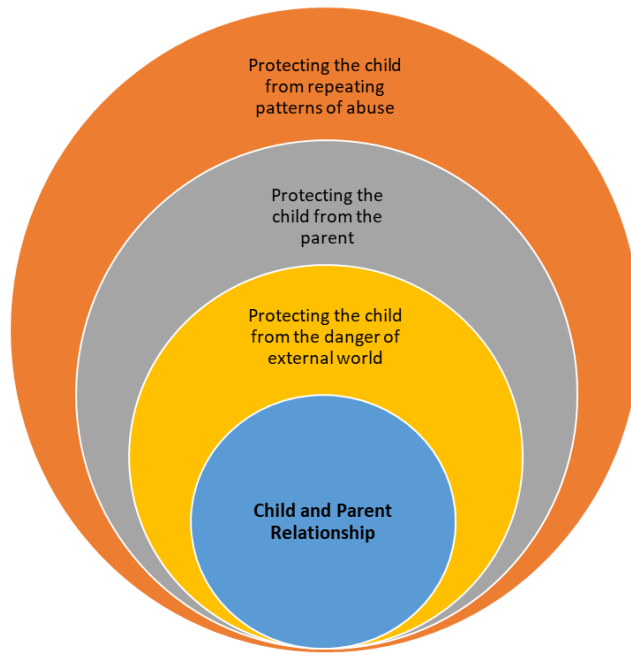
Figure 3: Layers of Threat and Protection

Whilst it was felt that becoming a parent could offer an increased sense of security, with children providing a form of healing and purpose (see previous conceptual theme), at other times parenting resulted in an increased sense of threat. Many parents seemed to experience the world and others as potentially dangerous and there was an underlying sense that harm would inevitably come to their children. Parents were often perceived as taking an overly-protective stance due to this and some parents would implement practical strategies and psychological defences as a means of protecting their children from dangerous others:

> *'It taught me that you have to have your daughter on some type of birth control pills no matter what because you can't prevent what they can't prevent' (Cavanaugh et al., 2015 p.512).*

> *'I wanted to protect the kids… from the cruel world they live in. I have built a wall around us, with no access to anyone. No-one could get close. This wall still exists … my kids have learned from me not to trust people' (Buchbinder, 2004 p. 314)*

Some parents experienced fear that they themselves could potentially harm their children. Despite desires to do things differently, some struggled with the belief that they would succumb to, what they feared were, predisposed generational patterns of abuse and expressed concern that their children might also need protecting from themselves:

'It would cross my mind sometimes with diapering them, just what they looked like – I never touched them or anything like that, but just, it would cross my mind as far as that' (O'Dougherty-Wright, Fopma-Loy & Oberle, 2012 p. 544).

'What if I – one of the things my mother did was swing me around, and what if I do that, and I really hurt him?' (Hall, 2011 p.33).

The fear associated with parents repeating former cycles of abuse with their own children seemed to be specifically prevalent within the domain of managing discipline. For some parents, the use of discipline may have become entangled with their traumatic histories making it harder for them to navigate the difference between abusive behaviours and 'healthy' boundary setting, with parents seeming not to trust their own judgement:

'It was hard for me to know what was normal, because I never knew normal. Normal to me was: okay, if I smack him, then he'll shut up…' (Hall, 2011 p.34).

'It's not that you want to strike your child. That's not what a parent wants to do, but you just want your child to stop. You just want your child to know, I say no and… no means no' (Kistin et al., 2014 p.6).

A further fear experienced by some parents was that their child may grow to follow in the patterns of predisposed intergenerational cycles of abuse, despite their best efforts to break this chain:

'I finally understood that I came from an unhealthy family, that I am a battered woman and that my boy would be a battering man…' (Buchbinder, 2004 p. 311).

'If you've been brought up on that, your kids will be brought up on that, and their kids will be brought up on that…' (Maxwell, Proctor & Hammond, 2011 p. 32).

There was a sense that parents may not only be fearful for how this will impact upon their child but also how their child could then become a source of threat towards themselves. Some parents seem to become hypervigilant in relation to their child's behaviour, looking out for any signs or patterns that might be indicative of future abusive behaviours, but simultaneously not knowing how to break this perceived cycle:

'He's doing this little hitting thing. Not hard, lightly or whatever and he laughs, but when you tell him no he just continuously does it and does it and does it' (Kistin et al., 2014 p.4).

'He's got a lot of rage… that's what I worry about with my son… I'm worried that this is, like a warning sign of future things to come… I don't want him to be a violent person' (Kistin et al., 2014 p.6).

3.2.3 The Need for Safe Support

This conceptual theme pertains to the expressed need for support systems for parents who have experienced trauma, whether that be in the realm of: family; friends; or professionals. Some parents expressed a desire for supportive others to offer

reassurance and validation in relation to their parenting, highlighting the need for an emotionally containing figure for the parent. Circles of support were largely seen to be absent for many parents:

'When its dark and things are scary, and… your just alone with your kid, I would have loved to have someone to call. I remember calling that suicide hotline… I wasn't going to commit suicide… I just needed somebody to talk to' (Hall, 2011 p.44).

For many parents there seemed to be a tension between needing and fearing support because available resources were not experienced as safe. Family systems were often felt to be imbedded with danger and parents may have become more attuned to this after having their own child. Parental attempts to protect their children from such danger might have resulted in increased isolation:

'My mother has never been allowed to babysit my kids… because she seems to have blinders on when it comes to sleazy men and my kids' (Hall, 2011 p.35).

'Whom can I rely on except my parent? If I cannot rely on them, I can't rely on no-one. I haven't trusted anyone [with their child]… nobody. Simply no one!' (Buchbinder, 2004 p.313).

For some parents, fear of negative judgement from others was a barrier to accessing support. Sharing their parenting experiences with others could be perceived as exposing, leaving parents feeling judged, vulnerable and unsafe to talk about their difficulties:

'I remember asking someone what they do when they feel like they want to throw their kid in the river, and she was like "I would never throw my

kid in the river". I remember feeling so embarrassed. I thought we were

friends. I thought that I could say something like that' (Hall, 2011 p.36).

Professional support structures were also experienced as unsafe, with the services that had been put in place to help, often generating fear and anxiety for some parents. Professional intervention was experienced as judgemental and threatening, perpetuating experiences of vulnerability and isolation for marginalised parents:

'social services were always in and out… I just felt that I was being

watched constantly… like if a certain way I held her, or say she'd been

sick on her blanket, that would all be written down in their notebook'

(Maxwell, Proctor & Hammond, 2011 p. 36).

4. Discussion

'In every nursery there are ghosts… even among families where the love bonds are stable and strong, the intruders from the parental past may break through the magic circle in an unguarded moment and a parent and his child may find themselves re-enacting a moment or a scene from another time' (Fraiberg, Adelson, and Shapiro, 1975 p. 387)

The present review synthesised research concerning the experiences of parenting in the context of parental childhood trauma. A meta-synthesis of eleven primary studies generated three conceptual themes. All parenting experiences, especially challenges, were viewed through the lens of trauma, to the extent whereby trauma was inextricably linked to parental identity. Many parents endorsed a sense of fear that their children would be harmed, and an important part of parenting was striving to protect their children from perceived threat and danger. Furthermore, throughout these parenting experiences there was an absence of support and whilst a desire for help was acknowledged, it was equally perceived as being unsafe. The following sections consider these findings in relation to existing literature, discuss strengths and limitations of the current review and consider the implications for clinical practice and future research.

Whilst the need to recognise trauma and meaningful responses to abuse are important, throughout the reviewed literature, all parenting difficulties tended to be framed through a trauma lens; neglecting the idea that parenting by its very nature is challenging. It is recognised that experiences of childhood trauma may lead to, or exacerbate, some parenting challenges; however, when a label of trauma is applied there can be a tendency to interpret all experiences within this context which can be unhelpful and pathologizing (Warner, 2000). Research has already suggested that parents with a history of trauma have been found to hold more negative views about themselves in relation to their perceived capability to parent (Sandberg, Feldhousen & Busby 2012). Whilst it is acknowledged that most parents may doubt their child-rearing practices and question being 'good enough' at times, this might be heightened for parents who have experienced childhood trauma, due to internalising the dominant

narratives around trauma and parenting (Hooper & Koprowska, 2004). Furthermore, parents who do not have their own 'appropriate' template for parenting, may look to the media and popular culture for guidance. This highlights the importance of establishing a 'healthier' and more balanced perspective on parenting within media and through communication by professionals, whereby experiences of exasperation; exhaustion; and ambivalent feelings are normalised so that parenting experiences are not compared against idealistic parental constructs (Spock, 2002).

It was highlighted that some parents experienced difficulty in forming emotional bonds with their children. From an attachment perspective, it is considered that primary care-givers predominantly set the blueprint for how to relate to others in adult life (Silver, 2013). If parents themselves received inconsistent care or abuse from their own attachment figures, then they will not have experienced what an attuned, warm and responsive attachment feels like, making it potentially harder to provide this for their own children (Hooper, 2007). There was a sense that parents could find it overwhelming, at times, to respond to their child's emotional distress and managing both their own and their child's emotional needs was a continual act of balance. Given parents' adverse childhood experiences and the emotional intensity that comes along with parenting, it makes sense that parenthood might trigger additional feelings of vulnerability. Parents who experience difficulty in recognising and managing their own emotional states, primarily learned through a secure attachment, will likely find it harder to notice, label and regulate their child's emotional experiences (Gerhardt, 2004) and respond to their child's internal world (Slade, 2005).

Within the review there was a strong sense of meaning found in becoming a parent and for many survivors of childhood trauma, parenting holds a significant importance (Basham, 2004). Parents were keen to '*break free'* from cycles of abuse by parenting differently to how they themselves had been raised, however some parents were unsure of their ability to successfully achieve this. Byng-Hall (1995) suggests that this can lead to parents acting in ways that are directly opposed to their own experiences of being parented, which can result in many supportive parenting behaviours. However, this can also generate problems if parents' attempts not to replicate bad experiences go 'too far' in another direction.

26

It is important to recognise that the intergenerational cycle of abuse does not hold for all parents and that the transmission of intergenerational abuse needs to be understood within wider contexts (Berlin, Appleyard & Dodge, 2011; Widom, Cazaja & DuMont, 2015). The parent-child dyad does not exist in isolation; they operate within extended family frameworks and community, societal and cultural contexts that will also influence parental experiences (Cleaver & Freeman, 1995; Warner, 2009). Within some of the reviewed studies there was reference to the impact of socio-economic factors on parenting experiences. Previous research has indicated that parents who endure childhood trauma are more likely to experience stressors associated with lower socio-economic status (e.g. Steele *et al.,* 2016). These structural inequalities will directly impact on parenting capacity and the ability to meet the most basic needs of children due to inadequate resources, as opposed to a 'parental-skills deficit' within parents (Dominelli, Stega, Callahan & Rutman, 2005; Tarczon, 2012). Furthermore, when parenting demands come to exceed available resources this can lead to higher rates of parental stress. This is likely to impair parents' abilities to provide responsive and attuned care, thus reinforcing negative perceptions of their parenting to themselves and others (Deater-Deckard, 2004; Hughes & Baylin, 2012).

The meta-synthesis highlighted how some parents experienced a constant threat that harm would come to their child and it was interpreted that to combat this, some parents would take an 'over-protective' stance. Childhood trauma, especially the trauma of being abused by an attachment figure that is supposed to provide safety, may interfere with a parent's ability to provide a sense of security for both themselves and their children (Koren-Karie, Oppenheim & Getzler-Yosef, 2008). However, it may also need to be considered that parents experiencing economic deprivation are more likely to reside in impoverished neighbourhoods where crime rates, substance misuse and violent encounters are more prevalent (Gil, 2018). Therefore, in such circumstances a heightened awareness of danger and a more protective parental stance may be both understandable and appropriate (c.f. Cromby & Harper, 2009). Caution should be taken in assuming that a parent's hypervigilance to danger is simply an 'effect' of trauma.

4.1 Strengths and Limitations

This review is, to my knowledge, the first to synthesise research exploring the experiences of parenting in the context of childhood trauma. It is unique in its position of including all forms of childhood trauma and exploring the experiences of both mothers and fathers. There were limited studies found that focused on the experience of the father, meaning the voices of the latter population were under-represented. However, arguably it was problematic to synthesise data concerning the experiences of mothers and fathers given how parenting is a gendered experience. Often disproportionate responsibility is placed with mothers who tend to express greater concerns around parenting abilities (Herman, 1981). The age ranges within the samples may have also created variations within the findings due to differences between younger mothers currently raising children and older mothers thinking more retrospectively in relation to parental experiences. A further consideration of this review is linked to how trauma was defined. The focus on experiences of developmental trauma, as defined by the researchers and existing literature, may not have accounted for cultural contexts and norms which influence parenting styles and definitions of child maltreatment (Ferrari, 2002). None of the reviewed papers focused on the experiences of parents who had intellectual disabilities, a population known to experience additional challenges to parenting (Powell, Parish & Akobirshoev, 2017). Furthermore, it is acknowledged that excluding studies focusing on mental health difficulties and parenting might have precluded relevant papers, given the well-established links between childhood trauma and the likelihood of being diagnosed with a functional psychiatric label (Dillon, Johnstone & Longden, 2012; Newman & Stevenson, 2005). A decision was made to focus on papers concerned with trauma as researchers utilising interpretive lenses relating to 'mental illness' would have viewed their data in different ways.

4.2 Implications

The meta-synthesis highlighted the precarious issue of the need for support for parents with a history of trauma, and the risk that support can sometimes be

28

experienced as threatening as opposed to containing. This could perhaps be expected when the lens of 'disorganised attachment' is applied, whereby a parent may have struggled to develop abilities to receive support because caregivers have previously been the source of abuse (c.f. Hesse & Main, 2000). Furthermore, it has been observed how 'skilled therapists' can use similar tactics to 'skilled abusers' in trying to gain the trust of those they work with, for example offering praise and warmth (Warner, 2000). It will be important for professionals to acknowledge the position of power they hold and how this could trigger threat-based responses for parents. In this sense, ambivalence to support could be usefully reframed as an understandable threat-response in the context of a parent's history (c.f. Johnstone *et al.,* 2018). Approaches to therapy that emphasise making explicit issues of power and therapist intentions (e.g. Smith, 2013; Warner, 2001) could be incorporated into interventions provided to support parents with trauma histories. Such approaches could be utilized to support reflection when delivering interventions influenced by attachment theory that have been found to be helpful in supporting parents develop secure and containing relationships with their children (e.g. Dallos & Vetere, 2009; Golding & Hughes, 2012; Hoffman, Marvin, Cooper & Powell, 2006).

Whilst a protective distrust of support could stem from the effects of abuse, as described above, the results of the synthesis highlighted how parents feeling judged acted as a barrier to accessing support. Professionals and services should be aware that it will be harder for parents to feel supported when input from services is mandated, and may be perceived as intrusive or threatening, particularly when it involves assessing parenting abilities (Holt, 2010). This could result in heightened powerlessness, with the potential to be a re-traumatising experience (Gil, 2018). It is important to think about what would be required to help parents feel 'safe enough' to expose their vulnerabilities. For the vast majority, it can be assumed that parents want to do their best for their children and acknowledgement from parents that they might not be meeting all their child's needs is likely to be affiliated with feelings of shame and guilt (Hughes & Baylin, 2012). Supporting parents to develop 'replicative scripts', whereby they consider elements of their experiences of being parented which they would like to

repeat, alongside things they would wish to change can support more attuned parenting in a way that reduces feelings of guilt and shame (Dallos, 2006).

Another consideration is how effective professional support systems can be for parents with limited social and material resources. Escobar-Chew, Carolan & Burns-Jager (2015) found that parenting interventions were experienced as overwhelming and unmanageable. Parents were expected to prove their parenting capacity by attending classes and therapy sessions; sourcing employment; and finding new accommodation, all with limited support to achieve these objectives. This highlights how support, whilst perhaps well-meaning, has the potential to be experienced as pathologizing and critical, increasing likelihood of disengagement. For support to be constructive, it would need to be thoughtfully considered ensuring objectives are feasible and accessible.

Whilst it is important to acknowledge that a history of trauma would not necessarily mean that parents will require specific help, it might still be useful to consider offering access to support within the early stages of parenthood. Professionals holding an awareness of how childhood trauma can potentially exacerbate the everyday challenges of being a parent, can normalise such experiences from the outset in the context of being meaningful adaptations to trauma (Shaw & Bailey, 2018). Furthermore, it might help reduce the stigma in seeking support as parenting difficulties could be conceptualised as meaningful responses influenced by trauma, as opposed to parents internalising beliefs about being bad or incompetent. This trauma-informed care approach would help to support parents from a place of respect, acknowledging their: survival skills; resilience; personal qualities; strengths; and subsequently help to reduce feelings of shame and stigma (Courtois, 2014; Shead, 2015; Sweeny, Clement, Filson & Kennedy 2016). Finally, most of the research involving experiences of parenting in the context of past trauma has focused on motherhood. Future research is needed to incorporate the experiences of fathers, who are much neglected within the literature.

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Chapter Two: Research Paper

'If Only I Could Have Said, If Only Somebody Was Listening': **Mothers' Experiences of Placing their Child into Care in the Context of Trauma**

Prepared for submission to the journal of Adoption & Fostering

(please refer to Appendix L for submission guidelines)

Abstract

Introduction: Mothers of children in care have been largely neglected in practice, research and policy and remain to be a marginalised and vulnerable group, with many having complex needs and simultaneously experiencing a lack of support provision. This research explored the experiences of mothers, with trauma histories, who had made or agreed with the decision for their child to be placed into care.

Method: Three mothers of children in care were recruited through mental health services and each mother participated in two semi-structured interviews. Data was analysed using Interpretative Phenomenological Analysis.

Results: Three superordinate themes were presented: *A fractured sense of motherhood* highlighted the struggle with mothering identities in line with feelings of disconnection and separation; *'I wish I could turn back the clocks': Living with feelings of failure and shame* illuminated the underlying feelings of guilt and shame in association with perceived failings; *'Less than a person': Becoming nothing and no-one'* alluded to the mothers' experiences of isolation and disempowerment, which led to feeling devalued and dehumanised.

Discussion: Themes were discussed in relation to existing theory and literature. Clinical implications highlighted the importance of acknowledging the role of loss and grief as well as the use of therapeutic interventions which are sensitive to the operation of power.

1. Introduction

1.1 Constructions of Motherhood

Dominant discourses concerned with motherhood perpetuate an idealised notion of what it means to be a 'good mother' (Dally, 1982). The dominance of the 'good mother' construct places pressure upon mothers to conform to idealised standards, which they are upheld against (Goodwin, & Huppatz, 2010). 'Good mother' discourses are thought to be influential in how women shape their maternal identity. They set the precedent that motherhood is 'instinctive' and that women are 'natural nurturers'; always equipped and available to provide care and who only experience positive feelings in relation to their children (DiQuinzio, 1999). The 'good mother' construct exemplifies how mothers will completely adapt to the needs of their child, to the exclusion of their own needs, thus diminishing the importance of mothers as individuals in their own right (Held & Rutherford, 2012; Warner, 2007). This discourse conveys messages about how mothers 'should' feel; that they should experience motherhood as all-fulfilling and joyous (Maushart, 1999). This narrative around mothering also serves another purpose; it places parental responsibilities firmly with the woman, linking their identities to the role of child-rearing and family nurturer (Goodwin & Huppatz, 2010).

Critical feminists have argued the damaging nature of such discourses and how the transition to motherhood can often be difficult and challenging, perhaps due to mothers feeling inadequate in relation to 'good mother' ideals (Herland & Helgeland, 2017). Research has found that mothers who do compare themselves against such narratives experience feelings of guilt, inadequacy and failure; which they felt compelled to conceal due to this not fitting with expectations of how they 'should' be coping (Choi, Henshaw, Baker & Tree, 2005; Maushart, 1999). Furthermore, mothers who have different experiences to the idealistic portrayal of motherhood are also more likely to come to view themselves as 'bad mothers' (Kielty, 2008).

1.2 Mothering in the Context of Trauma

Research has suggested that mothers who survive childhood trauma may experience parenting differently to non-traumatised mothers (Harel & Finzi-Dottan, 2018). Quantitative research in this area has largely focused on parenting capabilities, and has found that mothers with a history of trauma can experience difficulties in relation to; managing boundaries (DiLillo, & Damasheck, 2003); coping with intimate aspects of physical care (Douglas, 2000); and within their attachment and engagement with their children (Tarczon, 2012). Research that has explored the experiences of mothers with trauma histories has also found that mothers perceive their past abuse to impact upon their ability to parent effectively (e.g. Cavanaugh *et al.,* 2015; Hall, 2011; O'Dougherty-Wright, Fopma-Loy & Oberle, 2012). However, within the literature, there is a tendency for all mothering difficulties to be attributed solely to trauma, thus located internally within the mother. Internalisation of such discourses is likely to impact on how mothers perceive themselves and their ability to fulfil the mothering role (Hooper & Koprowska, 2004); and indeed research has found that mothers with trauma histories hold more critical views about themselves in relation to their capacity to parent (Sandberg, Feldhousen & Busby 2012).

1.3 Mothers of Children in Care

Figures from the Department for Education (2018) indicated that 75, 420 children were under the care of local authorities in March 2018, with the main reasons cited as: Children experiencing abuse or neglect; family dysfunction; or families in acute levels of distress. Despite these high figures, mothers of children in care have been largely neglected in practice, research and policy and remain to be a marginalised and vulnerable group, with many having complex needs (Cossar & Neil, 2010). Schen (2005) suggests that a possible reason for the absence of the 'birthmother' voice is that they often experience a reduced sense of power due to factors such as: Low socio-economic status; ethnicity; and mental health difficulties. Furthermore, the culture of mother-blaming and shaming (Kielty, 2008) is likely to perpetuate marginalisation and disempowerment of this vulnerable group.

There has been some research which has focused on mothers whose children have been forcibly removed. Neil (2000) found high rates of personal and psychological difficulties amongst birthparents who had been through this experience: 45% of the birthmothers were regarded as 'having' a 'mental health difficulty'; 28% were cited to be 'misusing' drugs or alcohol; and 23% had a criminal record. The literature highlights a cyclical nature between these experiences and child removal, whereby the removal of the child exacerbates pre-existing difficulties, and the pre-existing difficulties limit a parent's ability to cope with the loss of their child (Cossar & Neil, 2010). Qualitative research has explored the experiences of mothers who have had their children forcibly removed under duress. The findings from these studies highlight that these mothers experienced complex psychological processes associated with guilt; shame; stigma and identity (Janzen & Melrose, 2016; Memarnia, Nolte, Norris & Harborne, 2015). Earlier research has explored the experiences of mothers who voluntarily relinquished care of their children in the context of societal influences (e.g. having a child out of wedlock) (Lauderdale & Boyle, 1994; Wells, 1994; Winkler & Van Keppel, 1984). This research found that 'relinquishing mothers' experienced a profound sense of loss which intensified over time. Furthermore, this research highlighted that whilst on the surface, mothers were seen as 'voluntarily relinquishing', many of the mothers felt they had no choice and experienced high levels of familial and societal pressure.

1.4 Rationale and Aims of the Present Study

Whilst existing research has explored the experiences of mothers who 'voluntarily relinquished' care of their children, this is outdated and linked to the societal expectations at that time. There was a gap within the literature concerning the experiences of mothers who had made, or agreed with, the decision for their child to be placed into care in the context of trauma. It was thought that this group of mothers would likely have a unique and separate experience to those of mothers whose children were forcibly removed under duress. The following research question framed the study: *'How do mothers with trauma histories make sense of their experiences of motherhood and their decision [or agreement with the decision] to place their child into care?*

2. Method

2.1 Design

An Interpretative Phenomenological Analysis (IPA) approach was chosen as a framework to inform all aspects of the research process (Larkin, Watts & Clifton, 2006). IPA is an inductive approach concerned with the meaning-making of individuals and how people make sense of their lived experiences (Smith, Flowers & Larkin, 2009). IPA is both phenomenological and interpretative; with both researcher and participant engaging in a reflexive process to make sense of a person's lived experience (Willig, 2013). The idiographic focus of IPA privileges in-depth analysis of a small homogenous sample and is committed to understanding individual experience within a particular context (Willig, 2013). Given the focus of this research, I considered there to be utility in offering participants the opportunity to have two separate interviews, in line with suggestions by prominent IPA researchers (Flowers, 2008; Larkin & Thompson, 2011). In doing so, greater familiarity could be established, and participants could feel safer to authentically disclose their experiences, allowing for rich accounts.

2.2 Epistemological Position

The study was conducted from a phenomenological position (Appendix M).

2.3 Ethical Considerations

Prior to recruitment, the research proposal was peer-reviewed by University staff and by a service-user group. Ethical approval was granted from the NHS Research Ethics Committee (Appendix N) and governance and legal compliance was approved by the Health Research Authority (Appendix O). Research Sponsorship was provided by the University of Leicester (Appendix P) and approval sought from participating recruitment sites (Appendix Q). Issues of confidentiality; anonymity; informed consent and; participant distress and safety were given careful consideration (Appendices R & S).

2.4 Participants

Three mothers participated in a total of six interviews. Participant demographic data is outlined in Table 4. The inclusion criteria, listed in Table 5, was utilised to support homogeneity of the sample. All mothers identified with having past experiences of trauma and were all receiving support from mental health services at the time of interview. None of the mothers had any contact with their children following them being placed into care, although two of the mothers were now having a level of contact with their children who were in adolescence or adulthood.

Table 4: Participant Demographic Data

Participant Pseudonym	Age Bracket	Ethnicity	Research Interviews (Length in Minutes)	Number of Children in Care	Age Range of Child when they went into Care*	Time Range since Child went into Care
Stacey	41-50	White British	1st Interview: 48 2nd Interview: 41	1**	0-5 years old	11-15 years ago
Nina	21-30	Asian British	1st Interview: 53 2nd Interview: 40	1	0-5 years old	0-5 years ago
Claire	41-50	White British	1st Interview: 92 2nd Interview: 110	4	11-15 years old	11-15 years ago
					11-15 years old	11-15 years ago
					11-15 years old	11-15 years ago
					0-5 years old	6-10 years ago

* please note large ranges in time have purposefully been used to protect participant anonymity

** Stacey did report having another child who had been placed in care. However, she had maintained regular contact with this child throughout their time in foster care. Therefore, we focused on her experiences with her youngest child who had been adopted and where there had been no contact following her adoption.

Table 5: Participant Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion criteria
Mothers who had made the decision, or come to be in agreement with the decision, to place at least one of their children into care, thereby relinquishing parental responsibility (no time limit was set for when this happened). This was defined by either: - the agreement of a child arrangement which outlined that the child lived with another person - the child being in foster care or under special guardianship - the child being adopted	Mothers who had their child/children forcibly removed due to child protection issues, where this was contested
Mothers who no longer had direct contact (face-to-face or telephone) with the child/children that they had relinquished parental responsibility for (excluding letterbox contact)	Mothers whose children were voluntarily or forcibly taken into care due to difficulties caring for the child being exclusively associated with parental intellectual disability or brain injury
Mothers who self-identified as having experienced past trauma	Mothers who were separated from their child/children but still maintained regular contact and parental responsibility
Mothers who were under the care of a mental health / post-adoption support service at the time of the recruitment process	Mothers who were not able to speak English at a level to complete the interview without the aid of a translator
Mothers who were considered to be 'safe' enough and have enough 'distance' from the experience to be able to discuss this in the depth required without this becoming significantly overwhelming or distressing	Mothers who would have experienced significant distress from participating which would have undermined their ability to remain 'safe'
Mothers who were aged 18 or over and who could provide informed consent for themselves	Mothers who posed a risk to the chief investigator
	Mothers who were not able to offer informed consent to participate, as defined by the principles of the Mental Capacity Act

2.5 Procedure

Participants were recruited from mental health services across the midlands. Services were contacted to request clinician support in identifying and approaching potential participants (Appendix T). Clinicians identified people they worked with who met the inclusion criteria and were considered 'safe enough' to participate (guided by use of a 'Clinician Safety Checklist': Appendix U). Prospective participants were talked through the 'Participant Information Sheet' (Appendix V), by the clinician and given a 'Consent to be Contacted Form' (Appendix W) which could be returned to myself to declare interest in participating. Interviews were then arranged at a time suited to the participant and conducted within the service they were accessing. Informed consent was sought ahead of each interview (Appendix X). It was made clear that consenting to the first interview did not mean the person had to take part in a second interview.

Participants were requested to compete a 'Demographic Information Sheet' (Appendix Y) and partake in a semi-structured interview. An interview guide (Appendix Z) was devised to flexibly support the interview process. Questions were open-ended with the intention of eliciting meaning of experiences, allowing the participant to bring what they considered important. The first interview was an opportunity to cover as much of each participant's experience as they felt comfortable to disclose. The second interview allowed for content to be revisited following a reflective space; and also afforded me the opportunity to re-listen to the initial interview material to help consider the use of further questions. Following the interviews, time was allocated for questions and a debrief whereby participants were provided with information pertaining to additional sources of support (Appendix AA). Participants were invited to bring a 'sensory-prompt' to the second interview as a means of providing cues to support articulation of experience (Reavey, 2012: See Appendix BB). Interviews were audio-recorded and transcribed verbatim by myself to help develop a level of familiarity with the data (Finlay, 2011). Data was analysed using established guidelines for IPA (Smith, Flowers & Larkin, 2009: See Appendix CC). Extracts from different stages of the analytic process are illustrated in Appendix DD. A chronology of the research process can be found in Appendix EE.

2.6 Methodological Rigour

To help maintain high quality standards and validity at the different stages of the research process, I was guided by the four key principles developed by Yardley (2000) which are discussed in Appendix FF. The CASP (2018) criteria checklist was also consulted to ensure various aspects of quality control had been taken into consideration (Appendix GG). I maintained reflexive records throughout the research process to enhance awareness of my preconceptions and how these were shaping my engagement with the data (Appendix HH).

3. Findings

The in-depth analysis resulted in three superordinate themes and five subordinate themes (Figure 4). To support transparency, participants' contributions to themes can be found in Appendix II.

1. A fractured sense of motherhood

'There was just no bond between us': Being disconnected

Letting go and holding onto motherhood: Liminal mothers

2. 'I wish I could turn back the clocks': Living with feelings of failure and shame

'It's painful to think about': The guilt of failing at motherhood

The unspeakable shame

Escaping the pain of failing

3. 'Less than a person': Becoming nothing and no-one

Figure 4: Superordinate and Subordinate Themes

3.1 A Fractured Sense of Motherhood

This superordinate theme captures how all participants experienced a fragmented sense of motherhood. There was a profound sense of disconnection for some mothers and they all grappled with their mothering identities in line with perceived ideals of motherhood. When their children went into care all the mothers were left in a position of both; letting go of and holding onto motherhood.

3.1.1 'There was Just No Bond Between Us': Being Disconnected. This theme, titled using a quote from Claire, draws together how the mothers experienced a painful and profound sense of disconnection from their children, and the impact this had on developing a maternal identity. Both Nina and Claire experienced a profound sense of emotional disconnection from their children, either from the beginning or shortly after birth, and this was something that both mothers were overtly aware of and almost hypervigilant towards. Both mothers described how despite their best efforts nothing seemed to change, and there was a sense of futility and resignation in their narratives:

> I just wasn't close to him and you know, I-I as much as I tried I just couldn't (Nina)

> I couldn't feel for them, couldn't do it, it just… so I gave up... stopped trying to feel it (Claire)

For Claire, specifically, this seemed to leave her in an almost paralysed position. She was unable to position herself as a 'good mother', due to not being able to develop an emotional connection with her children, but she also recognised that she was not overtly abusive to her children, leaving her with a sense of 'nothingness' and detachment:

> I was just… inert, I was an inert parent (…) I wasn't physically neglectful of the children. Probably emotionally neglectful of them, well definitely emotionally neglectful of them (…) there was obviously no sexual abuse, there was nothing of these, some of these horrific stories that you hear, but then I wasn't mother-earth either (…) I didn't know which one to be, so I became nothing (…) because I couldn't do one correctly and I wasn't as bad as to be… evil. So, I filled the space in-between (Claire)

Being disconnected was aligned with feelings of pain and confusion. Both mothers found it difficult to articulate what it was like to desperately want to feel a bond with their children, yet not being able to achieve this:

> *It just wasn't there. I never looked at them and (…) it was the weirdest*
> *feeling… but… also, soul-destroying for me because I wanted to feel it,*
> *but… I just couldn't (Claire)*

> *I don't really know to be honest, I can't really say, I don't really know.*
> *It was, it was confusing… it was emotionally draining as well (…) it's a*
> *really difficult thing (Nina)*

All the mothers held preconceived ideals regarding what it meant to feel like a mother, which seemed to contradict with their experiences. Claire and Nina identified with the idea that maternal feelings should come 'naturally' and 'instinctively' and not feeling the way they perceived they 'should', seemed to undermine their maternal identities:

> *People talk about this feeling when you've just been through childbirth*
> *and they hand you this baby… this rush of emotion and I… it never*
> *happened for me (Claire)*

Claire experienced her lack of an '*all-encompassing, searing, overwhelming*' love for her children as evidence that she was not 'maternal'; and that this way of being was simply not available to her: '*I'm not maternal and I completely accept that now*'. For Nina, she described having an intense emotional experience when her son was first born. This seemed to become her template for what motherhood should feel like, so when this intense emotion was not sustained, she struggled to reconcile with feeling like a mother:

The first few days I felt really really close to my boy and I felt like I loved

him so much and he was the world to me, and then afterwards (…) I

never got that connection back (Nina)

Both mothers experienced their children as no longer belonging to them. Nina alluded to how she felt her son was not actually hers, as if this was the only way she could make sense of having such an extreme change in feelings: '*it felt like he wasn't my boy'.* For Claire, there was a strong sense of the children belonging solely to their father; and they were often referred to as 'the children' or 'his children'. This belief seemed to be so entrenched that: '*once he died, it was almost like I was expecting the children to disappear as well'.* Both women seemed to hold onto being in a parental role, fulfilling the practical duties of childcare, but did not identify themselves as 'mothers':

I was still feeding him and stuff, but I was just doing the stuff that a

normal carer would do (Nina)

I've never ever afforded myself that title [mum] (Claire)

Conversely, Stacey was prevented from attending to practical needs with her child going into care days after birth. Stacey defined her maternal identity in relation to fulfilling mothering tasks: '*Taking care of her, bathing her, feeding her…'.* That someone else was performing these duties resulted in her seeing herself as 'birthmother' as opposed to 'mother':

I knew I was birthmother but I couldn't see myself as her mom when I

haven't been doing things and bringing her up (Stacey)

3.1.2 Letting Go and Holding onto Motherhood: Liminal Mothers. This theme embodies the tensions and emotional complexity experienced for the mothers in relation to their children being placed into care. This seemed to result in liminal

mothering identities whereby the mothers at different times sought to move away from or hold onto motherhood. All the mothers seemed to hold the belief that going into care was the best thing for their children. Furthermore, the mothers endorsed strong ideas about their children thriving in their absence and there was a sense that maintaining this belief was an important part of the process of letting go:

For her, the right decision was made (Stacey)

He's with his grandparents now and he's come a really long way…. he's a really clever boy, he was always a clever boy, he's so intelligent and you know, erm… and he-he, he's just doing really well (Nina)

Putting them into care (…) was the right thing to do, it gave them that structure and everything that they, they needed (Claire)

However, the mothers also experienced tension and doubt about being separated and this was often laced with a sense of being torn and in a state of internal conflict. Whilst being apart was seen to be the right thing for their children, this seemed to conflict with what was best for themselves:

As much as I was, I didn't want to be a parent and by the time they went into care it was more of a relief than anything else, I didn't want them to go, it, that in itself is conflicting too (Claire)

That was the best option at the time, even though I didn't agree with it years ago and I was upset all the time, suicidal and low and depressed, erm…it probably was the best decision (Stacey)

For all the mothers, it was clear that although they were currently separated from their children, none of them had been able to make a clean break from motherhood. For Stacey, there was a real sense of living in limbo: *'waiting and hoping and praying for the day where she'd be in touch with me again'.* All the mothers sought

to maintain a symbolic connection with their children, and this seemed to be a way of holding onto motherhood. For Nina, there seemed to be an underlying desire for her son to remember her in order to retain a connection:

There's no doubt that he does remember me. I know he remembers me because, how, I don't think, I just think how can he not remember me? (…) he definitely remembers me, I know he does! (Nina)

The mothers spoke about their hopes and desires to see their children again in the future and all held fantasies of being reunited. There was almost a certainty in the way they talked about this, as if this was inevitable:

I think that everything will just be just fine, yeah, and I think that it be a lot easier now, you know because he's a lot older (…) so I just, yeah things things will be good. I think we'll just be able to fit back into a good routine (Nina)

The final icing on the cake will be when I actually get to hug her, meet her face-to-face and hug her (Stacey)

3.2 'I wish I Could Turn Back the Clocks': Living with Feelings of Failure and Shame

This superordinate theme, derived by a quote by Nina, pertains to how the mothers experienced an underlying sense of failing at motherhood which was associated with feelings of guilt and regret and a desire to be able go back and do things differently. There was a deep sense of intrinsic shame that permeated the mothers' narratives in relation to their perceived failings, which seemed to be both explicitly and implicitly difficult to talk about. There was an unbearable pain associated with feelings of failure that the mothers desperately tried to escape from.

3.2.1 'It's Painful to Think About': The Guilt of Failing at Motherhood. This theme, titled by a quote from Nina, captures how the mothers perceived they failed at motherhood and how they experienced strong feelings of guilt and regret in relation to this. Both Nina and Claire seemed to experience an overwhelming sense of not knowing how to be a mother and both seemed to feel insecure in their ability to fulfil this role:

> *I don't think that I was fully-equipped as to what motherhood was gonna be like… it was my first child, I didn't know anything about, about, being a mother and I-I wasn't aware of what it was gonna entail or, you know, or how it was gonna be… or what I had to do or you know anything (Nina)*

> *I didn't have a clue, didn't have a clue, at all, there was noth…it-it was hard, it was really difficult (Claire)*

Both mothers spoke of feeling that they were never able to fully meet their children's needs because they could not work out what these were or how to do this. This seemed to feed into them feeling they were fundamentally failing their children. There was a sense of blame throughout the narratives of Claire and Nina, and they seemed to hold themselves fully accountable for the failings they perceived they made, leaving them experiencing feelings of guilt:

> *I felt so guilty about what I'd done (Claire)*

> *I think I was under-feeding him for a very long time, and that makes me feel sooo guilty. That's one of the things that, just plays on my mind like constantly and I can't stop thinking about it (Nina)*

Stacey experienced an overwhelming concern that her daughter would be harmed when she went into the care system which she held herself fully responsible for: *'I was worried for years about whether she'd had a good life or not'.* For Nina and

Claire there was a strong sense of regret and an underlying wish to go back in time and do things differently:

> *I know how to do things now, I'm a lot, I'm a completely different person and erm… wish I could do it all again now (Claire)*

> *There's a lot of regrets (…) I really did screw-up and I really regret it and I really wish that I could change somethings and the thing is that I can't change them (…) but I do, really, really regret a lot of things that I did as a mom (…) I wish that I could change them, I wish I could turn back the clocks and I'm afraid I can't and you know… it hurts (Nina)*

3.2.2 The Unspeakable Shame. This theme relates to how all the mothers experienced an intrinsic sense of shame associated with their mothering difficulties and the experience of their child going into care, which was perceived as unspeakable. Two of the mothers articulated how they were unable to speak about how they were feeling or the difficulties they encountered in motherhood and this was experienced as something that needed to be concealed:

> *I would never have imagined in a million years turning round to a social worker and saying 'I don't like being a parent, you know, I really don't get it, I don't understand it and I'm struggling here' (Claire)*

> *It was really hard for me, but, I haven't spoken (voice trembles)…I haven't spoken to anyone about it to be honest with you (Nina)*

Stacey referred to *'underneath feelings'* when talking about being separated from her child, and there was a sense that these feelings needed to be 'buried' because they were too painful to acknowledge: *'I didn't really show the underneath feelings that I was feeling… upset and miserable without her in my life'.* Furthermore, talking about

the separation from their children was especially difficult for Nina and Stacey within the interviews and this interpreted as something that could not be spoken about:

> *It's difficult, but… I made that decision so… (trails off) (Nina)*

> *I don't really talk about that sort of thing really cos it's difficult not having em in your life (pauses)… I don't know how to answer that question (Stacey)*

3.2.3 Escaping the Pain of Failing. This theme encapsulates how the mothers seemed to cope with their feelings of pain and shame, linked to perceiving they had failed their children; and how there was an overwhelming need to avoid or escape these feelings. Claire spoke of reaching a point of 'shutting down' during her experiences of motherhood, coinciding with a sense of hopelessness that she would never meet the perceived standards of mothering. Shutting down was a process of survival and self-preservation to avoid perpetually being confronted with feelings of failure:

> *I did shut down completely! I was just like, 'I don't wanna do this anymore, I don't wanna be anybody's parent' (…) I stopped caring about everything really, just, I didn't give a toss, didn't give a toss, they all had their own opinions anyway so all I was doing was exhausting myself running around trying to change those opinions (Claire)*

For Claire and Nina being around their children seemed to tap into their feelings of failure and ultimately become a source of pain. This was reflected in the mothers' accounts of feeling that they needed to permanently avoid their children and motherhood, as this was perceived to be the only way of escaping their emotional pain:

> *I just wanted to get away from him to be honest (Nina)*

In the end Social Services will take you [the children], because they'll have no choice, quite honestly. I won't work with them, I won't engage, I won't do absolutely anything that they tell me to and… I will get what I want in the end [referring to the children being removed], because it was the only way I saw out of it (Claire)

The mothers spoke about how they used drugs and alcohol as a way coping, to numb their pain both during experiences of mothering and following their children going into care:

It was just, it was a horrible, horrible time to live. It was horrible. I drank a lot to numb it (Claire)

Drinking and smoking drugs to help it ease, to help ease the pain really (Stacey)

When Stacey and Claire's children had gone into care, there was a strong desire to escape from this experience and the pain it created. Whilst they seemed to do this in very different ways, there was an underlying sense of needing to create distance and an ending from the life where they could only see themselves as failed mothers:

I did try suicide attempts and that (…) I didn't really wanna be here (Stacey)

I was kicked out of social services [after the children went into care]… went back to the house, picked my dog up and… never went back there again, ever! Not even to pick up furniture, nothing, I just completely… left everything, everything (…) it was like I dropped everything, absolutely everything and… and then rebuilt myself, from nothing again (Claire)

3.3 'Less than a Person': Becoming Nothing and No-one

This final superordinate theme, derived by a quote by Claire, pulls together the pervasive sense of isolation and disempowerment that permeated the mothers' narratives. There was a sense of the mothers feeling de-valued as human beings to the extent of almost becoming diminished, whereby their needs were not recognised or heard, and they became 'othered' or dehumanised. Whilst all the mothers had others around them, there was an underlying sense of isolation. Claire spoke of feeling marginalised by other mothers in the travelling community, which she had married into. There was a painfulness to the isolation she experienced resulting in her feeling fundamentally different from the mothers around her and ostracized from their world: *'I was completely alienated (…) there was nobody, there was nobody at all that I could turn to, whatsoever (…) very isolating, very isolating really'.* All the mothers seemed to have a shared experience of others being oblivious or unconcerned with their welfare, whereby their needs and well-being were perceived to be unimportant and they felt treated as insignificant:

> *I don't think my parents even realised and to be honest they just left me to it (Nina)*

> *It was almost like I was… open for abuse, it didn't really matter do you know, the husband does it, we'll do it, we'll all do it (Claire)*

The mothers alluded to feeling they were never heard, and their wishes or needs were never taken into consideration. This seemed to be specifically present within their relationship with services, whereby their requests were often ignored or over-ridden, indicating that their voices were secondary to the voice of the professionals:

> *I did try to explain it to them but, they just increased my medication (Nina)*

> *I never had a social worker that ever paid the remotest little bit of interest in how I was feeling about things (Claire)*

They promised that once they adopted her that they'd send me photos and letters once every six months and they never sent me one single one (Stacey)

The mothers seemed to become almost diminished; feeling they had no power, agency or authority and experiencing themselves as holding no value:

It was hard, but… erm… I knew I couldn't do nothing about it really (Stacey)

I knew I was powerless to stop what was happening… once your life starts to snowball out of control, it's much easier to let the snowball build than it is to try and put the brakes on (Claire)

I didn't have any authority and I didn't have any like power to say that you know, this is what happened, and I had no-one to back me up and I had no-one to fight my corner (Nina)

Claire spoke of how she felt others only saw her as a '*bad, addicted, neglectful, parent*' and for her it seemed that she had simply been reduced to this label: *'That's the cap and then you wear it and then it becomes almost, you know like an urban myth, an unsaid complete story and it's true, it doesn't really matter, there is no fighting back for yourself then'*. She experienced this label as being the only lens through which others came to perceive her, and that this in turn enabled others to place blame upon her, rather than recognising the impact of wider circumstances. The stigma associated with this label seemed to leave Claire feeling dehumanised:

My addictions came before my children because obviously that's the nature of addiction, you can't say that to people because they instantly brand you as being a monster and that… couldn't be further from the truth (…) So societally, with the people that I lived with, and around… I was less of a person

4. Discussion

The aim of this research was to illuminate the experiences of mothers who had made, or agreed with, the decision to place their children into care. Three women were interviewed twice and using methods of IPA analysis I generated three superordinate themes: *A fractured sense of motherhood* highlighted how mothers struggled with their mothering identities in line with feelings of disconnection and separation; *'I wish I could turn back the clocks': Living with feelings of failure and shame* depicted the underlying sense of failing at motherhood and associated feelings of guilt and shame; *'Less than a person': Becoming nothing and no-one'* alluded to how mothers experienced isolation and disempowerment, which led to feeling devalued and dehumanised. These findings will be discussed alongside existing theory and literature. Clinical implications of the research will be discussed; consideration given to study strengths and limitations; and ideas suggested for future research.

4.1 Relationship with Extant Theory and Literature

The present findings highlighted how the mothers experienced a fractured sense of motherhood. There was a sense that motherhood did not come as naturally and instinctively as expected and this seemed to be linked, in-part, to not living up to perceived ideals of mothering. This finding can be considered in relation to social identity theory which proposes that a person's social identity is strongly constructed based on their group memberships (Tajfel, 2010). The mothers within this study experienced a sense of not belonging to the group of motherhood and two of the mothers specifically identified with having the label of 'bad mother' reinforced by their community and wider society. The mothering identity is socially constructed and linked to moral judgements in line with prioritising the need of the child (Schofield *et al.,* 2011). The strong societal discourses around motherhood create a stigma for mothers who don't perceive they fit the idealised 'good mother' concept (Marsh, Browne, Taylor & Davis, 2018). For the mothers within this study, the decision to place their child into care, even when this was perceived as being in the best interests of the child, was a further challenge to an already fragile mothering identity. The mothers seemed unsure

64

how to define their mothering identities when they were separated from their children and this was highlighted in the subtheme: *'both letting go and holding onto motherhood: Liminal mothers'.* Betz and Thorngren (2006) suggest that mothers of children in care may experience role confusion, where they are unsure if they can still identify with being a mother if they are no longer raising their child. The term birthmother is often used to define this position; however, this is a role which is often ignored or disregarded (Fravel, McRoy & Grotevant, 2000); and research has suggested that birthmothers often report feeling highly stigmatised and akin to 'outsiders' in society (Schofield & Ward, 2011).

For all the mothers in the present study, there was a significant sense of being de-valued, diminished and disempowered both within their experiences of mothering and in placing their children into care. The *Power Threat Meaning Framework* (PTMF) (Johnstone & Boyle, 2018), provides a useful lens through which to consider this finding. The PTMF is an over-arching structure which aims to move away from dominant discourses around distress and highlight the impact of societal influence on how individuals' experiences and meanings are shaped. This framework draws on a number of 'core needs' which are considered central to human survival, as well as being pivotal in providing the conditions for individuals to offer their children '*secure and loving early relationships'* (Johnstone & Boyle, 2018 p.190). There is a focus on how power operates within people's lives and how threats that are posed by such power impact on the attainment of core needs being met. Experiences of these threats are made sense of through a multi-layered process of 'meaning-making', which is socially, culturally and politically mediated. The meaning attributed to the threat will subsequently influence the threat response or 'survival strategy' of the individual, who will draw on the resources of power available to them to mitigate the threat (Johnstone & Boyle, 2018).

Previous research has indicated how powerlessness and marginalisation is experienced by mothers whose children are forcibly removed under legal contest (Charlton, Crank, Kansara & Oliver, 1998) and the current study highlights how power also operates, perhaps more insidiously, for mothers who make or (appear to) agree with the decision to place their child into care. For the mothers in this study, there was an overwhelming sense of powerlessness that permeated their narratives and power

seemed to operate within their experiences in various ways. The presence of power was seen to impact upon their ability to achieve core needs such as: *'to exercise and agency and control of their lives'*; *'to experience a range of emotions'; and 'a sense of justice and fairness'* (Johnstone & Boyle, 2018). The mothers all seemed to come to perceive themselves as holding no agency or value, both in terms of their experiences of mothering and in the process of their children being placed into care. This seems to fit with previous research into relinquishing mothers that has found even when they have made the decision, mothers are still left with a feeling of helplessness and a sense that their children have been taken away (Broadhurst & Mason, 2013). Research into child protection services has suggested how practices are often 'gendered', with fundamental responsibility and blame being placed on mothers (Featherstone & Fraser, 2012), feeding into lack of equality and sense of injustice. The subtheme of *'escaping the pain of failing'* can be viewed in the PTMF as threat responses and strategies adopted by the mothers in the face of disempowerment. In relation to social services involvement, professional narratives around threat responses such as detachment or avoidance are commonly referred to as 'non-engaging' or 'non-cooperative', which could further serve to reinforce a mother-blaming discourse (Featherstone & Fraser, 2012).

There was a notable absence of loss or grief from the mothers' narratives and there was a sense that this was potentially seen as not being legitimised. Mothers who have made, or agreed with, the decision to place their child into care may perceive that they are not permitted to experience such emotions. This would support previous research findings which have found that birthmothers believe they are not entitled to experience and express grief as this was either perceived as self-inflicted or conversely that it should be viewed positively due to acting in the best interests of the child (Robinson, 2002). These findings can be considered within the model of 'disenfranchised grief'; which pertains to a loss which cannot be openly acknowledged or socially supported due to the stigma associated with this experience, leaving the loss and the griever unrecognised (Doka, 1989). Mothers of children in care often feel silenced as this is not considered to be a socially acceptable loss, resulting in a more complex nature to the grief (Askren & Bloom, 1999; Jones, 2000). Furthermore, the loss of a child through adoption can be seen as 'ambiguous', due to the loss not being as

definite as bereavement as the child is physically absent but psychologically present (Boss, 1999). Professionals may not always recognise birthmothers' need to grieve, instead assuming the mothers are comfortable with the decision they made (Aloi, 2009). However, research has suggested that even when mothers experience confidence in their decision to place their child into care, this does not diminish their feelings of grief or loss over time (Madden *et al.*, 2018). The highly complex nature of this experience may result in an avoidant approach from others in discussing this, perhaps out of fear of evoking distress, subsequently leading to further disenfranchisement (Condon, 1986). The contrast between grief and disenfranchised grief, is that with the latter the grieving process is significantly impaired and therefore the grief intensifies over time as opposed to achieving a sense of healing (Coleman & Garratt, 2016). Given this, it is not surprising that mothers of children in care often experience higher rates of mental health difficulties (Logan, 1996). The mothers within this study all identified with experiencing mental health difficulties, and were recruited through mental health services, despite there being a significant length of time, for two of the mothers, since their children went into care.

4.2 Clinical Implications

The findings of this research highlight the complexity of the experience of mothers whose children are placed into care. Whilst all mothers referenced access to services and support systems, they seemed to experience this support as unhelpful and narratives around judgement, or simply being dismissed, were present within the mothers' accounts. Whilst there is an indisputable need to focus on and prioritise the needs of the child, such an emphasis may leave little room for considering the needs of the mother. The participating mothers felt disempowered in their relationships with professionals and this echoes previous research which has indicated that social service involvement was felt to exacerbate existing feelings of worthlessness, low self-esteem, loss of control and stigma (Slettebo, 2011; Smeeton & Boxall, 2011). There will always be disequilibrium of power within child protection work. However, it might be useful

for professionals to pay greater consideration to the power they inevitably hold, and how mothers may experience and react to such operations of power (Dumbrill, 2006).

Restriction and bureaucracy associated with social service involvement often means that emphasis is placed on a care management model of practice, which prioritises assessment and goal directed behaviour in relation to parenting practices, over counselling and therapeutic engagement with mothers (Stanley *et al.,* 2003). However, there is clearly a need for a dual focus, whereby mothers are recognised as individuals with their own specific needs, which are independent too (but linked with) parenting, and supported accordingly (Schofield & Ward, 2011). Support for mothers both during and following their child going into care continues to be unmandated and limited, despite emerging research highlighting the need for better provision (Broadhurst & Mason, 2013). Furthermore, the support that can be provisioned is usually provided by social services which may be contentious due to the mother's experience and prior relationship with this service (Mason & Selman, 1997).

Within this study, none of the participating mothers chose to bring a sensory item to their second interview. It is considered that using sensory methods to access experiences might be highly emotional, especially when the experience has been unexplored, and tapping into the senses might lead to exposing facets of the experience that has previously been concealed (Harris & Guillemin, 2012). In light of this, it might have been too painful for mothers to bring any sensory reminders of their children or motherhood. However, one mother specifically reported they had no items they could bring, and this may be another consideration for how grief and loss is unattended to within birthmothers. Mothers who experience stillbirth or neo-natal death are encouraged to keep mementoes (e.g. handprints, locks of hair, photographs etc) and to openly talk about their child and subsequent loss (Robinson, 2005). Unfortunately, birthmothers are often not afforded the same level of support and are subsequently not provided with the space to think about keepsakes, and thus often lack a concrete focus for their grief (Logan, 1996). Healthy grieving for birthmothers may be optimised through having a non-judgemental and supportive space where they are able to participate in a ritual marking or commemoration of the loss of their child (Coleman & Garratt, 2016). A further area of consideration pertains to openness of adoption (e.g.

whether the birthmother may be provided with information pertaining to her child once they are in care or have been adopted), and the potential impact this could have on both the child and birthmother (Cushman, Kalmuss & Namerow, 1993). Research has suggested that for some mothers an openness in adoption, where key information was shared regarding the health and wellbeing of the adopted child, was an important factor in helping to gain some resolution over the experiences of grief and loss (Henney, Ayers-Lopez, McRoy & Grotevant, 2007; Leon, 2002).

Within the current study, there seemed to be significant differences in the ease the mothers were able to talk about and make sense of their experiences. Two of the mothers disclosed that they had never spoken about their experiences of mothering and their children going into care, linking with the subtheme *'the unspeakable shame'*; and these mothers understandably found it more difficult to reflect on their experiences within the research interviews. Similar themes have been found in research relating to parents who have been bereaved of their child through suicide. Such parents reported feeling silenced by others, but also feeling the need to silence themselves due to concerns around how others would react and fear of being judged unfavourably (Maple, Edwards, Plummer & Minicheiello, 2010). This links to disenfranchised grief where the loss is never discussed and secrecy is maintained as it is assumed that others will not validate this loss and may respond negatively; a process which in turn blocks grief resolution (Simone, 1996). Given this, it was considered significant that all the mothers chose to participate in both the research interviews, despite the difficulties associated with articulating their experiences. This highlights the value in offering a non-judgemental space where it is outwardly acknowledged that this experience can be named and spoken about in a safe and contained environment. Furthermore, the mother who acknowledged that she had been able to share her story previously, seemed to be in a position where she had reached an understanding and some resolution in relation to her experiences, potentially as a result of having such a space.

Due to the lack of specialist provision, mothers of children in care are often left to try and access support via mainstream services, which may inadvertently end up treating 'symptoms' of distress. In the absence of specialist support, mental healthcare professionals will need to be aware of the complex needs of mothers of children in care

(Neil, 2013). Therapeutic interventions sensitive to the operation of power, including how ideological power and societal discourse can present threats to identity, could usefully support professionals to engage mothers in non-blaming conversations. This could support mothers in making sense of their experiences and threat responses, as well as normalising distress in relation to mothering and loss. Such approaches could be influenced by; the PTMF (Johnstone & Boyle, 2018); narrative therapy (White, 2007) or visible therapy (Warner, 2001). Finally, birthmother groups set up by both mothers themselves and by professionals have been found to be a powerful and effective source of support which help to; facilitate a sharing of loss and reduce feelings of isolation (Harris & Whyte, 1999); and act as an opportunity for the women to come to view themselves differently and recognise their strengths (Perl & Skimming, 1997).

4.3 Strengths and Limitations

The current study is the first, to my knowledge, to attempt to explore the experiences of mothers who made, or agreed with, the decision to place their children into care in the context of trauma. The sample size was appropriate for an IPA study (Smith, Flowers & Larkin, 2009) and allowed for an in-depth exploration of this widely neglected phenomenon. Inter-subjectivity is an important consideration within interpretive analysis and the current study is strengthened by the transparency of the data analysis process, as well as consideration of my reflexive and epistemological influences. The findings presented in this study offer a possible interpretation of the experiences of mothers whose children are placed into care. However, it is also considered that some of these findings can be theoretically transferable to mothers within similar contexts (e.g. mothers who have experienced the bereavement of a child through suicide) through the subjective evaluations of the readers (Smith, Flowers & Larkin, 2009).

Whilst efforts were made to ensure homogeneity within the research sample, unforeseen variables may have introduced a level of heterogeneity which present an important weakness of the study. There were significant differences in relation to the time point when the mothers' children went into care, which created variation within

their mothering experiences: One mother's child went into care when they were days old whereas for another mother this happened when the children were in secondary school. With regards to potential bias, my role as a Trainee Clinical Psychologist, may have influenced the information the participants were willing to share. I may have also been experienced as being part of the professional system where the participants had encountered difficult or negative experiences.

4.4 Future Research

Whilst the current study was a qualitative attempt to explore the experiences of mothers with trauma histories who had made, or agreed with, the decision for their child to be placed into care; the analysis and interpretation were completed without participant involvement by an 'outside researcher' (Dwyer & Buckle, 2009). Future research might benefit from a more collaborative approach to generating understanding of such mothers' experiences. Further research is also needed to explore the experiences of fathers of children in care, who are also significantly neglected within the literature.

4.5 Conclusion

This research has provided an in-depth exploration of the experiences of mothers with trauma histories who had made, or agreed with, the decision for their child to be placed into care. The study has contributed to some of the existing research and has highlighted the complex needs of this group of mothers. Clinical implications for supporting mothers both prior to their child being placed into care and following this experience have been considered as a result of this research.

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Appendix A*: Relevant Author Guidelines (Clinical Psychology Review)

CLINICAL PSYCHOLOGY REVIEW

AUTHOR INFORMATION PACK

TABLE OF CONTENTS

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Appendix B: Inclusion and Exclusion Criteria

SPIDER domain	Inclusion criteria	Exclusion criteria
Sample	Parents who experienced childhood abuse trauma	Parents who experienced non-abusive single episode traumas only Abuse/trauma endured in adulthood only *(abuse/trauma known to have different effects when occurring during the developmental period)*
Phenomenon of **I**nterest	Parenting in the context of surviving childhood abuse/trauma	Focus not on parenting experience (e.g. focus on experience of pregnancy) Focus on experience of parenting in relation to abuse endured in adulthood
Design & **E**valuation	Interview/qualitative data analysed using a methodology consistent with identifying experience and/or meaning-making	Data not provided by parents themselves Non-interview/qualitative data Methodologies that did not generate findings relating to experience and/or meaning-making
Research type	Qualitative studies (including mixed-methods if qualitative results clearly separated from quantitative) Peer-reviewed Available in English language	Quantitative studies; survey designs Non-peer reviewed Only available in a language other than English

References:

Cooke, A., Smith, D. & Booth, A. (2012). Beyond PICO: The SPIDER tool for qualitative evidence synthesis. *Qualitative Health Research, 22*(10), 1435-1443.

Appendix C: Data Extraction and Quality Appraisal Tool

Title:				
Author:			**Study Number:**	
Country:			**Peer Reviewed:** Yes / No	
Quality Assessment	**Guidelines**	**Check**	**Score:** *0 - No/Not Clear* *1 - Partially* *2 - Yes*	**Data Extraction**
Title	*Does it reflect the content?*		N/A	
Abstract	*Does it summarise the key concepts?*		N/A	
Rationale	*Is the rational for research clearly outlined?*		N/A	
Literature Review	*Comprehensive and up-to-date?*		N/A	
Aims	*Is the purpose clearly defined and stated?*			
	Appropriate and clear research question?			
	Consistent with methodology, analysis and findings?			
	Defined rationale for study?			
Methodology	*Clear description and justification of method used?*			
	Qualitative approach utilised and is this appropriate?			
	Theoretical Framework/ Epistemology outlined?			
	Is the study setting appropriate for exploring the research question?			
	Is the research design appropriate?			
Sampling	*Clearly explained (who? how many? - appropriateness?)*			
	Inclusion / exclusion criteria defined?			
	Characteristics of sample stated? (e.g. ethnicity, age etc.)			
	Recruitment process defined?			
	Is the sample adequate and consistent with the framework?			
	Is all the above consistent with the research question?			
Ethics	*Consideration / identification of ethical issues?*			
	Appropriate discussion of how these would be managed?			
	Safety of participants and their children considered? (Were safe-guards and debriefings offered?)			
	Ethical approval?			
Reflexivity	*Was the researchers own role and participation considered?*			
	Evidence of reflective journal/research diary?			

	Potential biases and influences discussed?			
	Consideration of how biases / difficulties have been addressed?			
Data Collection	*Method of data collection fully described? – appropriateness?*			
	In line with research question?			
	Range of methods used for triangulation?			
	Description of data collation; who collated? When? Who analysed?			
	Reliability / validity? Audit trail? (tapes, notes etc)			
	Systematic and transparency of data collection?			
	Sensitivity of data collection? (e.g. ceasing questions? Follow-up questions)			
	Was saturation of data considered to be reached?			
	How was data prepared for analysis?			
Data Analysis / Findings	*Rigour of analysis? (Is process described in enough detail to provide insight into meanings/ interpretations?)*			
	Use of supporting quotes to highlight themes/interpretations?			
	Representativeness of material?			
	Are findings linked with the research question?			
	Reliability and validity? (checking?)			
Discussion / Contribution	*Are the findings of the study contextualised with theory?*			
	Consideration of limitations?			
	Discussion of how the findings contribute to existing knowledge / understanding / literature?			
	Consideration of the utility of findings? (e.g. service provision, support structures, clinical implications, other research opportunities etc.)			
Total Score				

Additional Comments:

Appendix D: Quality Appraisal Scoring Table

Paper	Aims	Methodology	Sampling	Ethics	Reflexivity	Data collection	Data Analysis	Findings / Discussion		Total Score
Aparicio *et al.* (2015)	2	2	1	1	1	2	2	2		13
Armsworth *et al.* (1999)	2	1	2	0	0	1	0	1		7
Buchbinder (2004)	1	2	1	0	0	2	2	1		9
Cavanaugh *et al.* (2015)	2	2	1	1	1	1	1	2		11
Cross (2001)	0	0	1	0	0	1	0	1		3
Hall (2011)	2	1	1	1	2	2	1	1		11
Herland *et al.* (2015)	2	2	1	1	0	2	1	1		10
Kistin *et al.* (2014)	2	2	2	0	0	2	2	1		11
Maxwell *et al.* (2011)	2	2	2	1	0	1	1	2		11
O'Dougherty -Wright *et al.* (2012)	2	2	2	1	0	2	2	2		13
Pitre *et al.* (2011)	2	2	2	2	0	2	2	2		14
Tedgard *et al.* (2018)	2	2	2	1	0	2	2	2		13
Wood *et al.* (2010)	1	1	1	2	0	2	2	1		10

Key:
2 = Criteria fully met
1 = Criteria partially met
0 = Criteria not met / unknown

Note: The studies highlighted in red have been excluded from the systematic review due to their quality appraisal scores.

Appendix E*: Statement of Epistemological Position for Systematic Review

A contextualist epistemological position was adopted in the undertaking of this meta-synthesis. From this position, the idea that one 'true' reality exists, as held by traditional realist approaches, is rejected (Bunge, 1993). Contextual constructivism, instead, presumes that individuals interpret and make sense of their own accounts of 'reality' based on their frameworks of personal beliefs and cultural experiences. Therefore, perceptions and sense-making of an event may vary for individuals within similar contexts (Cobern, 1993) with every person holding a different and unique experience of reality (Madill, Jordan & Shirley, 2000). From this position, it was presumed there was not one true interpretation of the data from the original sources, and it was recognized that my preunderstandings would inevitably permeate the research process and shape the themes generated through the synthesis (Madill, Jordan & Shirley, 2000).

The contextualist epistemological position adopted, views such subjective bias as not only inevitable but privileged, as it is thought to promote a more comprehensive and higher-level account of the studied phenomenon (Pidgeon & Henwood, 1997). However, it is equally important to consider the position and context of the researcher, given their influence, and how issues pertaining to reflexivity were addressed (Madill, Jordan & Shirley, 2000). I am a white British woman and all reviewed studies were undertaken in the Global North, thus impacting upon transferability to other cultural contexts. I have no lived experience of childhood abuse. I do not have any children so therefore have no first-hand experiences of being a parent and have positive experiences of being parented. I have a keen interest in attachment theory and critical perspectives of trauma and in undertaking this meta-synthesis I became alert to how the literature often pathologizes the experiences of mothers with trauma histories; which will likely have impacted upon interpretations offered. I kept a reflexive log throughout the process and attended regular supervision meetings to support awareness of reflexivity throughout completing the review.

References:

Bunge, M. (1993). Realism and antirealism in social science. *Theory and Decision, 35,* 207-235.

Cobern, W.W. (1993). Contextual constructivism: The impact of culture on the learning and teaching of science. In K.G. Tobin (Ed.) *The practice of constructivism in science education.* Hillsdale: Lawrence Erlbaum Associates In.

Madill, A., Jordan, A. & Shirley, C. (2000). Objectivity and reliability in qualitative analysis: Realist, contextualist and radical constructionist epistemologies. *British Journal of Psychology, 91*(1), 1-20.

Pidgeon, N. & Henwood, K. (1997). Using grounded theory in research. In N Hayes (Ed.) *Doing qualitative analysis in psychology.* Hove: Psychology Press.

Appendix F: Definitions of Constructs

First-order constructs	Study participants' constructions and accounts of their own experiences related to the phenomenon of interest
Second-order constructs	Authors' of the identified articles re-constructions and interpretations of the data based on their own epistemological framework
Third-order constructs	My (the author of the meta-synthesis) reconstructions and interpretations of the findings of the identified articles based on my own epistemological framework

References:

Malpass, A., Shaw, A., Sharp, D., Walter, F., Feder, G., Rid, M. & Kessler, D. (2009). "Medication career or moral career"? The two sides of managing antidepressants: A meta-ethnography of patients' experience of antidepressants. *Social Science & Medicine, 68*(1), 154-168.

Appendix G: Summary of Findings Across Primary Studies

Paper	Themes	Summary of Second-Order Interpretations and Constructs
Aparicio et al. (2015)	**Darkness and despair** 1. **Substance abuse** – The devasting effects of parental substance misuse "she cared more about her drug habit than anything" 2. **Homelessness** – Lack of physical, stable home and absence of parents "somebody else is investing their time in you, but there is *nothing* like having your own mom and dad to be able to be there for you" 3. **Poverty-** Lack of money and resources both in childhood and parenting their own children. Reliance upon others for support. 4. **Breakdown of family ties and community disempowerment** – inadequate support and community systems leading to placement in foster care 5. **Absence and loss** – ongoing experiences of loss "my father was in and out of jail…he has been in and out of my life throughout my whole time I have been on this earth" 6. **Abuse and neglect** – experience of trauma and abuse and destruction of trust within relationships **Glimpses of light in the darkness** 1. **Widening the circle of support: babies' fathers and their families** – pregnancy seen as an opportunity to widen support networks, importance of father's involvement, even if not helpful. 2. **Lessons about motherhood** – desires to do things differently to the way they were parented. Role models of 'other-mothers' 3. **Support from foster care** – positive experience of material and emotional support from foster care in hindsight "it's not really that bad actually… it can be a good thing for young mothers" 4. **The enduring family** – positive relationships with extended family members 5. **Education** – belief in the importance of education. Education seen as a major struggle but also a source of empowerment **New beginnings** 1. **Identity as a mother** – motherhood as bringing families together and providing a new status "not saying that I was put here to have children but, I mean, now I feel like I have a steady ground because of her" 2. **Love for the children** – first time experience of real, genuine love when becoming a mother 3. **Hopes and dreams for the future** – Wanting/drive to do things differently to their parents, emotionally and materially "I can do better for myself and my kids"	• Difficult past experiences as having powerful and long-last effects on both their experience of being parented and their experience of parenting • Painful experiences of being a daughter leads to motherhood becoming an immensely powerful experience • Acknowledgement that whilst not perfect, there are glimpses of hope in relation to experiencing motherhood. • Motherhood as awakening hopes and dreams for the future • In line with other findings – that motherhood is a critical time in relation to both bringing up past feeling and providing a new sense of meaning.
Buchbinder (2004)	**Battered women's decision to be different as mothers: a driving force and paradoxical consequence** – memories of their won negative experiences with families as a driving force to be different "I have always said that when I have kids, I will not treat them the way my mother treated me" **Facing their own violence in the light of family-of-origin experiences** – the process of facing past experiences in light of their own behaviour towards their children "I said to myself I am exactly like my parents. I do what my father used to do" **Breaking the chain for the sake of the children: Optimistic and pessimistic voices** 1. **The optimist: The struggle for correction is worthwhile** – Sense of hope that enough change had been made to change the trajectory of the future for the child "we try to correct the violence that used to be here. Even if a child does absorb it, you can change the direction of the wheel for him" 2. **The pessimist: The struggle for correction is doomed** – past as entrapping and defeating their intentions to make positive change	• Mothers' attempt to repair their own past and own internal distress by creating a different relationship with their own children • Fear of becoming like their own parents acts as a driving force to foster change • Recognition of past self in present parenthood. • Developing an awareness of the gap between hopes of parenthood would be like and the reality • Positive projection for their children's future perceived as an important indicator of their different existence as mothers. • Sense of responsibility in 'breaking the chain' of abuse • Children as becoming part of the chain of abuse. Children's behaviour is symbolic of the unification of the past and present
Cavanaugh et al. (2015)	**Being a parent** 1. **Efforts to protect** – protecting children through restriction and education "I have taken steps to educate them, but it happens so much" 2. **Reaction to real or imagined abuse** – uncomfortableness in children having physical contact with anybody else, even fathers 3. **Their children as victims** – experience of children being victims of abuse 4. **Children prompting positive change** becoming a mother as motivation to seek help, to learn and change 5. **Parenting difficulties** – bonding with child as difficult process, different difficulties for male and female children **Family or origin dysfunction** 1. **Family disruption** – changes in family composition that affected family of origin	• Sense of mothers feeling hopeless and futile in their efforts to protect their children. Idea that abuse is unpreventable and inevitable • Former experiences of abuse being a barrier to bonding with child • Fears of being able to protect children exacerbated by having a daughter as opposed to a son

100

	2. **Poor boundaries** – lack of adequate supervision during childhood, taking on adult responsibilities as a child 3. **Other abuse** – poor sexual boundaries and sexual violations within the family 4. **Mental health problems** – parental mood disorder and substance misuse 5. **Additional family stressors** – poverty, interpersonal family conflicts **Impact of abuse** 1. **Difficulties with trust** – difficulties trusting others within existing relationships and new relationships 2. **Sexual problems** – difficulties with sex and sexual experiences "it wasn't that I didn't want to have sex. I was appalled by it, disgusted by it" 3. **Interpersonal difficulties** – poor choices in relationships, insecurity within relationships, conflicting emotions toward men "I think it is kind of love the relationship with men, I hate them… but I really need them" 4. **Emotional impact** – ongoing feelings of anger, shame, blame and fear. Loss of innocence "inside I really feel that I just have no self-worth" **Abuse history and response to abuse** 1. **Abuse characteristics** – perpetrators, timings, type 2. **Coercive dynamics** – being silenced, being drugged, being physically punished for not complying, threats to self and family, abusive behaviour being framed as love "I thought he told me that that was cause he loved me and that's what you do when you love somebody" 3. **Own attempts to resist or stop abuse** – physical attempts to escape and resist abuse, feeling unable to prevent abuse "It's like being caught unaware all of a sudden, like a spider been caught in a web, don't know how to get out" 4. **Post-abuse disclosure** – experiences of disclosing abuse, disclosure for self and protection of others 5. **Reactions from others when learned of abuse** – negative reactions of others following abuse disclosure; disbelief, denial, blame, anger, lack of support 6. **Perceptions related to abuse** – positive responses following disclosure; parental protection, the abuse stopping, receiving support **Coping** 1. **Positive coping –** maintaining sobriety, seeking treatment, attempts to forgive 2. **Poor coping** – drugs and alcohol, overeating, hiding feelings from others, keeping abuse a secret, avoidance and dissociation **Hopes and desires** 1. **For self** – desire to heal, learn better ways of coping, move forward 2. **For others** – helping others, protecting others from abuse	
Hall (2011)	**Parenting challenges** 1. **Parenting self-image** – challenge of confronting self-doubt about ability to parent, fears of being "biologically predestined" to abuse their child 2. **Parenting decisions**- feeling abnormal and not knowing how to act normal, unsure of normal child development and behaviour 3. **Protecting children: fear and trust** – fear that they could become the 'abusive parent' or the 'non-protecting parent' "in what ways am I like my dad, or my mom?", fear of own feelings towards child "overwhelming love" 4. **Seeking social support** – lack of social support as a factor effecting ability to parent 5. **Life without a safety net** – lack of resources e.g. financial, professional support, education **Parenting strategies: Vows to create a better life** 1. **Vowing to end the intergenerational cycle of abuse** – resolution to protect their own children from abuse "I made a vow to protect my children no matter what" 2. **Creating safety for our children** – being able to protect their own children as a source of pride 3. **Becoming an advocate** – building a secure foundation and being a role model for support "I'm on my kids side" 4. **Growing in interaction with our children** – process of learning how to be better parents through feedback from their children 5. **Finding eclectic role models** no parental role model in childhood, process of observation and taking "bits" from others	• Sense that traumatised/abused parents perceive themselves as less capable than non-traumatised/abused parents • Lack of practical child-rearing skills associated with feelings of shame and self-inadequacy • Fear that children can see/know that something is wrong with them and that they are bad or inadequate parents • Reconciling the notion of 'normal' parenting requiring re-evaluation of behaviours and concealing past experiences • Lack of trust in self and others to keep their child safe leading to social isolation • Abusive experiences being a barrier to parents feeling able to access social support • Initial guiding principal of wanting to parent their children in a different manner from they way they had been parented • Evolving as a parent
Herland *et al.* (2015)	**Recurring patterns** 1. **Unsettling relations** – relationship with own parents being triggered by relationship with their child	• Experience of fatherhood tied into a sense of grief over own lost childhood • Sense of past issues reoccurring being unavoidable

	2. **Distance from their own children** – the distance fathers experienced in their own parental relationships is repeated with their children, patterns of rejection and withdrawal
	Making a break with the past
	  1. **Personal traits and own strengths** – internal characteristics which are linked with creating a different relationship with own children "I am a strong, positive man, some know about my past, but it's not something I brag about"
	Significant support
	  1. **Having someone to share parenthood with** – significance of having support to share parenting with (usually the mother)
	  2. **Assistance from the child welfare service** – mixed feelings in relation to support from professionals; enabling vs hindering
	A fragile act of balance – keeping the past difficulties and present parenting experiences separate and balanced
		• Parental relationships tied into how men perceived themselves as fathers
		• separation and distance from own children used as a solution to the difficulty of fatherhood
		• Drawing on painful past experiences as building blocks to carve out different future
		• Needing 'the mother' to enable being a father

Kistin *et al.* (2014)	**Repetitive child behaviours are the most stressful** – mothers perceived feeling stressed by children's repetitive behaviours when they perceived themselves as ineffective and unable to control their child "when you tell him no he just continuously does it and does it" **Coping by taking time away** – mothers using time away as a coping strategy to prevent themselves from reacting punitively and also as a punishment **Harsh punishment is a purposeful solution to ensure appropriate long-term child behaviours** – deliberately using harsh punishment to rectify misbehaviour "I have to start it now. If I don't, like, put my foot down now, she'll just – you know what" **Mothers' traumatic experiences influence their parenting fears and goals** – Parents experience children's negative behaviour in association with past abusive experiences "when you have children they tend to come out like you, the way my family and my siblings are"	• Internalisation of child's behaviours as a means of malicious punishment • Children's normal developmental behaviour perceived as parent's ineffective ability to cope and misbehaviour perceived as a warning sign of future trouble. • Sense that gentle approaches to discipline will be seen as ineffective and parents won't be taken seriously. Can only gain control with harsher discipline practices

Maxwell *et al.* (2011)	**The ideal AND… the reality**
	  1. **Mothers role to right the wrongs of the past** - taking active steps to be a different kind of parent,
	  2. **Child holds hope of something better** – hope that their child can have a different experience to that of their own childhood "I just want him to grow up to be…to make something of his life"
	  3. **Past models of parenting guide what parent would like (not) to be** – chance for parents to become the 'ideal' parent they would have wished for
	  4. **Life circumstances make motherhood challenging** – external factors meant that 'ideal' parenting was at times side-lined e.g. post-natal depression
	  5. **Motherhood as challenging and difficult** – aspects of motherhood as hard and disappointing "I kept saying, we've just had a baby, we should be happy"
	Motherhood as building positive views of self and others BUT ALSO… Motherhood highlights vulnerabilities and insecurities
	  1. **Relationship with child as enjoyable and fulfilling** – motherhood as rewarding "heather will always make my day happy"
	  2. **Motherhood as giving mother a sense of self-pride** – opportunity to see themselves in a more positive light
	  3. **Mothers as having impact on child, able to fulfil child's needs** – motherhood as providing an integral role "I taught her to walk and then the things that she knows and does I taught her"
	  4. **Mothers as having a capacity to cope and be resilient** – strength and resilience in motherhood
	  5. **Powerless to make things 'right' for the child** – watching the past repeat itself, re-experiencing trauma through eyes of their child
	  6. **Self-doubt** – feelings of not being a 'good' parent
	  7. **Struggles to manage own feelings** – perception of failing their child when prioritising their own emotional needs
	  8. **Desire to be loved and needed by child** – motherhood as filling the void of being loved "I want to keep her close"
	  9. **Fear of rejection / abandonment** – fear that they will do something wrong which will lead to being rejected by their child
	  10. **Moments of feeling vulnerable, unwanted** - sensitivity and fear of being unwanted, especially as child becomes more independent
	Mother identifies with her child BUT… mother can feel taken over by her child
	  1. **Feel as one with child** – unique and special connection with child akin to being in a separate unit in their own world
	  2. **Understands child's experiences through her own experiences** – identifying with child through noticing shared characteristics
	  3. **Mother lacks separateness from child** – little differentiation between child and mother "she's actually completely like me"
	  4. **Mother over-identifies with child's upset and pain** – experiences of being emotionally taken over by child and their feelings
	  5. **Child as changing the course of mother's life and relationships** – feelings of entrapment and regret
	External world as needed BUT… external world unwanted and destabilising
		• Hope as being placed within the child
		• The reality of motherhood as overwhelming
		• Incongruence between the ideal expectations of motherhood and the reality of their experience
		• Motherhood providing an opportunity to see a more positive side of the human experience
		• Relationship with child as creating new opportunities to be proud but also generating feelings of vulnerability
		• Intensity of emotions and feelings leading to mothers no longer being able to contain and sperate themselves from their children's feelings
		• Internalisation of negative discourses leading to greater feelings of inadequacy and self-scrutiny
		• How support was experienced by mothers was influenced by how much they felt in control of support, or whether it was imposed

	1. **Support from family needed and sought** – active process of seeking support 2. **Birth mothers' support wanted** - for some this awakened the desire to be looked after by their own birthmothers 3. **Others' involvement can be unhelpful and intrusive** - desire for support to be supportive, but was sometimes found to be critical 4. **Negative views and teenage pregnancy and LAC** - negative societal discourses 5. **Internalised and destabilising** – support could be seen as destabilising and impacting on mother's relationship with child	
O'Dougherty-Wright *et al.* (2012)	**Mothering as a survivor** 1. **Committing to the work** – mothers committing to their recover in order to become a better mother 2. **Expanding awareness** – gaining a new awareness of effects of past abuse on them as mothers "if you've got shit in here it comes out… because of parenting her" 3. **Developing a personal model** – having to develop a new model for parenting due to not being provided with a healthy template from their own parents. 4. **Evaluating the work** – importance of meeting mothering goals by evaluation of self and others "I have a big button about bad mommy" **Navigating the work of mothering: parenting challenges** 1. **Protecting from danger, pain and unhappiness** – strategies implement to ensure children are safe and protected e.g. guarding and surveillance. Difficulties in finding the balance between over-protection and under-protection 2. **Building the mother-child relationship** – difficulty associated with being emotionally present for their children 3. **Providing physical care giving** – wariness of physical touch and intimacy with child "it would cross my mind sometimes with diapering them, just what they looked like – I never touched them or anything like that, but just, it would cross my mind" 4. **Discipline and limit setting** – difficulty in knowing how to appropriately discipline children 5. **Promoting autonomy** – difficulty in knowing when to develop age appropriate expectations, responsibilities and privileges. Separation and independence as particularly problematic 6. **Promoting healthy sexuality** – concerns over child's sexual curiosity and sexual behaviour **Navigating the work of mothering: mothering through the pain** 1. **Managing triggers** – importance of learning to anticipate and manage triggers in order to obtain parenting goals 2. **Battling for balance** – balancing recovery work with meeting the needs of motherhood "I couldn't identify my own emotions, much less help him identify his" 3. **Asking for help** – recognising the necessity of asking for help 4. **Managing emotions** – managing the emotions precipitated or exacerbated by the interaction of recovery work and mothering 5. **Grieving losses** – grieving for parents own lost childhoods "I look at her and I think… God, that's what I could have been" 6. **Struggling to be there** – mothers' ability to remain emotionally attuned and available to their child during the process of recovery work "I'm often being triggered and in the situation of needing to cope, there's a button being pushed" **Developing a mothering self** 1. **Self-mother** – initial stage of minimal self-awareness and processing of motherhood 2. **Victim as mother** – developing a beginning awareness and acknowledgement of abuse and effects of abuse 3. **Survivor mother** – personal identification of the self as a survivor 4. **Self-Mother** – developed understanding and acceptance of personal limitations and a healthy self-worth, enabling ability to nurture and protect their child	• Motherhood and children seen as "a calling" • Developing a model for motherhood as an on-going process as child reaches new developmental stages and revision is required • Selecting a 'mother model' to emulate • Hoped for mothering self / actual mothering self / feared mothering self • Mothering in a way that is consistent with personal model whilst mothering through the pain of recovery • Awareness of potential dangers/abuse transformed into a strength that helps maintain safety of children • Fear of becoming an abusive parent leading to emotional distance in the mother/child relationship • Sense of difficulty in mothers responding with empathic understanding due to comparisons with own childhood • Avoidance of physical intimacy with children as a strategy for ensuring that abusive behaviours do not occur • Discipline seen as in direct contrast with being a different parent and keeping children safe and happy • Child' independence leading to mother re-experiencing feelings of being invisible and abandoned from childhood • Milestones of parental childhood abuse become triggers during own children's development • Balancing the demands of mothering own child vs the demands of mothering inner child through recovery work • Parental networks being a source of support but also a barrier to support • Process of working out and identifying whose needs need to be met in ant given situation (mothers needs vs child needs) • Cyclical nature of developing a mothering self
Pitre *et al.* (2011)	<u>**Living the legacy of childhood violence experiences**</u> – childhood experiences as being unpredictable and dangerous, leading to distrust in self and others <u>**The storied space of mothering after childhood violence experiences**</u> –mothers being determined to liberate themselves from painful past experiences and provide a different maternal experience for their children <u>**Changing the story… in the name of safety, control and voice…**</u> perception of motherhood being a gift and high importance placed on the need to create a safe, supported and loving environment for their children "I like that my kids know that we're there for them. And not just that we're physically there but we're - we'll back them up" <u>**Managing self-doubt… walking on a thin line**</u> – Efforts to provide a new experience for their own children are constrained by self-doubt. On-going concerns over loss of safety and control "I second-guess myself. There is always this measure of not being confident as a parent in making decisions"	• Influence of legacy of abuse on maternal experiences and choices • Positioning agency at the core of the mothering space • Holding the tension in the mothering space between defying influences from the past in the face of self-doubt and confirming to societal expectations of being a mother • Motherhood as a space that holds the power to establish a different environment and change the narrative • Parents as searching for meaningful anchors to compensate for their uncertainty about parenting decisions and to guide them in changing the story

	The persistence of distrust… setting boundaries I can live with – distrust of others in the mothering space. Sense of fear and doubt regarding the intentions of others and constant anticipation of harm, especially as child explores outside the home.	• Child independence experienced as heightened danger increasing hypervigilance and anxiety. Parents employing gate-keeping strategies to manage their reactions and maintain child's safety

Tedgard *et al.* (2018)	**Experiences of childhood with substance abusing parents**
	  1. **Family climate/prevalence of emotional abuse and neglect** – Family climates experienced with: fear; insecurity; aggression and; a high degree of unpredictability "mother was very considerate and loving and totally unreliable and erratic and very very manipulative"
	  2. **Inadequate support to develop functional affect regulation** – Children experiencing great difficulties in understanding and dealing with their feelings and parents being incapable of helping them
	School and social network during childhood
	  1. **School** – Difficulties for children in concentrating and learning at school, but also school providing a more stable and positive experience when children received positive affirmation
	  2. **Social network** – lack of relationships, friendships and social networks
	Challenges in being a parent oneself
	  1. **High degree of parental stress** – parenting as highly demanding experience. Additional stress caused by lack of a constructive role model for how to be a parent, wanting to be "100% different" to own parents
	    - **Difficult and challenging feelings** – parental stress compounded by parental difficulties in naming and managing their own emotions and subsequently their child's emotions
	    - **Difficulties being separated from the child** – parents being unable to separate emotionally or physically from their child "Aron was my comfort blanket and I've been carried along his back"
	    - **Guilt feelings** – guilt feelings associated with not being continuously available and able to satisfy child's every desire reinforcing idea of being an inadequate parent
	  2. **Parenting qualities that they wish to avoid using in their role as a parent** – emotional coldness, the silence, lack of engagement
	  3. **Psychosocial situation and psychological well-being** – work and social network being a protective factor for parents
		• Children as being silenced through lack of social networks
		• Experiencing threat and danger everywhere, both as a child and a parent leading to becoming over-protective
		• Role-reversal between parent and child, with child taking on parental responsibility
		• Sense of parents not being able to find a balance of either leading or following their child emotionally
		• Enmeshment of identity between the parent and child
		• Parents becoming over-protective of their child as a way of managing their feelings of inadequacy at being able to keep their child safe

Wood *et al.* (2010)	**Shame** – experience of shame of body and subsequently shame associated with breastfeeding "it always amazed me as to how beautiful an experience [breastfeeding] could be, and yet for me it was such a trauma" **Touch** – three kinds of touch were identified as difficult: self-touch; infant touch; and medical touch. Touch perceived as violating "I was very traumatised thinking about the delivery. Not about the pain, but about the other person touching" **Breasts** – Breast seen, by some, as the cause of abuse impacting on breastfeeding. Others experienced positive changes in the way the saw their breast after having a child **Dissociation** – dissociating with the experience of breastfeeding "I remember the breastfeeding. I remember the frustration. But I can't say I remember any feeling from it – physical sensation" **Medical care** – lack of nurturance of care experienced from professionals. Difficulty within power/authority perceived within the relationship with professionals **Healing** – Birthing and breastfeeding seen as healing experience	• Shame of bodies exacerbated by breastfeeding and difficulties with breastfeeding • Medical touch being a re-traumatising experience • Dissociation as helping women functionally cope with experiences, but also disconnecting them from emotional experience of breastfeeding • Women's connection to their breasts impacted on by abusive experiences, with this influencing relationship with breastfeeding • Birthing and becoming a parent seen as a nourishing and transformative experience

Appendix H: Mapping of Third-Order Constructs

Lack of parental role model

Loss of own childhood

Reoccurring patterns of parenting

Motivation & commitment to change

Trying to be a different parent / wanting to do things differently

Knowing how to be a parent

No template for parenting; only know what "not to do"

Commitment to parenting

Distancing self from the past

Change

How to discipline and set limits?

Identity and Healing

Healing and Resolution

Forming a Parental Identity Through the Lens of Trauma

Battling for balance; parent needs vs child

Resilience

Hope

Breaking Free from Past Abuse

Negative self-perception as a parent

purpose as a mother

Repairing past through relationship with child

Feeling ineffective as a parent

Experiencing past self in present motherhood

Learning through relationship with child

Inadequacy and self-scrutiny

Parental needs being met through child

Intergenerational abuse

The Emotional Demands of Parenting

Feeling overwhelmed

Child as source of fear/threat

Fear and distrust of self

Distancing self from child

Attachment as not a natural process

Mothering through emotional pain

Threat from the outside world

Protecting Against Perceived Threat

Fear of rejection and abandonment

Touch and emotional intimacy

Abuse and trauma as inevitable

Painful to 'be there' for child (emotionally and physically)

Survival

Protection of self

Monitor and surveillance of child

Fear

The Need for Safe Support

Lack of resources

Protecting the child

No safety net

Judgement: self; others; professionals; child

Support can be unsafe / intrusive

Power

Asking for help

Appendix I: Representation of Themes across the Primary Studies

Study	Forming a parental identity through the lens of trauma		Protecting against perceived threat	The need for safe support
	The struggle to meet the emotional demands of parenting	Breaking free from past abuse		
Aparicio et al. (2015)	✓	✓		✓
Buchbinder (2004)	✓	✓	✓	✓
Cavanaugh et al. (2015)	✓	✓	✓	
Hall (2011)	✓	✓	✓	✓
Herland et al. (2015)		✓	✓	✓
Kistin et al. (2014)		✓	✓	
Maxwell et al. (2011)	✓	✓	✓	✓
O'Dougherty-Wright et al. (2012)	✓	✓	✓	✓
Pitre et al. (2011)	✓	✓	✓	
Tedgard et al. (2018)	✓	✓	✓	✓
Wood et al. (2010)	✓	✓	✓	✓

Appendix J: Demographics of Participants included in the Primary Studies

Paper	Participants	Age Range	Ethnicity / Heritage	Childhood Trauma Experience	Relationship Status	Educational / Employment	No: of Children	Age Range of Children	Living with Child / Children	Age of Parent when had first Child
Aparicio et al. (2015)	6 mothers	19-22 years old	5 African 1 Hispanic study location: USA	6 neglect 4 physical abuse 2 sexual abuse 4 witness of domestic violence	not included	Not included	1-3	1-6 years old	not included	14-17 years old
Buchbinder (2004)	20 mothers	25-56 years old	Not included study location: Israel	witness to domestic violence physical abuse	7 married 6 separated 7 divorced	2 high school 3 university 15 diplomas	2-5	1-25 years old	not included	not included
Cavanaugh et al. (2015)	44 mothers	20-58 years old	24 White 11 Hispanic 6 African 3 Other study location: USA	44 sexual abuse	not included	38 high school 6 not recorded	not included	not included	not included	not included
Hall (2011)	3 mothers	50-65 years old	1 African-American 2 White study location: UK	3 physical abuse	not included	not included	not included	not included	not included	19 – mid thirties
Herland et al. (2015)	15 fathers	40+	not included study location: Norway	physical abuse emotional abuse neglect	not included	8 employed 7 unemployed	not included	not included	6 yes 9 no	not included
Kistin et al. (2014)	30 mothers	20-39 years old	14 Black 8 White 1 Asian 7 Other study location: USA	13 physical abuse 18 bereavement 17 emotional abuse 14 rape 12 sexual abuse	not included	9 primary school 10 high school 6 college 5 university	not included	0-36 months	not included	not included
Maxwell et al. (2011)	6 mothers	18-20 years old	6 White British study location: UK	6 Abuse and neglect	not included	not included	1-3	1-3	not included	17-19 years old
O'Dougherty -Wright et al. (2012)	15 mothers	25-53 years old	14 White 1 not recorded study location: USA & Canada	15 sexual abuse	12 married 3 divorced	not included	1-4	not included	not included	not included
Pitre et al. (2011)	12 mothers	32-55 years old	11 Canadian 1 South- American study location: Canada	physical abuse emotional abuse sexual abuse	8 married 2 divorced 1 single 1 widow	10 university 2 diplomas	not included	9 months – 32 years old	not included	not included
Tedgard et al. (2018)	13 mothers 6 fathers	21-40 years old	not included study location: Sweden	18 emotional neglect 15 emotional abuse physical abuse	9 married 10 single	6 college / university 11 high school 2 unemployed	not included	12-48 months	not included	not included
Wood et al. (2010)	6 mothers	not included	not included study location: Canada	6 sexual abuse	not included	not included	not included	not included	not included	not included

Appendix K: Design and Quality of Reviewed Studies

Research Design and Methodology

For all studies, methodologies were congruent with the research aims and over half of the studies referred to the associated theoretical orientation of the research (Aparicio, Pecukonis & O'Neale, 2015; Buchbinder, 2004; Cavanaugh *et al.,* 2015; Herland, Hauge & Helgeland, 2015; O'Dougherty-Wright, Fopma-Loy & Oberle, 2012; Pitre, Kushner & Hegadoren, 2011).

Sampling

Most studies used an appropriate sample size, however none of the studies discussed sample size in relation to data analysis and associated literature. One study which used a grounded theory (GT) approach had a sample size of three which would be considered a significantly low sample size (Hall, 2011). Only one of the GT studies claimed to reach 'saturation' (Kistin *et al.,* 2014). The absence of this in other papers was not deemed problematic for the purpose of an interpretive meta-synthesis.

Data Collection

Systemacity and transparency varied across the studies. Nine studies included information about interview schedules (Buchbinder, 2004; Cavanaugh *et al.,* 2015; Hall, 2011; Herland, Hauge & Helgeland, 2015; Kistin *et al.,* 2014; Maxwell, Proctor & Hammond, 2011; O'Dougherty-Wright, Fopma-Loy & Oberle, 2012; Pitre, Kushner & Hegadoren, 2011; Tedgard, Rastam & Wirtberg, 2018). Only one study provided details pertaining to data collection (Kistin *et al.,* 2014), with four papers making no reference to this information (Buchbinder, 2004; Cavanaugh *et al.,* 2015; Herland, Hauge & Helgeland, 2015; O'Dougherty-Wright, Fopma-Loy & Oberle, 2012).

Data analysis and Findings

Most studies defined their method of data analysis with only one study not explicitly providing this information (Buchbinder, 2004). Only three studies referred to

the epistemological position adopted within the research (Aparicio, Pecukonis & O'Neale, 2015; Herland, Hauge & Helgeland, 2015; O'Dougherty-Wright, Fopma-Loy & Oberle, 2012). In relation to transparency, eight studies provided narrative descriptions of the analysis procedures with only three studies not providing this detail (Maxwell, Proctor & Hammond, 2011; Pitre, Kushner & Hegadoren, 2011; Wood & Esterik, 2010). Most studies made reference to attempts to increase the creditability of their analysis and findings by employing appropriate strategies (in line with the varying qualitative methodologies) such as: using more than one analyst; using analysts independent to the research; keeping audit trails; and member checking (Buchbinder, 2004; Cavanaugh *et al.,* 2015; Kistin *et al.,* 2014; O'Dougherty-Wright, Fopma-Loy & Oberle, 2012; Pitre, Kushner & Hegadoren, 2011; Tedgard, Rastam & Wirtberg, 2018; Wood & Esterik, 2010). All studies used quotations from participants to ground findings and enhance transparency.

Discussion and Contribution

In all papers, findings were linked to the original research aims and existing literature, with only one study omitting discussion of clinical implications (Herland, Hauge & Helgeland, 2015). One study did not discuss the limitations of their findings (Buchbinder, 2004).

Ethics, Reflexivity, Context and Positioning

Most studies did not consider the wider ethical issues pertaining to the study with only three studies referring to the sensitive nature of the research and how participant distress might be managed (Hall, 2011; Pitre, Kushner & Hegadoren, 2011; Wood & Esterik, 2010). The majority of studies noted that the research had received ethical approval and considered the basic ethical requirements such as consent. However, two studies did not discuss any ethical considerations (Buchbinder, 2004; Kistin *et al.,* 2014).

Most studies did not attend to issues of reflexivity (Buchbinder, 2004; Herland, Hauge & Helgeland, 2015; Kistin *et al.,* 2014; Maxwell, Proctor & Hammond, 2011;

O'Dougherty-Wright, Fopma-Loy & Oberle, 2012; Pitre, Kushner & Hegadoren, 2011; Tedgard, Rastam & Wirtberg, 2018; Wood & Esterik, 2010). One study pertained to the idea of this being a consideration during the analysis process (Cavanaugh *et al.*, 2015) and a further study referred to the use of a reflective journal (Aparicio, Pecukonis & O'Neale, 2015). Only one study considered reflexivity alongside the context and positioning of the researcher (Hall, 2011). The position of power was not considered explicitly within any of the studies. This is especially significant considering how researchers may have been perceived to be part of the wider social systems associated with child welfare services, who had been involved with research participants.

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Wood, K. & Esterik, P.V. (2010). Infant feeding experiences of women who were sexually abused in childhood. *Canadian Family Physician, 56*(4), 136-141.

Appendix L*: Relevant Author Guidelines (Journal of Adoption & Fostering)

General guidelines (as up-to-date from January 2019)

Journal Details

Journal of Adoption and Fostering

Editor: Roger Bullock

Adoption & Fostering is a quarterly peer reviewed journal which has been at the cutting edge of debate on childcare issues for over 50 years. It is the only UK journal dedicated to adoption and fostering issues, providing an international forum for a wide range of professionals: academics and practitioners in social work, psychology, law, medicine, education, training and caring for children and young people. As the official journal of the CoramBAAF Adoption & Fostering Academy, the UK's leading adoption and fostering charity, the journal supports CoramBAAF's aims of promoting the highest standards of practice in adoption, fostering and childcare services, to increase public understanding of the issues and to provide an independent voice for children and families, disseminating new research and practice developments, informing and influencing policy-makers, all those responsible for children and young people, and public opinion at large. In addition to informative and thought-provoking articles from around the world, Adoption & Fostering offers regular legal notes and health notes prepared by dedicated practitioners and professionals concerned with the welfare of looked after children and young people in the UK.

Aims and Scope

Adoption & Fostering is the only quarterly UK peer reviewed journal dedicated to adoption and fostering issues. It also focuses on wider developments in childcare practice and research, providing an international, inter-disciplinary forum for academics and practitioners in social work, psychology, law, medicine, education, training and caring.

1. Article Types

Articles may cover any of the following: analyses of policies or the law; accounts of practice innovations and developments; findings of research and evaluations; discussions of issues relevant to fostering and adoption; critical reviews of relevant literature, theories or concepts; case studies. All research-based articles should include brief accounts of the design, sample characteristics and data-gathering methods. Any article should clearly identify its sources and refer to previous writings where relevant. The preferred length of articles is 5,000-7,000 words excluding references. Contributions should be both authoritative and readable. Please avoid excessive use of technical terms and explain any key words that may not be familiar to most readers.

2. Peer Review Policy

Adoption & Fostering operates a strictly anonymous peer review process in which the reviewer's name is withheld from the author and the author's name from the reviewer. The reviewer may at their own discretion opt to reveal their name to the author in their review but our standard policy practice is for both identities to remain concealed. Each manuscript is reviewed by at least two referees. All manuscripts are reviewed as rapidly as possible, and an editorial decision is generally reached within 6-8 weeks of submission.

3. Authorship

All parties who have made a substantive contribution to the article should be listed as authors. Principal authorship, authorship order, and other publication credits should be based on the relative scientific or professional contributions of the individuals involved, regardless of their status. A student is usually listed as principal author on any multiple-authored publication that substantially derives from the student's dissertation or thesis.

4. Acknowledgements

All contributors who do not meet the criteria for authorship should be listed in an Acknowledgements section. Examples of those who might be acknowledged include a person who provided purely technical help, or a department chair who provided only general support. Please supply any personal acknowledgements separately to the main text to facilitate anonymous peer review.

5. Funding

Adoption & Fostering requires all authors to acknowledge their funding in a consistent fashion under a separate heading. Please visit the Funding Acknowledgements page on the SAGE Journal Author Gateway to confirm the format of the acknowledgment text in the event of funding, or state that: This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

6. Declaration of Conflicting Interests

Adoption & Fostering encourages authors to include a declaration of any conflicting interests and recommends you review the good practice guidelines on the SAGE Journal Author Gateway.

<u>Publishing Policies</u>

1. Publication Ethics

SAGE is committed to upholding the integrity of the academic record. We encourage authors to refer to the Committee on Publication Ethics' [International Standards for Authors](#) and view the Publication Ethics page on the [SAGE Author Gateway](#)

2. Plagiarism

Adoption & Fostering and SAGE take issues of copyright infringement, plagiarism or other breaches of best practice in publication very seriously. We seek to protect the rights of our authors and we always investigate claims of plagiarism or misuse of published articles. Equally, we seek to protect the reputation of the journal against

malpractice. Submitted articles may be checked with duplication-checking software. Where an article, for example, is found to have plagiarised other work or included third-party copyright material without permission or with insufficient acknowledgement, or where the authorship of the article is contested, we reserve the right to take action including, but not limited to: publishing an erratum or corrigendum (correction); retracting the article; taking up the matter with the head of department or dean of the author's institution and/or relevant academic bodies or societies; or taking appropriate legal action.

3. Prior Publication

If material has been previously published it is not generally acceptable for publication in a SAGE journal. However, there are certain circumstances where previously published material can be considered for publication. Please refer to the guidance on the SAGE Author Gateway or if in doubt, contact the Editor at the address given below.

<u>Manuscript Preparation</u>

1. Formatting

The preferred format for your manuscript is Word. LaTeX files are also accepted. Word and (La)Tex templates are available on the Manuscript Submission Guidelines page of our Author Gateway.

2. Artwork Guidelines

Illustrations, pictures and graphs, should be supplied with the highest quality and in an electronic format that helps us to publish your article in the best way possible. Please follow the guidelines below to enable us to prepare your artwork for the printed issue as well as the online version.

- Format: TIFF, JPEG: Common format for pictures (containing no text or graphs).
- EPS: Preferred format for graphs and line art (retains quality when enlarging/zooming in).

- Placement: Figures/charts and tables created in MS Word should be included in the main text rather than at the end of the document.
- Figures and other files created outside Word (i.e. Excel, PowerPoint, JPG, TIFF, EPS, and PDF) should be submitted separately. Please add a placeholder note in the running text (i.e. "[insert Figure 1.]")
- Resolution: Rasterized based files (i.e. with .tiff or .jpeg extension) require a resolution of at least 300 dpi (dots per inch). Line art should be supplied with a minimum resolution of 800 dpi.
- Colour: Please note that images supplied in colour will be published in colour online and black and white in print (unless otherwise arranged). Therefore, it is important that you supply images that are comprehensible in black and white as well (i.e. by using colour with a distinctive pattern or dotted lines). The captions should reflect this by not using words indicating colour.
- Dimension: Check that the artworks supplied match or exceed the dimensions of the journal. Images cannot be scaled up after origination
- Fonts: The lettering used in the artwork should not vary too much in size and type (usually sans serif font as a default).

3. Title, Keywords and Abstracts

You will be asked to supply a title, short title, an abstract and keywords to accompany your article. The title, keywords and abstract are key to ensuring readers find your article online through online search engines such as Google

4. **Reference Style**

Adoption & Fostering adheres to the SAGE Harvard reference style.

Appendix M*: Epistemological Position of the Researcher

Reflexivity has an important role in qualitative research and its application is influenced by both the aims of the reflexive process and by the theoretical position and epistemological stance taken by the researcher. Therefore, it is important to be explicit about the position held by the researcher and the assumptions made concerning the relationship between the data and reality (Koro-Ljungberg, 2016). In the process of adopting an epistemological position to research mothers' experiences of placing their child into care, I was not looking to seek an objective truth but instead sought to make sense of the mothers' experiences within their own unique contexts. It was considered this could be best achieved from a phenomenological position. The phenomenological perspective is concerned with how the world is experienced within a particular context, at a specific time. From such a position, it is assumed that it is not possible to separate out our meaning-making from the experience of the world and a phenomenon (Willig, 2013). Therefore, the phenomenological position is characterised by how people's perceptions and meaning-making are a function of their engagement with and relationship to the world (Finlay, 2011).

It was considered that completing research from a phenomenological position would require a qualitative phenomenological methodology. I chose an interpretive phenomenological approach, as this is primarily concerned with the meaning-making individuals give to their specific lived experiences (Smith, Flowers & Larkin, 2009). The framework of this methodology was thought to be congruent with the philosophical underpinning of a phenomenological position whereby: mothers' sense-making of their experiences will be explored within the contexts deemed important to the participant; the researcher's intersubjective and reflexive role is acknowledged; and there is an emphasis on interpretation to develop an understanding of the studied phenomenenom (Smith & Osborn, 2008; Smith, Flowers & Larkin, 2009). This fitted within the aims of the study in attempting an in-depth exploration of the lived experiences of mother's who have placed their children into care.

Interpretive Phenomenological Analysis (IPA) views research as a dynamic process with the researcher becoming a co-constructer of the findings. Researchers can be, from this point, viewed as being both 'part of' and 'apart' from their research; and encourages the researcher to reflect upon their own beliefs, preconceptions and expectations (Goldspink & Engward, 2018). Therefore, it is important to state my own stance and relevant experiences in order to 'own [my] perspective' (Elliot, Fischer & Rennie, 1999).

I am a white woman in my early thirties. Although, I consider myself from a working-class background, I have been afforded the opportunity to access higher education up to doctoral level. I do not have any children so therefore have no personal experiences of being a parent and have positive experiences of being parented. I am in a long-term and stable relationship with plans to marry and start a family in the future. I am aware that my personal experiences will offer me a level of privilege and resources to support my own potential maternal journey. Throughout my clinical experiences and professional journey, I have worked with parents who have experienced childhood trauma and I have also worked with some mothers who have made, what I perceive to be, altruistic decisions to place their children into care. I have become more aware of the stigma around this experience and the negative discourses around parents (but specifically mothers) who have children in care. My experiences and observations have likely engendered in myself the belief that such women have no voice and no safe space to talk about these experiences, and that some professionals may feel uncertain in knowing how to broach the topic. My experience and beliefs will likely have guided my decision to research this phenomenon, as well as my choice to privilege a qualitative research methodology. A process of continuous reflection, through writing and supervision, has been utilised to develop a greater awareness of my own pre-conceptions of this experience throughout the research journey.

References:

Elliot, R., Fischer, C. T. & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British journal of clinical psychology, 38*(3), 215-229.

Finlay, L. (2011). *Phenomenology for Therapists: Researching the lived world*. West Sussex: John Wiley & Sons, Ltd.

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Koro-Ljungberg, M. (2016). *Reconceptualising qualitative research: Methodologies without methodology*. London: Sage.

Smith, J.A., Flowers, P. & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, method and research*. London: Sage.

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Willig, C. (2013). *Introducing qualitative research in psychology (3rd Eds).* England: Open University Press.

Appendix N*: Research Ethics Committee Approval Letter

NHS
Health Research Authority

West Midlands - Black Country Research Ethics Committee
The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

19 February 2018

Miss Kate Louise Siverns
Trainee Clinical Psychologist

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Dear Miss Siverns

Study title:	Mothers' experiences of placing their child into care in the context of mental health difficulties or historical trauma: A phenomenological study
REC reference:	████████████
Protocol number:	██████
IRAS project ID:	███████

Thank you for your letter of 6ᵗʰ February 2018, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact hra.studyregistration@nhs.net outlining the reasons for your request.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for NHS permission for research is available in the Integrated Research Application System, www.hra.nhs.uk or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from the HRA. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only)	n/a	30 November 2017
GP/consultant information sheets or letters	1.0	27 November 2017
GP/consultant information sheets or letters [Clinician Safety Checklist]	1.0	27 November 2017
GP/consultant information sheets or letters	1.0	27 November 2017
Interview schedules or topic guides for participants	1.0	27 November 2017
IRAS Application Form [IRAS_Form_07122017]		07 December 2017
Letters of invitation to participant [Consent to be Contacted form]	1.1	06 February 2018
Non-validated questionnaire	1.0	27 November 2017
Other	n/a	14 September 2017
Other	n/a	07 June 2017
Other	n/a	22 August 2017
Other	n/a	07 August 2017
Other	n/a	07 August 2017
Other [REC Cover Letter]	n/a	06 February 2018
Participant consent form [Initial Interview]	1.1	06 February 2018
Participant consent form [Second Interview]	1.1	06 February 2018
Participant information sheet (PIS) [Gift Voucher Receipt Form]	1.0	27 November 2017
Participant information sheet (PIS) [Sensory Prompt Sheet]	1.0	27 November 2017
Participant information sheet (PIS)	1.1.	06 February 2018
Participant information sheet (PIS) [Debrief and Signposting Sheet]	1.1	06 February 2018
Research protocol or project proposal	1.0	27 November 2017
Summary CV for Chief Investigator (CI)	1.0	30 October 2017
Summary CV for supervisor (student research) [Gareth Morgan CV]	n/a	11 December 2017
Summary of any applicable exclusions to sponsor insurance (non-NHS sponsors only)	n/a	28 July 2017
Summary of any applicable exclusions to sponsor insurance (non-NHS sponsors only)	n/a	28 July 2017
Summary, synopsis or diagram (flowchart) of protocol in non technical language	1.0	30 October 2017

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research

Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

<u>Reporting requirements</u>

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

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

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:
http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Training

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

████████████	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project.

Yours sincerely

P P C Halliwell

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123

Appendix O: Health Research Authority Approval Letter

NHS
Health Research Authority

Miss Kate Louise Siverns

Email: hra.approval@nhs.net

07 March 2018

Dear Miss Siverns

Letter of HRA Approval

Study title:	**Mothers' experiences of placing their child into care in the context of mental health difficulties or historical trauma: A phenomenological study**
IRAS project ID:	
Protocol number:	
REC reference:	
Sponsor	**University of Leicester**

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

Participation of NHS Organisations in England

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

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

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

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

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

Appendices

The HRA Approval letter contains the following appendices:

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

After HRA Approval

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

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

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

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

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

Scope

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

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found through IRAS.

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

User Feedback

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

procedure. If you wish to make your views known please use the feedback form available on the [HRA website](#).

HRA Training

We are pleased to welcome researchers and research management staff at our training days – see details on the [HRA website](#).

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

Yours sincerely,

████████
████████

Email: hra.approval@nhs.net

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Appendix P*: Sponsorship Approval Letters

Our Ref: ███████████████

30th November 2017

UNIVERSITY OF LEICESTER

To whom it may concern,

UNIVERSITY OF LEICESTER CLINICAL TRIAL/PROFESSIONAL INDEMNITY INSURANCE

Title of Study – Mothers' experiences of placing their child into care in the context of mental health difficulties or historical trauma: A phenomenological study

Chief Investigator – Miss Kate Louise Siverns

I confirm that the University of Leicester will provide Clinical Trials and Professional Indemnity insurance cover in respect of its legal liability in relation to the above trial within the UK only.

Any significant departure from the programme of research as outlined in the application (such as changes in methodological approach, large delays in commencement of research, additional forms of data collection or major expansions in sample size) must be communicated to us.

The cover is provided subject to normal policy terms and conditions.

Sue Banbury

Sue Banbury
Insurance & Risk Manager

University of Leicester

UNIVERSITY OF LEICESTER

27th July 2018

Research & Enterprise Division
University of Leicester

Miss Kate Siverns

Dear Kate

Ref:
Study title: Mothers' experiences of placing their child into care in the context of mental health difficulties or historical trauma: A phenomenological study.
Study Status: Approved
End Date: 30/09/2019
Site:

I am pleased to advise you that following confirmation of a Favourable Opinion from an Ethics Committee, HRA and NHS Trust R&D Capacity and Capability confirmation, and where relevant regulatory authority agreements have been received, the University are able to confirm sponsorship for the above research at the above site.

I would be grateful if you can forward a copy of this letter to the Principal Investigator for their Site File.

Please note you are required to notify the Sponsor and provide copies of:

- Changes in personnel to the Study
- Changes to the end date
- All substantial amendments and provisional and favourable opinions
- All minor amendments
- All serious adverse events (SAEs) and SUSARS
- Annual progress reports
- Annual MHRA (DSUR) safety reports (if applicable)
- End of study declaration form
- Notifications of significant breaches of Good Clinical Practices (GCP)or Protocol

If your study is adopted onto the Clinical Research Network Portfolio please ensure that your recruitment figures, end dates and study status are the same on the EDGE database and Open Database Platform (ODP) CPMS.

Please copy the Sponsor into all correspondence and emails by using uolsponsor@le.ac.uk.

Please note it is essential that you notify us as soon as you have recruited your first patient to the study at this site.

I would like to wish you well with your study and if you require further information or guidance please do not hesitate to contact me.

Yours sincerely

Dr Michelle Muessel
Research Governance Manager

Appendix Q: Approval from Research and Development Committee

We Research

26th March 2018

Miss Kate Louise Siverns

Dear Kate

RE: CONFIRMATION OF CAPACITY & CAPABILITY:
Mothers' experiences of placing their child into care in the context of mental health difficulties or historical trauma:
A phenomenological study

Study Codes:			
Trust Reference:	▓▓▓	IRAS (REC) Reference:	▓▓▓
EDGE ID:	▓▓▓	Portfolio ID:	N/A
Sponsor Reference:	▓▓▓		
Study Sponsor:	University of Leicester		

I am writing in confirmation of your application in respect of "confirmation of capacity and capability" (formerly known as NHS Management Permission), to conduct recruitment for the above study within ▓▓▓ The Trust can **confirm that we have capacity to support this research**. Your research has been entered onto the Trust's Research Database. All research studies taking place <u>may</u> be subject to monitoring in respect of confirmation timelines, recruitment to time and target and so on. As a result, some of this information is reproduced in the table below. The key monitoring target is a 70-day timeline from receipt of a Valid Research Application at site (aka Site Selection), which incorporates the 30-day timeline, within which the first patient or participant should be recruited.

Confirmation of Capacity & Capability STATUS						
Full Approval	☒	Approval in Principle	☐	Approval refused	☐	
TIMELINES						
Date of Favourable Ethical Review (Time A)	19/02/2018	Date Full Documentation (Valid Application) Received (Site) (Time B)	07/03/2018	Sign-off timeline (A-B) 15 Days		
Date of SoA/Funding Agreement/SIV[1]	26/03/2018	Date of Confirmation of Capacity (Time C)	26/03/2018	Sign-off timeline (B-C) 18 Days		
Date of Final HRA Approval[2]	07/03/2018	Target Date: First Patient/Participant Visit (FPFV)	7th May 2018			

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[1] Underline as appropriate
[2] Where required; studies may not begin if final HRA Approval not secured.

disability confident EMPLOYER

129

The conduct of your study (including examination of the site file) at this site may be subject to audit for protocol adherence and other monitoring. This approval is subject to the accuracy of the following information:

Study Summary				
Chief Investigator (Supervisor):	*Miss Kate Louise Siverns*			
Principal Investigator (Local Collaborator):		CRN Delivery Co-ordinator		*N/A*
Other Investigators:	*Dr Gareth Morgan:*			
Indemnity Provider:	*University of Leicester & NHS Indemnity*		Start Date (Local)	*26th March 2018*
NIHR Portfolio:	*No*		End Date (Local)	*30th September 2019*
Student Project	*Yes*		Target Recruitment	*6-8*
Funding Source:	*None*		Amount:	*None*
Local NHS Support Costs:	*TBC*			

Please note that all research with an NHS element is subject to the provisions of the UK Policy Framework for Health & Social Care (November 2017). If you are unfamiliar with the standards contained in this document, or the ▮policies that reinforce them, you can obtain advice from the R&D Office or your Sponsor. You must stay in touch with the R&D Office during the course of the research project, particularly if/ when:

- There is a change of Principal Investigator;
- To fulfil requirements for performance reporting;
- The project finishes (please complete a summary report form);
- Amendments are made, whether minor or substantial;
- Serious Adverse Events occur (adhere to local and Sponsor SOPs).

This is necessary to ensure that your indemnity cover is and remains valid. Should any issues arise that inhibit study delivery it is essential that you contact the R&D Office immediately. If patients or staff members are involved in an incident, you should also contact the Clinical Risk Manager and report as per Trust Policy.

Provision against NHS Costs: The Trust reserves the right to invoice the study team, in the unlikely event of any unexpected additional costs arising during this study, including, but not limited to:

- Staff Time attending interviews.
- Travel and administrative costs

I hope the project goes well, and if you need any help or assistance during its course, please do not hesitate to contact the Office.

Kind regards

Copies to:
Dr Gareth Morgan

Appendix R*: Checklist to Ensure Anonymity of Participants

	Checked in Executive Summary/Abstract/ Overview (if included in assignment)	Checked in main text	Checked in appendices
Pseudonym or false initials used	✓	✓	✓
Reference to pseudonym/false initials as a footnote	✓	✓	✓
Removed any reference to names of trusts/hospitals/clinics/services (including letterhead if including letters in appendices)	✓	✓	✓
Removed any reference to names/specific dates of birth/specific dates of clinical appointments/addresses/location of client(s) (including relatives), and supervisor(s)	✓	✓	✓
Removed/altered references to client(s) jobs/professions where this may potentially identify them	✓	✓	✓
Removed any information that may identify the trainee (consult with course staff if this will detract from the points the trainee is making)	✓	✓	✓
No Tippex or other method has been used to obliterate the original text – unless the paper is subsequently photocopied and the trainee has ensured that the obliterated text cannot be read	✓	✓	✓
The "find and replace" function in word processing has been used to check the assignment for use of client(s) names/other confidential information	✓	✓	✓

Appendix S: Ethical Considerations

<u>Informed Consent</u>

Consent to receive information about the study was initially sought from the recruiting clinician who introduced the participant to the research. After potential participants received and read the information sheet it was up to them to decide if they wished to participate or not. I was unaware of who had been approached and was not provided with any details of the individuals who received the study information, unless they explicitly expressed interest in participating and consented to be contacted by myself. Participants were made aware of the voluntary nature of their participation and were informed that their decision to participate or not-participate in the research would have no impact on their access to current support. This helped to ensure that participants had not felt coerced by professionals. A minimum of 72 hours was ensured between participants receiving the study information and consenting to take part in the face-to-face interview.

Each participant was provided with information detailing: The nature and purpose of the research; confidentiality and anonymity; data storage and analysis; and their rights as a participant in written and verbal form. This helped to ensure that each participant fully understood the nature of the research and afforded them the opportunity to ask any questions or raise any concerns. Participants were explicitly made aware of their right to withdraw should they wish too without having to provide a reason. My contact details were made available so that participants could request the removal of their data from the study, should they decide to withdraw. It was made known to participants that this option would be time-limited, and it would not be possible to extract their data from the study if it had been over a month since the second interview, (or over two months if the person participated in just one interview), due to further data analysis being initiated. None of the participants within this research chose to do this. Participants were requested to sign a written consent form if they were happy to proceed, including agreeing to the audio-recording of the interviews. Participants were also given the option as to whether they would like to receive a summary of findings, which could be posted to them. Participants were invited to take part in a

second interview, with it being made clear that they were under no obligation, and they all took up this opportunity. Separate consent forms were used for the initial and second interview, outlining consent for participation for each specific interview.

Confidentiality and Anonymity

Multiple recruitment sites across a wide geographical area were approached to help support anonymity. Participants were made aware that any identifiable and biographical information would be removed from their data and they were informed how their information would be used and stored. Participants were assigned a unique ID number and pseudo-name. Participant data (e.g. completed consent forms, demographic information, audio recordings etc) were stored securely at the University of Leicester. Interviews were transcribed and analysed by myself, with support from my research supervisor. All electronic and paper records will be stored securely for a period of five years after completion of the research in accordance with the Data Protection Act (2018), and with the University of Leicester's data storage policy. After this period, all records will be securely destroyed.

Payment

Participants were provided with the opportunity to receive an 'inconvenience payment' for their involvement in the research, to the sum of a £10 gift voucher per interview, which they all accepted. This was considered an appropriate amount in recognition of the participant's time, yet not too high a payment to entice people to participate solely for financial gain. The value of the voucher was also in accordance with the DClinPsy's Service User Reference Group recommendations. Whilst there is debate around the use of payment within research, it was considered that this payment would be a way of acknowledging the participant's contribution to the study and a means of reimbursing them for their time. Furthermore, it can be a way of potentially addressing some of the power imbalance issues between the investigator and the researched, due to the mutual benefits of participation (Head, 2009). Participants were also afforded the opportunity to be reimbursed for their travel expenses to attend interviews to help alleviate any financial barriers that may have impacted on participation, although no-one required this.

I was aware of the highly emotive nature of the research topic and the potential for participants to experience distress as a result of reflecting on their experiences. To manage this, recruitment was limited to participants who were currently accessing services, to help ensure a level of support was readily available. Recruiting clinicians were requested to complete a 'Clinician Safety Checklist Form' to help ensure careful consideration was given to who was invited to partake in the research and to act as a further safe-guard. Participants were made aware that part of my research protocol involved informing their recruiting clinician of their participation in the study, in case they required additional support during this time, but that the information provided within the interview would remain confidential. The limits of confidentiality were explained, and participants were made aware that if I had concerns over their safety (or the safety of others) I would inform the relevant professionals involved in their care, although this situation did not arise in the current study.

The potential for some distress to occur through participating in this study was explicitly highlighted to participants and I was conscious to ensure that the interview process was not conducted in a manner which could be perceived as intrusive. Participants were made aware that they did not have to answer any questions which they did not feel comfortable to and that it was their choice as to how much information they wished to share. It was hoped that these processes would help to promote participants' control over the research process and enable them to monitor and protect their own well-being as far as possible. At the beginning of each interview, it was discussed how it would be best to manage any situations should the participant become overtly distressed.

Whilst there is a distinct difference between a research interview and a clinical interview, I was able to draw upon my clinical skills throughout the research process. I was aware of the importance of making the interview a non-judgemental space. This was especially important in light of the sensitivity of the topic and ensuring the interview was not felt as criticising or blaming causing unnecessary feelings of guilt or shame. Participant well-being was monitored throughout the interviews with breaks, 'check-

in's, and reassurance being offered at times when it felt necessary. Time was reserved at the end of each interview so that any issues or concerns could be raised and a debrief could occur. All participants were provided with information pertaining to additional sources of support. Participants were also reminded that, should any concerns arise pertaining to this study, they could contact myself, my research supervisor or utilise standard NHS complaints procedures.

There is a particular tension in the importance of protecting participants from harm and acknowledging the potential for distress to participants as a result of participating in this research. However, it was thought that this study would help to include some of the more marginalized groups of individuals who often get overlooked within research whilst offering appropriate protocols and consideration of how to maintain participant safety.

Potential Researcher Distress and Safety

Researcher safety was also considered within the initial screening phrase of the 'Clinician Safety Checklist Form' whereby any participants deemed to pose a significant risk to the researcher would be excluded from participating. As I would not be known to any of the participants and would not have access to their background information or potential risks, it was deemed appropriate for interviews to be conducted at the participant's mental health service, as opposed to in their home. Not only would this potentially provide a 'safe space' for the participant, but also for myself. I also had access to regular supervision and support from my research supervisor.

References:

Head, E. (2009). The ethics and implications of paying participants in qualitative research. *International Journal of Social Research Methodology, 12*(4), 335-344.

Appendix T: Participant Recruitment Information Sheet for Clinicians

Department of Neuroscience, Psychology and Behaviour
Doctorate in Clinical Psychology
University of Leicester
Centre for Medicine
Lancaster Road
Leicester
LE1 7HA
Tel: 0116 223 1648

UNIVERSITY OF
LEICESTER

PARTICIPANT RECRUITMENT INFORMATION SHEET FOR CLINICIANS

Research Title:	A mother's experience of placing their child into care
Main Researcher:	Kate Siverns (Trainee Clinical Psychologist, University of Leicester) ▮▮▮▮▮▮ ▮▮▮▮▮▮
IRAS Number:	▮▮▮

Introduction

My name is Kate Siverns and I am a Trainee Clinical Psychologist with the University of Leicester. I am completing some research which aims to look at the experiences of mothers who make the decision (or who have come to be in agreement with the decision made) to place their child into care in the context of their mental health difficulties or experiences of trauma. This study has received approval from both the University of Leicester and by the ethical body for the NHS. This research will be submitted as part of a Doctorate in Clinical Psychology and is also intended to be submitted for publication to a relevant peer-reviewed journal. Given the societal discourses that are inherent within the context of motherhood it is hoped that this research will be useful in understanding the experiences of these mothers, in a way that is non-judgemental and non-blaming. Furthermore, it may be used as a platform to help think about how professionals and services can better understand the needs of mothers in such situations.

Participants

I would greatly appreciate your help in identifying any potential participants who may be interested in taking part in this study. I am aiming to recruit four participants with the intention of interviewing them each twice. However, participants would not have to complete the second interview should they not wish too. Interviews are estimated to take around one hour (although this is flexible) and will be audio-recorded.

There are some criteria that potential participants **must** meet to be included in the study:

- Mothers who have relinquished parental responsibility and have had one or more children placed into care (no time limit will be set for when this happened). This is defined by either:
    o the agreement of a child arrangement order from the court which outlines that the child lives with another person
    o the child being in foster care or under special guardianship
    o the child being adopted
- Mothers must either have made the decision for their child to be placed into care; been in agreement with the decision made; or have come to be in agreement with the decision made over time.
- Mothers must no longer have direct contact (face-to-face or telephone) with the child/children that they have relinquished parental responsibility for (excluding letterbox contact).
- Mothers must self-identify as having experienced past trauma or mental health difficulties. They would also need to be under the care of a mental health service or be receiving support in relation to the separation from their child (e.g. post-adoption counselling) at the time of both interviews (the

Participant Recruitment Information Sheet.   Page 1 of 2   Final Version 1.1   28/08/2018

136

interview process is estimated to take around 6-8 weeks from the time the participant expresses an interest to the researcher).

- Mothers would need to be considered 'safe' enough to be able to discuss this in the depth required without this becoming significantly overwhelming or distressing.
- Mothers would need to be aged 18 or over and be able to provide informed consent for themselves.

There are some criteria that would mean participants **would not** be suitable to participate in the study:

- Mothers who have had their child/children forcibly removed, where the mother has consistently contested this decision.
- Mothers who are currently going through court proceedings relating to their child being placed into care (due to the legal issues surrounding this).
- Mothers whose children were voluntarily or forcibly taken into care due to difficulties caring for the child being exclusively associated with parental intellectual disability or brain injury.
- Mothers who are separated from their child/children but still maintain regular contact and parental responsibility.
- Mothers who would likely experience significant distress from participating which would undermine their ability to keep themselves safe.
- Mothers who are not able to speak English at a level to complete the interview without the aid of a translator.
- Mothers who may pose a risk to the researcher.
- Mothers who are not able to offer informed consent to participate, as defined by the principles of the Mental Capacity Act.

Recruitment

If you are aware of any potential participants that would meet the criteria for this study could I please request that you briefly discuss this with them and if they are interested provide them with a 'Participant Information Pack'. The information pack includes full details of the study along with information as to how they can contact myself to express an interest in participating in the study.

Could I also request that you complete a copy of the 'Clinician Safety Checklist Form' for any prospective participants that you discuss the research with. This is an incredibly brief checklist relating to participant and researcher safety. Please give this completed form to the individual and I will then contact any participants who express an interest to make arrangements for the interview.

If you have any questions or would like to discuss the research further, please do not hesitate to contact me

Thank you in advance for all your help with this process

Kate Siverns
Trainee Clinical Psychologist
Main Researcher

If you have any questions or concerns about how the study is being conducted, or would like to make a complaint you can contact Dr Gareth Morgan (Research Supervisor) at: University of Leicester, Centre for Medicine, Lancaster Road, Leicester LE1 7HA 0116 223 1648 / E-mail:

Participant Recruitment Information Sheet.   Page 2 of 2   Final Version 1.1   28/08/2018

137

Appendix U: Clinician Safety Checklist Form

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CLINICIAN SAFETY CHECKLIST FORM

Research Title:	A mother's experience of placing their child into care
Main Researcher:	Kate Siverns (Trainee Clinical Psychologist, University of Leicester) ▮▮▮▮▮▮▮▮▮▮ ▮▮▮▮▮▮
IRAS Number:	▮▮▮▮

Please complete this form for any individual that you have discussed the study with and who might be interested in participating

Name of individual you are completing the form on behalf of:

…….

Please **initial** the corresponding boxes to confirm you agree with each statement. Thank you

Please Initial

I believe that the individual would be 'safe' enough to participate in this study, without this having a detrimental impact on their mental health or well-being. ☐

The individual would still have access to support from myself (or this service) whilst completing the research interviews. The interview process is estimated to take between 4 – 6 weeks from when the individual expresses an interest to the researcher. ☐

To my knowledge, I do not foresee any risk posed to the researcher in relation to this individual partaking in the study. ☐

I have no reason to doubt this person would not have capacity to consent to participation. ☐

Clinician Name:………………………………………………………**Signature:**…………………………………………………

Clinician Role:……………………………………………………………**Date:**…………………………………………………

Location:…….

Tel:………………………………………………………**E-mail:**………………………………………………………………….

Please hand this completed form to the individual. They can send this to the researcher should they choose to participate.

Thank you

If you have any questions or concerns about how the study is being conducted or would like to make a complaint you can contact Dr Gareth Morgan (Research Supervisor) at: University of Leicester, Centre for Medicine, Lancaster Road, Leicester LE1 7HA ▮▮▮▮ *0116 223 1648 / E-mai* ▮▮▮▮▮▮

Appendix V*: Participant Information Sheet

Department of Neuroscience, Psychology and Behaviour
Doctorate in Clinical Psychology
University of Leicester
Centre for Medicine
Lancaster Road
Leicester
LE1 7HA
Tel: 0116 223 1648

UNIVERSITY OF
LEICESTER

PARTICIPANT INFORMATION SHEET

Research Title:	A mother's experience of placing their child into care
Main Researcher:	Kate Siverns (Trainee Clinical Psychologist, University of Leicester) ███████ ███████
IRAS Number:	███

Researcher introduction
My name is Kate Siverns and I am a Trainee Clinical Psychologist. I would like to invite you to take part in a research study I am completing as part of my Doctorate qualification in Clinical Psychology at the University of Leicester. To help you decide if you would like to participate, I would like you to understand why the research is being done and what it would involve for you.

What is the purpose of the study?
I am interested in finding out about the experiences of mothers who: have made the decision; been in agreement with the decision made; or have come to be in agreement with the decision made over time, to place their child or children into care due to distress relating to their mental health difficulties or past experiences of trauma. There can be a lot of stigma surrounding this topic and I would like to use this research as an opportunity to hear the voices of such mothers, so that professionals and services can better understand the needs of mothers in similar situations.

Why me?
Information about this study has been passed onto you by your healthcare professional because they believe you might have some interest in taking part. They will have discussed this research with you because you are a mother who has experienced mental health difficulties or historical trauma and who has made the decision (or come to be in agreement with the decision) to place your child into care (this does not have to be the case for all of your children). This could mean that your child has; gone into foster care, been adopted or they are permanently living with a legal guardian. For this purpose of this study I am interviewing mothers who: no longer have parental responsibility for their child; and who no longer have direct contact with their child (apart from letterbox contact)

Do I have to take part?
No. I understand that the subject matter is very personal and it is entirely up to you to decide if you wish to take part or not. Whatever decision you make will **not** impact on the current support you receive in any way.

What will happen if I decide to take part?
If you do decide to participate, I will arrange a date and time to come and meet with you at your local mental health / post-adoption support service to complete an interview *(you will be able to claim back your transport costs up to the value of £13.50 per interview, if receipts are provided – please ask me about this prior to the interview)*. There will be an opportunity to discuss the study further and ask any questions. You will be asked to sign a consent form to show that you understand what your participation involves and that you have agreed to participate. I will also ask you to complete a short questionnaire based on some general information about yourself and some questions about your experiences. The interview will involve asking you to share your experiences about your child being placed into care. The interview questions will focus on:

Participant Information Sheet.   Page 1 of 3   Final Version 1.2   28/08/2018

139

- Your experiences of support from others
- Your expectations of becoming a parent
- Your experiences of parenting
- Your experience of decision making about parental responsibility
- Your experiences of living away from your child

It is important that you are aware that there are no right or wrongs answers; I am solely interested in your experience. I would also like you to know that you do **not** have to answer any questions that you do not wish to and you should only provide as much information as you feel comfortable to share. I will not be requesting any information or records from your mental health / post-adoption support service and the only information I would have access to, is what you voluntarily share with me. The interview is expected to take around an hour; however you will be able to choose to end the interview whenever you want (up to a maximum of two hours). I would also like to meet with you again for a second interview and this would be used as a space to further think about what was previously discussed. You will be free to withdraw from the study, even if you have already completed both interviews. You will not have to give a reason and you can choose to have your information removed from the study. However, it will not be practically possible to remove your information if it has been over two months since your first interview (or one month since your second interview).

Are there any benefits or risks to taking part?
It is thought that some people might find the opportunity to have their voices heard a rewarding experience. Furthermore, some individuals may also feel positive about contributing to research that may be of benefit to other mothers sharing similar experiences. In recognition of your time, you will be offered a £10 gift voucher for each interview you attend (this will not affect your right to withdraw from the study at a later point).

Given the nature of the topic it is understandable that some people might find talking about this difficult or distressing. Whilst it is ok for feelings to come up within the interviews, it is important that you think carefully about your participation and whether you feel that you will be able to manage these. You will be given time at the end of each interview to talk about how your feel and have the opportunity to think about what support may be available to you.

What if I am harmed by the study?
It is very unlikely that you would be harmed by taking part in this type of research study. However, if you wish to complain or have any concerns about the way you have been approached or treated in connection with the study, you can speak to myself, Kate Siverns, the main researcher (my contact details are above), or you can speak with my research supervisor, Dr Gareth Morgan (his contact details are below) and we will do our best to answer your questions. If you remain unhappy and wish to address your concerns or complaints on a formal basis, you should contact: Patient Advice and Liaison Service (PALS) ███████████████████████████████████

In the event that something does go wrong and you are harmed during the research and this is due to someone's negligence then you may have grounds for legal action for compensation against the University of Leicester but you may have to pay your legal costs. The normal National Health Service complaints mechanisms will still be available to you (if appropriate).

What will you do with the information I provide?
The interview will be recorded on a secure audio-device and then typed up by myself. The transcription will then be analysed as part of the research process. The study will be written up and submitted to the University of Leicester. It may also be published in a peer reviewed research journal. I hope to share the results of the study widely so it can be helpful in trying to reduce the social stigma around this topic and also for helping services to think about what support may be useful for mothers with similar experiences. You will be able to receive a written summary of the research findings, if you wish to (this will be available from autumn 2019), which can be sent out via post or e-mail.

Participant Information Sheet.   Page 2 of 3   Final Version 1.2   28/08/2018

140

Is my information safe?

Yes. All the information you provide will be handled in confidence and stored securely at the University of Leicester for a period of up to five years, after this time it will then be destroyed. The only people that would have access to your personal information would be myself (Kate Siverns), the main researcher and my research supervisor (Dr Gareth Morgan). Your personal details will be kept separately from your interview material and your name (and names of others you mention) will be changed on the script of the interview in order to protect your identity. Some direct quotes from your interview may be included in the final research report; however, care will be taken to remove any information that could potentially identify you. Whilst I would inform the healthcare professional who spoke to you about this study (and your clinical care team), about your decision to participate in the study and when this will happen, I would **not** disclose any of the information you provide during the interview. The only exception to this would be if concerns were raised about the safety of yourself or others and then it may be necessary to share your information with relevant professionals. I would always try and discuss this with you first, if possible.

Who has reviewed this study?

This study has been formally reviewed and approved by the University of Leicester and by the ethical body for the NHS. The study has received sponsorship from the University of Leicester and NHS service-users have also been able to review and subsequently approve the study. As part of the monitoring and audit processes, authorised individuals from the sponsor, regulatory authorities, or host trust sites may have access to the data from this study at any time.

What happens now?

If you do not wish to take part in this study, then you can simply destroy all the forms provided and no-one will contact you (your details have **not** been passed on to me).

If you have any questions or would like to discuss this further with me, you can contact me on the above details (the telephone number is for the University of Leicester where a message can be left for me to return your call). Please be aware that, unfortunately, I am not able to provide support and the contact details can only be used for matters related to the study. If you have decided that you would like to express an interest in participating in the study then please complete the following forms and return them to me in the stamped-addressed envelope provided so that I can make contact with you.

Check List Tick Box

The completed '**Consent to be Contacted Form**'   ☐
(I am unable to contact you without this)

The completed '**Clinician Safety Checklist Form**'   ☐
(This should have been completed and given to you by the healthcare professional who spoke to you about this study)

Thank you for taking the time to read this information

Kate Siverns   *[Photograph of*
Trainee Clinical Psychologist   *trainee]*
Main Researcher

If you have any questions or concerns about how the study is being conducted, or would like to make a complaint you can contact Dr Gareth Morgan (Research Supervisor) at: University of Leicester, Centre for Medicine, Lancaster Road, Leicester LE1 7HA ███ 0116 225 1648 / E-mail: ███████

Participant Information Sheet.   Page 3 of 3   Final Version 1.2   28/08/2018

141

Appendix W: Consent to be Contacted Form

Department of Neuroscience, Psychology and Behaviour
Doctorate in Clinical Psychology
University of Leicester
Centre for Medicine
Lancaster Road
Leicester
LE1 7HA
Tel: 0116 223 1648

UNIVERSITY OF **LEICESTER**

CONSENT TO BE CONTACTED FORM

Research Title:	A mother's experience of placing their child into care
Main Researcher:	Kate Siverns (Trainee Clinical Psychologist, University of Leicester) ███████████ ███████████
IRAS Number:	██████

By providing the information below, you are confirming that you have read the 'Participant Information Sheet' (Final Version 1.2 dated 28/08/2018) and that you are happy for me (Kate Siverns) to contact you about taking part in this study. When I phone you, you will have the chance to discuss the research further and arrange an interview date if you do choose to take part. Please note that signing this form does **not** mean that you are consenting to participate and you have the option to change your mind at any point. Also, please be aware that, unfortunately, I am not able to provide support and my contact details are given for the purposes of getting in touch to set-up interviews or to ask questions about the research.

Please confirm the following by ticking one *box* (*I appreciate some of these questions may feel emotionally difficult to answer*)**:**

I have made the decision (or come to be in agreement with the decision made) to place my child into care and I no longer have parental responsibility or contact with my child:	Yes	☐	No	☐
I have experienced mental health difficulties, OR, past experiences of trauma:	Yes	☐	No	☐
I am aged 18 or over:	Yes	☐	No	☐
I have thought about my participation in this research and feel that I will be able to talk about my experiences without this having a significantly negative impact on my mental health / well-being:	Yes	☐	No	☐
I know that it is my choice to take part in the study and that any decision I make about participation will not affect my access to support:	Yes	☐	No	☐
I am aware that the professional who first spoke to me about this research (and my clinical care team) would be informed of my participation and the date/time of my interview(s). I know that what I talk about in my interviews would **not** be disclosed:	Yes	☐	No	☐

I, *(print name)* ……., give my consent to be contacted by Kate Siverns (main researcher) regarding the above research study.

Preferred Contact Number:……

Signature:……………………………………………………………………………. **Date:**………………………………………………………

Please let me know if there are any days and times where it would more convenient to contact you:

……..

Please return this completed form in the stamped-addressed envelope provided.

Thank you for expressing an interest in this study. I will get in contact with you shortly.

Appendix X*: Participant Consent Forms (Initial & Second Interview)

Department of Neuroscience, Psychology and Behaviour
Doctorate in Clinical Psychology
University of Leicester
Centre for Medicine
Lancaster Road
Leicester
LE1 7HA
Tel: 0116 223 1648

UNIVERSITY OF LEICESTER

INITIAL INTERVIEW PARTICIPANT CONSENT FORM

Research Title:	A mother's experience of placing their child into care
Main Researcher:	Kate Siverns (Trainee Clinical Psychologist, University of Leicester)
IRAS Number:	██████
Participant ID:	.... *(completed by researcher)*

Please **initial** the corresponding boxes to confirm you agree with each statement. Thank You

Please Initial

1   I have read and understood the contents of the 'Participation Information Sheet' (Final Version 1.2 dated 28/08/2018) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered to my satisfaction.

2   I understand that my participation in this study is entirely voluntary and I can choose to stop the interview at any stage. I know that this will not affect the support I am currently receiving. I am aware that I am under no obligation to answer any particular questions and that I do not have to share any information that I am uncomfortable with during the interview.

3   I understand that if I chose to participate in one interview it does **not** mean I have to participate in a further interview. I understand that if I chose not to participate in a second interview, the information from my first interview may still be used unless I have stated that I want this withdrawn from the study.

4   I understand that if I choose to withdraw from the study, I have the right to withdraw any data associated with my involvement and I will not be required to provide an explanation. However, I understand that the option to withdraw is time-limited and that my data cannot be withdrawn if it has been over two months since the interview. I have the contact details of Kate Siverns, (the main researcher) and can contact her about this. I understand that her contact details can **not** be used to access support and are provided for the purpose of discussing research participation only.

5   I agree to my interview being recorded and then transcribed by Kate Siverns (the main researcher). I am aware that my interview data will be given a participant ID code (e.g. Interview A01) and a unique name to protect my identity.

6   I am aware that the information I provide will be handled in confidence and the only people that would have access to my information would be the research team (Kate Siverns and Dr Gareth Morgan). I understand that my healthcare professional / clinical care team will be informed of my participation in the study, but no details from my interview would be disclosed.

Initial Interview Participant Consent Form.   Page 1 of 2   Final Version 1.2   28/08/2018

143

| 7 | I understand that whilst my interview will be treated with confidentiality, Kate Siverns (the main researcher) may have to share my information with relevant professionals if there is a serious concern about my safety or the safety of others. It is only under exceptional circumstances that breaking confidentiality would not be discussed with me. | ☐ |

| 8 | I understand that data collected as part of this study may be looked at by authorised individuals from: the NHS; the Research Ethics Committee; the University of Leicester (Sponsor) or from regulatory authorities, for monitoring and audit purposes. | ☐ |

| 9 | I am aware that if I decide to receive a written summary of the research findings through the post or via e-mail, then it is possible that anyone who may have access to reading this letter or e-mail would become aware that I had participated in the study. | ☐ |

| 10 | I agree to take part in this study | ☐ |

I, *(print name)* …………………………………………………………………………………., agree to take part in this study

Signaure:……………………………………………………………**Date:**……………………………………………………….

Please delete as appropriate: I *would / would not* like to receive a written summary of the research findings which will be available from autumn 2019

Please indicate how you would like to receive this summary (if applicable) and provide the relevant details:

☐ E-mail ……

☐ Post ……

……

Name of Researcher:……………………………………………………………………………………………………

Signature:………………………………………………………………. **Date:**……………………………………………

If you have any questions or concerns about how the study is being conducted, or would like to make a complaint you can contact Dr Gareth Morgan (Research Supervisor) at: University of Leicester, Centre for Medicine, Lancaster Road, Leicester LE1 7HA 0116 223 1648 / E-mail:

Initial Interview Participant Consent Form.   Page 2 of 2   Final Version 1.2   28/08/2018

Department of Neuroscience, Psychology and Behaviour
Doctorate in Clinical Psychology
University of Leicester
Centre for Medicine
Lancaster Road
Leicester
LE1 7HA
Tel: 0116 223 1648

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SECOND INTERVIEW PARTICIPANT CONSENT FORM

Research Title:	A mother's experience of placing their child into care
Main Researcher:	Kate Siverns (Trainee Clinical Psychologist, University of Leicester) ███████████ ███████████
IRAS Number:	██████
Participant ID:	…………………………………………………………………… *(completed by researcher)*

Please **initial** the corresponding boxes to confirm you agree with eachstatement. Thank You

Please Initial

1. I have read and understood the contents of the 'Participation Information Sheet' (Final Version 1.2 dated 28/08/2018) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered to my satisfaction

2. I understand that my participation in this study is entirely voluntary and I can choose to stop the interview at any stage. I know that this will not affect the support I am currently receiving. I am aware that I am under no obligation to answer any particular questions and that I do not have to share any information that I am uncomfortable with during the interview.

3. I understand that if I choose to withdraw from the study, I have the right to withdraw any data associated with my involvement and I will not be required to provide an explanation. However, I understand that the option to withdraw is time-limited and that my data cannot be withdrawn if it has been over one month since the interview. I have the contact details of Kate Siverns, (the main researcher) and can contact her about this. I understand that her contact details can <u>not</u> be used to access support and are provided for the purpose of discussing research participation only.

4. I agree to my interview being recorded and then transcribed by Kate Siverns (the main researcher). I am aware that my interview data will be given a participant ID code (e.g. Interview A01) and a unique name to protect my identity.

5. I am aware that the information I provide will be handled in confidence and the only people that would have access to my information would be the research team (Kate Siverns and Dr Gareth Morgan). I understand that my healthcare professional / clinical care team will be informed of my participation in the study, but no details from my interview would be disclosed.

6. I understand that whilst my interview will be treated with confidentiality, Kate Siverns (the main researcher) may have to share my information with relevant professionals if there is a serious concern about my safety or the safety of others. It is only under exceptional circumstances that breaking confidentiality would not be discussed with me.

7   I understand that data collected as part of this study may be looked at by authorised individuals from: the NHS; the Research Ethics Committee; the University of Leicester (Sponsor) or from regulatory authorities, for monitoring and audit purposes.

8   I am aware that if I decide to receive a written summary of the research findings through the post or via e-mail, then it is possible that anyone who may have access to reading this letter or e-mail would become aware that I had participated in the study.

9   I understand that it is my choice if I bring an item or object, to this interview, that represents something about my experiences.

10   I agree to take part in this study

I, *(print name)* ………………………………………………………………………………………, agree to take part in this study

Signature:……………………………………………………………………**Date:**……………………………………………………………

You only need to complete this section if you wish to change your response from the one you provided at the first interview

Please delete as appropriate: I *would / would not* like to receive a written summary of the research findings which will be available from autumn 2019

Please indicate how you would like to receive this summary (if applicable) and provide the relevant details:

☐   E-mail   ………

☐   Post   …….

                ………

                ……….

Name of Researcher:……….

Signature:……………………………………………………………………………. **Date:**……………………………………………......

If you have any questions or concerns about how the study is being conducted, or would like to make a complaint you can contact Dr Gareth Morgan (Research Supervisor) at: University of Leicester, Centre for Medicine, Lancaster Road, Leicester LE1 7HA ▮ *0116 223 1648 / E-mail:* ▮

Second Interview Participant Consent Form.   Page 2 of 2   Final Version 1.2   28/08/2018

146

Appendix Y: Demographic Information Sheet

Department of Neuroscience, Psychology and Behaviour
Doctorate in Clinical Psychology
University of Leicester
Centre for Medicine
Lancaster Road
Leicester
LE1 7HA
Tel: 0116 223 1648

UNIVERSITY OF **LEICESTER**

DEMOGRAPHIC INFORMATION SHEET

Research Title:	A mother's experience of placing their child into care
Main Researcher:	Kate Siverns (Trainee Clinical Psychologist, University of Leicester) ▮▮▮▮▮▮▮▮ ▮▮▮▮▮▮▮▮
IRAS Number:	▮▮▮▮
Participant ID:	…………………………………………………………… *(completed by researcher)*

The following information will help to provide me with some of the specific details around your experiences. The information that you provide would not be linked to your interview in any way that would identify you as a participant in this study. Whilst this information would be helpful, it is ok if you choose not to answer some of the questions and please only provide details which you feel comfortable to share. Thank you.

Your age:……

Please tick the box that best describes your ethnic origin:

White British	☐	Asian / Asian British: Pakistani	☐
White Irish	☐	Asian / Asian British: Indian	☐
White Other	☐	Asian / Asian British: Other	☐
Mixed White and Black Caribbean	☐	Black / Black British: Caribbean	☐
Mixed White and Black African	☐	Black / Black British: African	☐
Mixed White and Asian	☐	Black / Black British: Other	☐
Mixed Other	☐	Chinese	☐
Asian / Asian British: Bangladeshi	☐	Other	☐

What country were you born in? ………………………………………………………………………………………………………..

Please tick the box that best describes your marital status:

Married	☐	Divorced	☐
Living with Partner	☐	Widowed	☐
In a relationship but not cohabiting	☐	Single	☐

Demographic Information Sheet.   Page 1 of 4   Final Version 1.1 (28/08/2018)

147

<u>**Questions about your Children**</u>

How many children have you given birth to?..

How many children have been placed into care?..

What type of care has your child/children gone to?

First Child:	Foster Care	☐	Adoption	☐	Living with guardian	☐	Other.....................................
Second Child:	Foster Care	☐	Adoption	☐	Living with guardian	☐	Other.....................................
Third Child:	Foster Care	☐	Adoption	☐	Living with guardian	☐	Other.....................................
Fourth Child:	Foster Care	☐	Adoption	☐	Living with guardian	☐	Other.....................................

Was the decision for your child/children to go into care made by you?

First Child:	Yes	☐	No	☐
Second Child:	Yes	☐	No	☐
Third Child:	Yes	☐	No	☐
Fourth Child:	Yes	☐	No	☐

If not, were you in agreement with the decision made OR have you come to be in agreement with this decision?

First Child:	Yes	☐	No	☐
Second Child:	Yes	☐	No	☐
Third Child:	Yes	☐	No	☐
Fourth Child:	Yes	☐	No	☐

How old were you and your child/children when they went into care?

First Child Age:.............................. Your Age:...........................

Second Child Age:.......................... Your Age:...........................

Third Child Age:............................. Your Age:...........................

Fourth Child Age:.......................... Your Age:...........................

How long has it been since they went into care?

First Child:………………………………………………………………

Second Child:………………………………………………………….

Third Child:………………………………………………………........

Fourth Child:…………………………………………………………….

Demographic Information Sheet.   Page 2 of 4   Final Version 1.1 (28/08/2018)

148

Do you have any contact with your child/children?

First Child:	Yes	☐	No	☐
Second Child:	Yes	☐	No	☐
Third Child:	Yes	☐	No	☐
Fourth Child:	Yes	☐	No	☐

If yes please indicate the type of contact and frequency:

First Child:	Face to Face	☐	Telephone	☐	Letter	☐	Other……………………………………
Second Child:	Face to Face	☐	Telephone	☐	Letter	☐	Other……………………………………
Third Child:	Face to Face	☐	Telephone	☐	Letter	☐	Other……………………………………
Fourth Child:	Face to Face	☐	Telephone	☐	Letter	☐	Other……………………………………

First Child:	Daily	☐	Weekly	☐	Monthly	☐	Yearly	☐	Other…………………………………
Second Child:	Daily	☐	Weekly	☐	Monthly	☐	Yealy	☐	Other…………………………………
Third Child:	Daily	☐	Weekly	☐	Monthly	☐	Yearly	☐	Other…………………………………
Fourth Child:	Daily	☐	Weekly	☐	Monthly	☐	Yearly	☐	Other…………………………………

Questions about your Well-Being

How long have you experienced mental health difficulties for?..

How long have you been accessing mental health services *(if you have been)*?..

Can you briefly explain your mental health difficulties *(if you feel comfortable to)?*

………..……………………………………

………

………

………

………

………

Do you feel that you have experienced a degree of trauma in your life experiences before your child/children went into care?

Yes	☐	No	☐	Unsure	☐	Prefer not to say	☐

Demographic Information Sheet.   Page 3 of 4   Final Version 1.1 (28/08/2018)

149

Could you tell me a little bit about these experiences in your own words *(if you feel comfortable to)?*

……

……

……

……

……

……

……

Thank you for taking the time to complete this form.

Appendix Z*: IPA Interview Guide

Department of Neuroscience, Psychology and Behaviour
Doctorate in Clinical Psychology
University of Leicester
Centre for Medicine
Lancaster Road
Leicester
LE1 7HA
Tel: 0116 223 1648

UNIVERSITY OF LEICESTER

IPA INTERVIEW GUIDE

Research Title:	A mother's experience of placing their child into care
Main Researcher:	Kate Siverns (Trainee Clinical Psychologist, University of Leicester)
IRAS Number:	▮▮▮▮

Note: The following questions represent a flexible topic guide and it is not designed as a prescriptive schedule. Prompts may or may not be used depending on the nature of each interview. The interviewer may also ask different questions depending on experiences and reflections that are described within answers. The first interview will be an opportunity to cover as much of this topic as feels comfortable for the participant. The second interview will allow for content to be revisited, allowing the participant to reflect upon and expand on what was previously spoken about. Further questions may also be developed from re-listening to / transcribing the original interview.

Topic 1: General Orientation

1. What made you interested in taking part in this research?

Topic 2: Circle of Support (exercise to establish some familiarity to help the individual feel more comfortable to start discussing their experiences)

2. Can we work together to briefly draw out your circle of support, to show who was in your life at the time you were pregnant with your child?
   Possible elements to cover:
   - Explore what each of these relationships were like
   - Other people's thoughts/feelings about the pregnancy

Topic 3: Parenting Expectations

3. Can you tell me about your expectations of becoming a parent?
   Possible prompts:
   - What did you think being a parent would be like?
   - How did you feel about becoming a parent?
   - Do you have a sense of where these expectations / feelings / beliefs came from? *(can ask about specific ones that may have come up)*

IPA Interview Guide.   Page 1 of 3   (Please turn over)

151

Topic 4: Experiences of Parenting

4. Can you tell me about your experiences of parenting?
   Possible prompts:
   - What was parenting like for you?
   - Were there any particular experiences of parenting that stand out for you? What was that like for you?
   - How did you see yourself as a parent?
   - What were your thoughts about parenting?
   - How did being a parent make you feel?
   - What did being a parent mean to you? How do you make sense of this?
   - Can you tell me what your relationship was like with your child? How do you make sense of this?
   - How did being a parent fit with your expectations of parenting? If it was different, how do you make sense of why it was different?

Topic 5: Experiences of Decision Making about Parental Responsibility

5. Could you tell me about your experience of making the decision for your child to go into care / into the care of another?
   Possible prompts:
   - What comes into your mind when I ask you about this experience? Any particular images / metaphors?
   - What was life like for you during the process of making this decision?
   - Thinking back to your circle of support, how did you experience these relationships in relation to this time / decision?
   - How was the decision made?
   - How did it make you think / feel?
   - When you think back to your expectations of being a parent, how do you make sense of this decision?
   - How do you make sense of your mental health difficulties / past trauma experiences?
   - How do you make sense of your mental health and trauma in relation to your experiences of parenting and the decision for your child/children to go into care?

Topic 6: Experiences of Living Away from your Child

6. Can you tell me about your experience of living apart from your child?
   Possible prompts:
   - What does this experience mean to you?
   - What has life been like for you since living apart from your child?
   - How does living apart from your child leave you thinking / feeling?
   - How did you make sense of living away from your child in relation to your expectations and experiences of being a parent?
   - How do you see yourself now in relation to being a parent?
   - In what ways do you feel different or the same as a parent?
   - What would be your hopes for the future in relation to your child and being a parent?

Topic 7: Your Experiences and Support

7. What has been your experience of support so far in relation to living apart from your child?
   Possible prompts:
   - What would it be helpful for other people to know about these experiences you have talked about today?
   - What advice would you give other people going through these experiences?
   - If another mother who had placed their child or children into care, been in the room with us today, one that had gone through similar experiences that you have, what might she admire about how you had coped? What might she take from your story?
   - How have mental health professionals talked to you about your parenting decisions? Who has been involved? What was your experience of this like?
   - What advice would you give to professionals who are working with mothers who are apart from their children?

Topic 8: Other

8. Before we finish this interview, I wonder whether there is anything else you would like you would like to tell me in relation to any of the experiences we have discussed today which you think would be important to include?

End of Interview

How has it been talking about these things today?
How do you feel now?
What will you do when you leave here?

Appendix AA: Debrief and Signposting Sheet

Department of Neuroscience, Psychology and Behaviour
Doctorate in Clinical Psychology
University of Leicester
Centre for Medicine
Lancaster Road
Leicester
LE1 7HA
Tel: 0116 223 1648

UNIVERSITY OF LEICESTER

DEBRIEF AND SIGNPOSTING SHEET

Research Title:	A mother's experience of placing their child into care
Main Researcher:	Kate Siverns (Trainee Clinical Psychologist, University of Leicester)
IRAS Number:	

Firstly, thank you for your invaluable participation in this study. If you have any further questions or concerns regarding the study after your interview, please feel free to contact me. Unfortunately, my contact details can not be used to access support and can only be used for matters related to the study. However, I appreciate that sometimes sharing personal information can be an upsetting process and you may want someone to talk to about this. It might be helpful for you to contact the professional that initially informed you about the study to seek some additional support during this time, if you feel this is necessary. Additionally, I have put together a list of contact details for organizations that might be able to advise or support you in relation to your needs.

Thank you again for sharing your very personal experiences with me

Support Type	Organisation Name	Contact Details	Contact Times
Parent–Child Separation	**Family Lives (previously known an ParentLine)** Helpline for guidance, advice and support on all matters relating to parenting	☎ **Helpline: 0808 800 2222** (free number) Skype services available	Monday-Friday 9am-9pm Saturday-Sunday 10am-3pm
	Family Rights Group Support, help and advice for families/parents who have been involved with local authority children's services	☎ **Helpline: 0808 801 0366** (free number)	Monday – Friday 9.30am-3pm
	After Adoption Support for birth parents following the adoption of a child	☎ **Helpline: 0800 840 2020** ✉ **E-mail:** actionline@afteradoption.org.uk	*details not provided on their website*
Mental Health	**Focus Line** Telephone support and information for anyone affected by mental health issues	☎ **Helpline: 08000 272 127** (free number)	Monday-Friday 5.00pm-1.00am
	Saneline Helpline which offers practical and emotional advice and support to anybody affected by mental health problems	☎ **Helpline: 0300 304 7000**	Everyday 4.30pm-10.30pm
	MIND Provides information on mental health issues and where to access help	☎ **Helpline: 0300 123 3393**	Monday-Friday 9.00am-18.00pm (excluding bank holidays)

Debrief and Signposting Sheet.   Page 1 of 2   (Please turn over)

Trauma	**The National Association for People Abused in Childhood (NAPAC)** Helpline which offers practical and emotional advice and support to anybody affected by childhood trauma	☎ Helpline: 0808 801 0331 (free number)	Monday-Thursday 10am-9pm Friday 10am-6pm
	CISters Telephone helpline for survivors of rape and/or sexual abuse	☎ Helpline: 02380 338080	24-hour answerphone service. Calls are returned within 24 hours
	Mothers of Sexually Abused Children (MOSAC) Telephone service which provides emotional and practical support for parents of children who have been sexually abused	☎ Helpline: 0800 980 1958 (free number)	Monday-Friday 10am-5pm
Emergency or Crisis	Support can be accessed via your GP and through the Accident and Emergency Department	Please make a note of your GP contact number here: ☎ ……………………………………………… For serious and life-threatening emergencies, dial 999	Monday-Friday working hours Everyday 24 hours

Other resources that you may also find useful

Websites: http://www.bravelove.org
http://rightsofwomen.org.uk/
http://survivingsafeguarding.co.uk/
http://www.frg.org.uk/ParentsForum

Books: 'A Life Let Go: A Memoir and Five Birth Mother Stories of Closed Adoption' by Patricia Florin *(can be purchased on Amazon for £11.00)*

'Adoption and Loss: The hidden grief' by Evelyn Burns Robinson *(can be purchased on Amazon for £6.49)*

Social Media: Birth Parents and Adoptive Parent Support Facebook Page

If you have any questions or concerns about how the study is being conducted or would like to make a complaint you can contact Dr Gareth Morgan (Research Supervisor) at: University of Leicester, Centre for Medicine, Lancaster Road, Leicester LE1 7HA ▓▓▓ *0116 223 1648 / E-mail* ▓▓▓

Final Version 1.1   Page 2 of 2   06/02/2018

155

Appendix BB: Sensory Prompt Sheet

Department of Neuroscience, Psychology and Behaviour
Doctorate in Clinical Psychology
University of Leicester
Centre for Medicine
Lancaster Road
Leicester
LE1 7HA
Tel: 0116 223 1648

UNIVERSITY OF LEICESTER

SENSORY PROMPT SHEET

Research Title:	A mother's experience of placing their child into care
Main Researcher:	Kate Siverns (Trainee Clinical Psychologist, University of Leicester)
IRAS Number:	

There will be some space between now and when we meet again for our second interview and we can decide together how long this may be (possibly around two weeks). The idea of this space is to give you some time to think about the questions we have covered and what we have spoken about, and also if there is anything else you would like to share with me. Sometimes it can be useful to have an item or an image that reminds you of the things we are speaking about. This may help you to remember certain things or to be able to put words to what it makes you think or feel. For the next interview, it might be helpful if you bring something like this, that might help you to talk about your experiences. Some examples of things might be:

- Photographs
- Pictures
- Objects (toys, clothing, symbolic references etc.)
- A song or piece of music
- A book or poem

We can spend some time talking about what you have brought and what this means for you at our next interview, but you do **not** have to bring anything if you do not want to. We will also talk about the same themes we covered today and anything that you have thought about in relation to this in the space between the interviews.

We will meet again on:

Date: *(insert date)* ………………………………………………………………………… **at:** *(insert time)*…………………

Where: *(insert location)* ………………………………………………………………………………………………………

If there is any problem in making this day/time please contact me either by e-mail or phone (my details are above). Unfortunately, my contact details can not be used to access support and is for the purpose of discussing research participation only. Please have a look at the 'Debrief and Signposting Sheet' I gave you if you do feel like you need to talk to someone or access some support.

It is also important for you to know that it is ok if you change your mind and decide you would rather not attend a second interview. Please let me know if you decide this.

If you have any questions or concerns about how the study is being conducted, or would like to make a complaint you can contact Dr Gareth Morgan (Research Supervisor) at: University of Leicester, Centre for Medicine, Lancaster Road, Leicester LE1 7HA   0116 223 1648 / E-mail:

Appendix CC: IPA Approach to Data Analysis

The analysis process, detailed below, followed the guidelines outlined by Smith, Flowers & Larkin (2009). Although there are defined stages, the analysis process was not linear and was instead seen as an iterative and inductive cycle that maintained a phenomenological orientation.

Stage	Process
Reading and re-reading	The first transcript was read multiple times by myself whilst listening to the audio recording of the interview. This helped me to become immersed in the data. During this stage, I used free coding to note down my initial thoughts and feelings, and any of my curiosities or pre-conceptions of the interview data.
Initial coding	This stage involved the close line-by-line coding of the transcript. Exploratory comments were noted in the right-hand margin focusing on the descriptive, linguistic and conceptual features within the participant's account. Descriptive analysis referred to content-related information such as key events and experiences that were seen as important to the participant. Linguistic analysis attended to the language used by the participant and conceptual analysis focused on interpretive and inquisitive engagement with the data. I used coloured pens to differentiate between the different codes in my exploratory comments. I also included my own thoughts and considerations and hypothesised meanings in the context of the participant's account of their experiences.
Developing emergent themes / patterns of meaning	I then moved on to critical consideration and interpretation of the exploratory coding, which led to the grouping of initial codes into emergent themes. Developing emergent themes was viewed as trying to capture the 'psychological essence' of the data. This involved searching for patterns of meaning at a more abstract level and attempting to capture pertinent chunks of data and consider the meaning and importance of this in the context of the participant's world. This process enabled me to introduce my own interpretations and reflections of the participant's sense-making. It was important at this stage, for me to be aware of not staying too 'narrow' and descriptive of the data and to try and start deepening my interpretations at a conceptual level, whilst being fore-grounded in the original data (Larkin, Watts & Clifton, 2006). Emerging themes were noted in the left-hand margin.

Looking for patterns across emergent themes	Once I had established the emergent themes, the next step involved exploring the connections and patterns of meaning across emerging themes to develop theme clusters. Emerging themes were typed up and printed out so they could be moved around to enhance visual mapping of how they might fit together. Theme clusters were developed through abstraction; comparison; polarisation; frequency; contextualisation; and functional meanings. This process involved staying quite close to the original data and participant quotes were used to reflect back to the initial codes. Once emergent themes had been collapsed into theme clusters, they were given names which reflected the meaning and quality of the cluster and then a case summary for the participant was produced. As each participant was interviewed twice, the two interviews were initially analysed separately. Emerging themes were then brought together and consolidated into a single case summary. Finally, a brief idiographic narrative was written for the participant in order to ensure important aspects of concern were retained within the analysis.
Repetition of process with the other transcripts	The previous stages were then repeated with the subsequent transcripts. It was important for me to adopt an open-mind during this process to maintain a commitment to the idiographic experiences of each participant.
Looking for patterns across cases	Once this process had been repeated for each participant, I completed a cross-case analysis of the theme clusters. This involved looking for patterns and relationships across the cases and considering how each participant's experiences related to the others. Themes were reconfigured to reflect group level themes whilst attempting to capture the idiosyncrasies of individual cases. This was a visual process and I used coloured post-it's to manipulate the themes and ensure that all participants were represented.
Translating the themes into a narrative account	The patterns and relationships across cases were considered at an increasing level of abstraction, leading to the formation of superordinate and subordinate themes. I then organised these themes into a narrative account, which facilitated a further level of interpretation.

References:

Larkin, M., Watts, S. & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative research in psychology*, *3*(2), 102-120.

Smith, J. A., Flowers, P. & Larkin, M. (2009). *Interpretative phenomenological Analysis: Theory, Method and Research.* London: Sage.

Appendix DD*: Process of Analysis

1. The below pictures shows an example of line-by-line coding and emerging theme development taken from Claire's interview

Emergent Themes | **Transcription: Claire** | **Exploratory Comments**

(handwritten top annotations) providing children seen as culturally important

sexual abuse normalised within community

Emergent Themes (left margin):

disempowerment
culturally within
community
– harder to make
change

Children as
not "hers"

– not
attached:
physically /
psychologically /
emotionally

Active decision to
stop having children
→ no longer passive in that respect

~~(scribbled out text)~~

Feelings as
unsafe?

– opt for knowledge

The unknowing
mother
+ knowing "had to" not
"how to"
being left with
children that
didn't belong to her

Transcription (centre):

disempowered by
community

126 lot of religious things going on, there was no birth control, the

she doesn't connect with banned

127 relationship consisted of a lot of, erm… well its rape basically,

matter of
fact

128 you know. Not that I ever held that against the children, that's

→ contradiction with not being maternal

129 funny enough I didn't, that's not where this stems from, and…

hard to believe herself?

end of
journey takes control

130 but then in the end I gave him, I gave him his boy and things

instant? dawning

131 still didn't change (clicks finger) then I stopped having

↳ from a place of hindsight

132 children, I think that's very telling. Still nothing changed and

act of resistance

133 then I secretly went on birth control then erm… big no-no that,

134 but no, but thankfully nobody ever found out, and then when

breaking the rules – threat from
community

135 the children were five, four and three he died. So, then I was

end of threat?

abandoned? → not mine →

136 *leftt* with these three children that these three human beings

sense of
responsibility

137 that I didn't know anything about, I just knew that, that's when

138 the drinking started and… I just knew that I had to, I knew I

had to cope with new situation

139 had to take care of them and that's why I said the physical

10

Exploratory Comments (right):

having to comply with imposed religious beliefs

Relationship framed with abuse
depersonalised → no "him" or "me"   important for
her that didn't
take this out on children

logical stance of children not being accountable for
father's actions "The" children, not mine!

strange turn of phrase: Not funny! hard or strange
for her to believe this was the case of all the things
found difficult in parenting & relationship with children
this wasn't

stems from deeper/earlier place

Became more Active & less passive in decision-making
Realisation of truth – children not leading to change

Desicion as being powerful & informative → picture
paints a thousand words

secrecy of decision – giving up trying to solve situation

couldn't tell anybody → being alone with the desicion
+ in the community [Isolation]

becoming a single-parent in context or not feeling
like a parent to begin with

sense of being left with something that doesn't belong
to her

Knowing but not really knowing? revert to knowledge
left → alone → angry at this? rather than feeling

knowing vs not knowing → knowing in essence what
to do e.g. take care of them, but not knowing what
this means, what this looks like or how to do this

Bottom annotations:

this being
obvious
knowing had to
another problem not how to
Isolation

threat from husband no longer present, but then became
left with the children → end of one problem, start of another.

Absence of talking about
how this situation left her feeling

160

Key
Descriptive Comments: orange
Linguistic Comments: green
Conceptual Comments: purple

Emergent Themes

Transcription: Claire

Exploratory Comments

→ enough for children?
enough to show others?
over-exageration?

substituting practicalities for emotion
└ everything else was made perfect to compensate
└ hope this would be good enough

pain in acknowledging "emotional damage" towards children – reinforcing failure

Broken inside
unable to feel as a mother
└ nothing emotionally left to give children

Empty shell

Loss of hope
– time as unchanging

140 things I did for them were perfect, they were clean, outwardly I

141 thought that that would be enough and... I didn't think about

did all she could

142 how emotionally I was damaging them because I just... I

hard to express

143 often, I often describe it as you know like staring down at this

→ feeling as powerless as the "little person" → cant understand/meet their needs

144 little person thinking, 'what do you want?'... you know, I,

rather than her child

145 'you're clean, you're dressed, I've just fed you, WHAT MORE

Practicalities taken care of

146 DO YOU WANT?', you know, now go and play and, and I can

└ constant feeling failure

147 have a drink now because my soul is so destroyed and

148 crushed that, I have no feelings to give you, at all, so on you

nothing inside- emptiness

149 go, on you go and play with your lego that's a year older than

150 you are because it's a little bit more difficult and it makes you

pain of constantly being asked to give something that you dont have

151 concentrate more and then you don't bother me, you know. I

contact with children
unbearable

152 was very, very detached, and still am from them, still am very

negative

153 much so, it never came.

loss of future
↓
Sadness — never found her
└ forever lost

11

outwardly perfect. Importance of outward perception of being a mother –easier to do this
practically fulfilling role as mother aspect of parenting
playing the role ▪▪ of mother, but not connecting with this role
ownership of difficulties
aware but couldn't acknowledge? avoided thinking about this?

Child described as same way you might describe a stranger
not knowing own child → who they are or what they need
→ anger, frustration associated with this

→ point of no return → unrepairable → fear of feeling for children?
black, dead, absent! → runed by other people
not withholding → absence of feelings + meaning there nothing to give children emotionally → empty inside
toys becoming a substitute for parent
contradiction between awareness of emotionally damaging children but also not understanding / knowing what they need.
Avoiding the emptiness felt with children
practicalities is all that can be offered + they are done "perfect" → substitution for what cannot be given

time as not changing
expecting things to change + feelings to come? Hope is lost
waiting for something to happen/change. still waiting to feel like a mother?
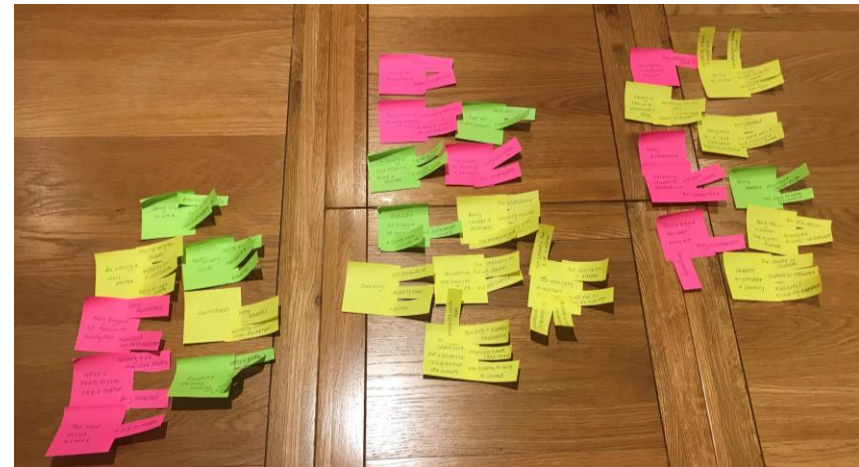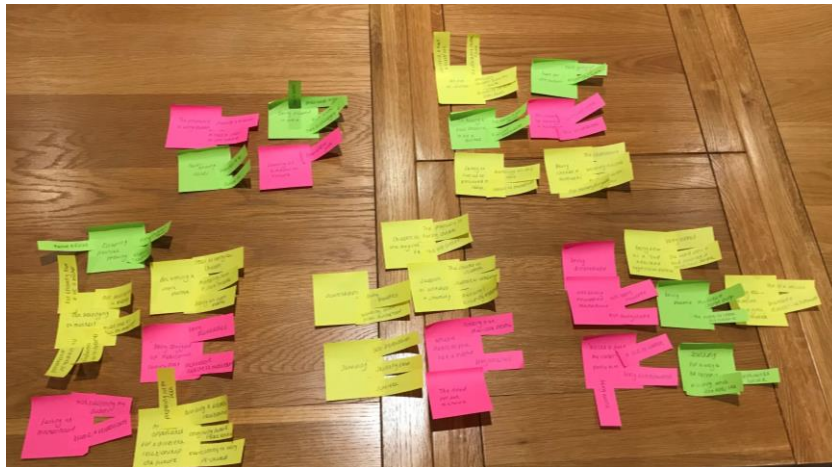
161

2. The below picture shows an example of looking for patterns and connections across emergent themes for Claire. This was visually mapped to explore how themes might fit together or contrast. Emergent themes were then tentatively clustered.
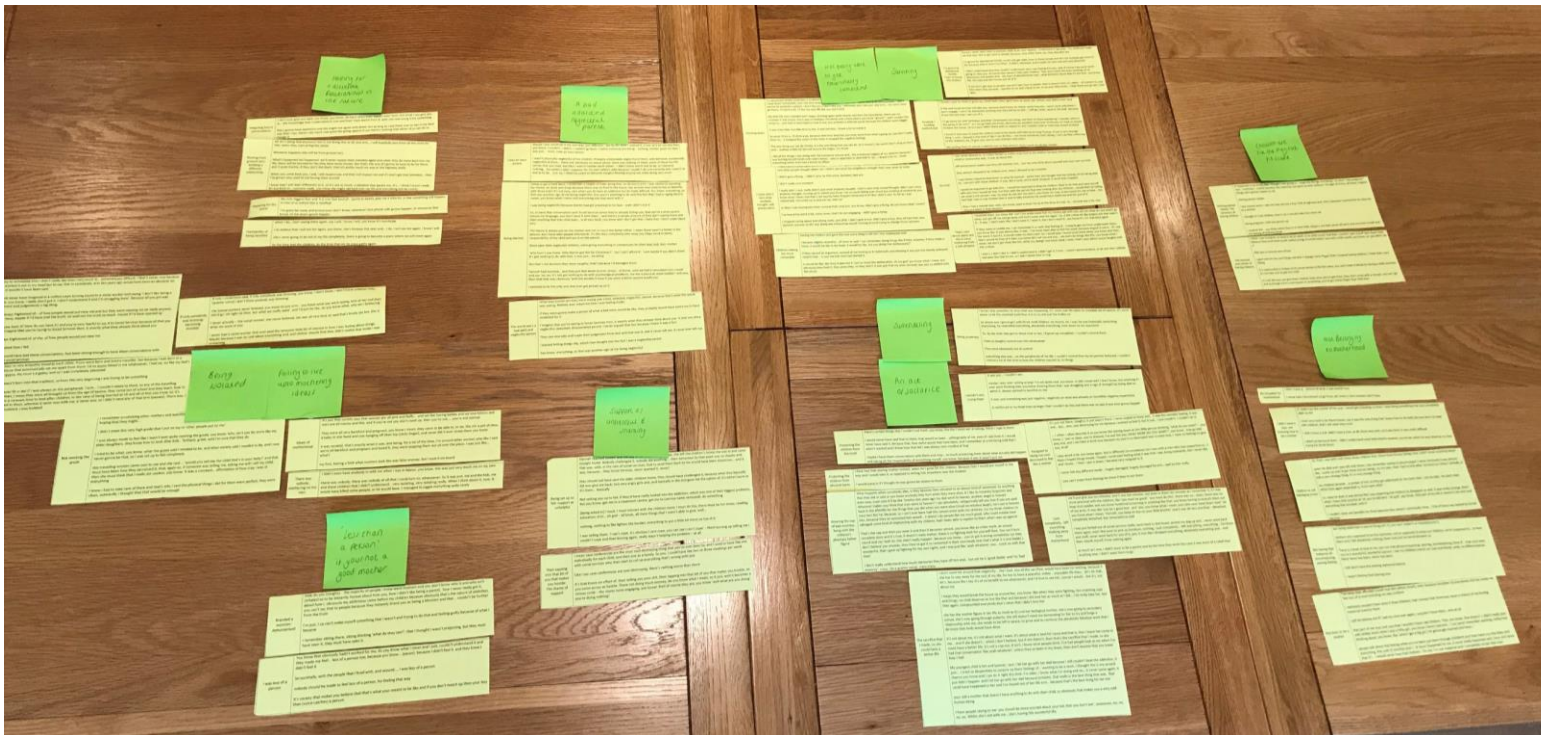
3. The below table is an example from Claire's case summary where emerging theme clusters from both her interviews were consolidated into a single case summary.

Cluster Title	Emergent Themes	Transcript Excerpts	Page/Line
Not belonging to motherhood *This theme cluster is concerned with how Claire came to view herself as being un-maternal, due to not being able to obtain an "all-compassing, searing, overwhelming" love for her children. She seemed to locate this as being innately within her. There is almost a sense of her feeling that she shouldn't have had children as she believes she wasn't born to be a mother*	Not having that maternal all-encompassing, searing feeling	but being maternals a natural thing isn't it, you can't make it or manufacturer it	58 / 804-805
		mothers are supposed to be the nurturers, we're supposed to enjoy our children, we're supposed to... to love them and I felt absolutely nothing, there was just no bond between us	4 / 50-52
		There is a level of love in me, just not that all-encompassing, searing, overwhelming, kind of... that your won, you're a wonderful, wonderful person. I see my children exactly as I see everybody, yeah, no differentiation, there never has been, never has been	26 / 362-367
		I wasn't feeling that searing love	32 / 442-443
	Not born to be a mother	I've never ever afforded myself that title before [mum], ever	102 / 1419
		I definitely wouldn't have done it [had children], had I known that there was never a chance of me feeling maternal towards them	22 / 297-299
		I still do believe and if I had my time over again, I wouldn't have them... erm at all	114 / 1581-1583
		that part of me now, just says that I wouldn't have had children. That, you know, that doesn't, I didn't really play with dollies much when I was a little girl, you know I never had erm... I can never remember wanting, really ever thinking about, you know, like 'when I get a big girl, I'm gonna get married and have...'	132 / 1824-1829
		people talk about this feeling when you've been just been through childbirth and they hand you this baby and everything, this rush of emotion and I... it never happened for me, it never really happened and I have said since that if I... I would never have had children. I'm not, I'm not maternal and I completely accept that now	4 / 55-60
	No template for motherhood	I didn't have a... picture of what a real mother was	117 / 1628
		I never had a benchmark to go from, all I knew is that mothers don't love	38 / 520-521

4. The below pictures are an example of looking for patterns and relationships across the cases as part of the cross-case analysis. Clusters of meaning were written onto the larger post-it notes, which were colour coded for each participant. The emergent themes that contributed to the theme cluster were written onto the smaller post-it notes and placed onto the theme cluster. This allowed for them to be moved and re-developed as the analysis evolved. The theme clusters were then visually mapped to explore how themes might fit together or contrast. The left-hand picture depicts an earlier tentative grouping of themes and the right-hand picture depicts a more developed illustration of cluster groupings that were more defined and closer to the final three superordinate themes.

5. The below table shows an example of superordinate theme development

<table>
<tr>
<td colspan="2">

'I wish I could turn back the clocks': Living with feelings of failure and shame

This theme is concerned with how the mothers all experienced an underlying sense of failing at motherhood which was associated with feelings of guilt and regret and a desire to be able go back and do things differently. There was a deep sense of intrinsic shame that permeated the mothers' narratives in relation to their perceived failings, which seemed to be both explicitly and implicitly difficult to talk about. There was an unbearable pain associated with feelings of failure that the mothers desperately tried to escape from

</td>
</tr>
<tr>
<td>

'It's painful to think about': The guilt of failing at motherhood

This theme captures how the mothers experienced an underlying sense of failing at motherhood and how mothers experienced strong feelings of guilt and regret in relation to this

</td>
<td>

Not knowing how to be a mother
Not feeling fully-equipped for motherhood
Failing at motherhood
Being to blame
Haunted by fear
Living with guilt and regret
Taking blame and responsibility

</td>
</tr>
<tr>
<td>

The unspeakable shame

This theme relates to how all the mothers alluded to not being able to talk about their mothering difficulties and the experience of their child going into care. This seemed to be intrinsically linked to a sense of shame associated with feelings of failing at motherhood, which was thought of as being unspeakable

</td>
<td>

Difficult emotions are not spoken about
The unspeakable
Underneath hidden feelings
The unspeakable
The crime of not being a good mother

</td>
</tr>
<tr>
<td>

Escaping the pain of failing

This theme encapsulates how the mothers seemed to cope with their intolerable feelings of pain and shame, that were linked to perceiving they had failed their children. There was an overwhelming need to avoid or escape the pain of these feelings

</td>
<td>

Shutting down
Escaping painful feelings
Escaping motherhood
Self-preservation and survival

</td>
</tr>
</table>

Key:
Blue Text – Claire Theme Cluster
Green text – Stacey Theme Cluster
Red Text – Nina Theme Cluster

Appendix EE*: Chronology of the Research Process

Research Stage	Timescale
Consultations with Research Supervisor and Clinicians in Related Fields	January – May 2017
Development of Initial Research Proposal	April – May 2017
Internal Panel Review of Research Proposal	June 2017
Refinement of Research Proposal and development of Research Materials	June – August 2017
Peer Review of Research Proposal	August 2017
Service-User Reference Group (SURG) Review of Research Proposal	September 2017
Further Refinement of Research Proposal and Research Materials	September – November 2017
Obtained Approval for Research Costs	November 2017
Obtained Research Sponsorship from the University of Leicester	December 2017
Submission of Integrated Research Application System (IRAS) form for REC and HRA Review	December 2017
Favourable Opinion from REC Received	February 2018
HRA Approval Obtained	March 2018
Approval from R&D teams at Recruitment Sites	March – August 2018
Submitted Non-Substantial Amendment (incorrect IRAS number on some of the research materials)	March 2018
Participant Recruitment and Data Collection	April – December 2018
Submitted Non-Substantial Amendment (added more recruitment sites)	August 2018
Submitted Substantial Amendment (widening inclusion criteria to assist with recruitment)	September 2018
Transcription and Analysis of Data	October 2018 – April 2019
Write-Up of Thesis Manuscript	January – May 2019
Thesis Submission to the University of Leicester	May 2019
Preparation for Research Viva	May – July 2019
Research Viva	July 2019
Dissemination of Findings	June – September 2019
Preparing Poster	August – September 2019
Poster Presentation at the University of Leicester	September 2019

Appendix FF*: Quality Framework

The current research used four essential criteria developed by Yardley (2000) as a guide to maintaining high quality standards and validity at different stages of the research journey, which are summarised and discussed below:

Sensitivity to Context

Sensitivity to the theoretical and clinical context of the study was considered throughout the research process via: Exploration of existing literature; peer-review processes; and thoughtful consideration of ethical issues enabling the research to be conducted in an ethical and sensitive manner. I specifically considered sensitivity in relation to data collection and how the interview might be experienced by participants. The importance of developing a therapeutic rapport and creating a warm, empathic and non-judgemental space were held in mind throughout the research process. This helped me to ensure that data collection, analysis and write-up of the participants' experiences were meaningfully and sensitively contextualised.

Commitment and Rigour

I undertook training by attending two applied IPA workshops (facilitated by Fiona Holland and Michael Larkin) to develop skills and competencies in the application of an IPA methodology, with specific focus on analysis. These workshops offered the opportunity for peer scrutiny and helped to ensure rigour within the data analysis. Commitment to the methodology was further achieved by engaging in regular supervision with a research supervisor familiar with IPA methodology. I was able to explore my initial responses to the interviews, as well as discuss all stages of analysis from initial coding to the development of superordinate themes in research supervision. This enabled the analysis to be critically reflected upon and ensured I was not being overly descriptive, but also that interpretations were grounded in experiential claims.

Transparency and Coherence

In qualitative research, the researcher's personal experiences and values invariably influence the process of meaning-making and research findings (Willig, 2013). Therefore, reflexivity on behalf of the researcher is essential and I kept a reflective journal throughout the research journey to document expectations and assumptions about the phenomenon, as well as reflections during the data collection and analysis process. Reflexive issues were also discussed within research supervision. Transparency was maximised by keeping an audit trail of the research process. All themes were evidenced with quotations from participants to illustrate how findings were grounded within the data (Smith, Flowers & Larkin, 2009).

Impact and Importance

The impact and importance of the research was thoroughly considered, especially in the initial proposal of the study. Engagement with the existing literature, consultation with professionals working with both birthmothers and looked-after children, as well as feedback from the service-user reference group, highlighted its clinical utility. Future clinical considerations and implications for future research have been proposed as a result of conducting this study. Plans for academic and clinical dissemination have been outlined to ensure that impact is maximised, which was considered of significant value in relation to giving this marginalised group of mothers a voice.

References:

Smith, J.A., Flowers, P. & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research.* London: Sage.

Willig, C. (2013). *Introducing qualitative research in psychology (3rd Eds).* England: Open University Press.

Yardley, L. (2000). Dilemmas in qualitive health research. *Psychology & Health, 15*(2), 215-228.

Appendix GG*: CASP Checklist

CASP Criteria	Checked
Was there a clear statement of the aims of the research?	✓
Is a qualitative methodology appropriate?	✓
Was the research design appropriate to address the aims of the research?	✓
Was the recruitment strategy appropriate to the aims of the research?	✓
Was the data collected in a way that addressed the research issue?	✓
Has the relationship between researcher and participants been adequately considered?	✓
Have ethical issues been taken into consideration?	✓
Was the data analysis sufficiently rigorous?	✓
Is there a clear statement of findings?	✓
Is the research considered of value?	✓

References:

CASP. (2018). Critical Appraisal Skills Programme. *CASP Qualitative Checklist.* Available via: http://www.casp-uk.net/casp-tools-checklists (last accessed 21st February 2019)

Appendix HH*: Extracts from Reflexive Journal

This appendix contains short extracts from my reflective journal that I kept throughout the research process.

Reflexive comments during recruitment process

Recruitment for this study has been challenging. Whilst I anticipated that this would not be an easy study to recruit for, I had assumed this would be due to the lack of mothers who had been though (or could openly acknowledge going through) this experience, or alternatively that not all mothers would be keen to talk about this experience. However, I found myself surprised at how difficult it has been to try and gain access to this group of mothers through gate-keeping services (e.g. mental health teams). When contacting a charity devoted to supporting mothers who have become separated from their children, I found myself frustrated by their response that they only support mothers who are unjustly separated from their children. This made me think of how a mother who had made the decision to place their child in care might have felt if they had reached out to this charity for support. When approaching clinicians to help support recruitment, I was stuck by how one particular inclusion criteria was often not held in mind*: 'Mothers must either have made the decision for their child to be placed into care or been in agreement with the decision made'.* On several occasions clinicians responded to my e-mail indicating that they knew of a mother who had no contact with their child, who was in care, who could be potentially approached for research participation. However, it was unclear whether this had been decided (or agreed) by the mother. This made me wonder about whether there was space for such conversations within clinical encounters. For example, whether it would even be considered that mothers might have actively made, or been in agreement, with this decision. Or would such questions about the experience simply not be asked because they are not held in conscious awareness? And if the questions are not asked what might that mean for mothers? Alternatively, I also got several responses from clinicians who were working with mothers whose children were in care, but this was not with the consent of the mother. Whilst I am not disputing that this isn't the reality, this also made me wonder if these conversations had taken place and if assumptions around this experience might also

play a part. I also wondered, given the stigma around this experience, if not directly asked, would mothers be able to voice any thoughts/feelings around this experience that are potentially seen to be 'different' to how a mother might be expected to feel in this circumstance.

Reflexive comments during interviews

I arrived early for my first interview with Claire due to being unfamiliar with the service. After I had found the room and prepared what was needed for the interview, I was waiting for several minutes. During this time, I became aware I could hear the muffled sounds from the waiting room and could make out the noise of a young child running up and down. I also noticed a poster on the wall of the interview room encouraging parents to ensure their children were vaccinated. There was a picture of a small child on the poster and I deliberated whether I should take this down for the interview. I found myself feeling apprehensive about these 'reminders of motherhood' being present whilst completing the interview. Once the interview had commenced, I seemed to forget about my initial concerns, likely because Claire did not seem to express any discomfort, or possibly even notice these 'motherhood reminders'. When I reflected on this after the interview, I thought about the impossibility of being able to remove or hide all traces of motherhood from someone's existence. Motherhood is everywhere. This made me wonder what it must be like for the mothers to live in a world that is dominated with constant reminders. It also made me think about my possible over-reaction to this and how this might have reflected an inner desire of mine to avoid or hide from the anticipated pain of this experience.

Reflexive comments during analysis

I had anticipated finding the interviews emotionally challenging and draining but had found this generally not to be the case. I came to understand this as being linked to how the mothers either avoided talking about the pain of their experiences or how they were emotionally disconnected from their stories, telling them in a very matter-of-fact fashion. I experienced more of an emotional connection when completing the analysis

and during the process of becoming immersed in the data. I often found myself quite moved during the exploration of the mothers' accounts. This made me think, in particular, about what Claire had said in relation to social workers not being tapped into her feelings: *"Maybe because I was so cold about everything and, and clinical, maybe that they didn't realise that inside I was screaming"*. Whilst I had certainly experienced Claire as a warm human-being, I had also been someone else who had not been able to reach her pain during our interaction. I considered if this might be in part due to the time lapsed since her children had gone into care and some of this being possibly more resolved in the present. However, the pain and poignancy of her experiences were certainly present in the analysis. I wondered whether this was due to my own barriers being potentially more present within the interview, where it was more possible to hide behind a professional status as a researcher and Trainee Clinical Psychologist, than it was completing the analysis unguarded at home. I also wondered whether this also partly reflected just how deep this pain needed to be buried, and how this could only be accessed if you were completely connected or immersed with the person and their experience.

Appendix II: Contributions to Themes

Superordinate Theme	Subordinate theme	Claire	Stacey	Nina
A fractured sense of motherhood	*'There was just no bond between us': Being disconnected*	✓	✓	✓
	Letting go and holding onto motherhood: Liminal mothers	✓	✓	✓
'I wish I could turn back the clocks': Living with feelings of failure and shame	*'It's painful to think about': The guilt of failing at motherhood*	✓	✓	✓
	The unspeakable shame	✓	✓	✓
	Escaping the pain of failing	✓	✓	✓
'Less than a person': Becoming nothing and no-one		✓	✓	✓