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# The prenatal maternal representations of mothers at risk of recurrent care proceedings in the Family Drug and Alcohol Court: A thematic analysis

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**Abstract**

**Background:** A substantial number of birth mothers experience repeat removals of their infants and children due to child protection concerns. The perspectives of mothers going through repeat removals and their experiences of pregnancy are insufficiently researched.

**Aims and methods:** The current qualitative study aimed to explore the maternal representations of five pregnant mothers at risk of recurrent care proceedings. A thematic analysis of these mothers' responses to the Pregnancy Interview focused on their representations of themselves as mothers, of their babies, and of the mother–baby relationship.

**Results:** Seven key themes were identified: (1a) "Uncertainty and fear of losing the baby," (1b) "Uncertainty but hope of becoming a mother," (2) "Not wanting to be like their own mother," (3) "Experiencing recovery and pregnancy as two interdependent processes," (4) "Struggling to imagine the baby," (5) "The omnipresence of previous children," (6) "Pleasure at starting to have a connection with the baby," and (7) "Noting the baby's dependency."

**Conclusion:** The results are clinically relevant as they highlight grief, maternal self-identity, recovery from substance abuse, and ability to manage uncertainty as critical areas of intervention for these mothers.

KEYWORDS
care proceedings, mother–infant relationship, Pregnancy Interview, prenatal maternal representations

## 1 | INTRODUCTION

### 1.1 | Mothers in recurrent care proceedings

A highly vulnerable and marginalized population of at-risk mothers repeatedly loses care of their children through care proceedings following child protection concerns (Cox, 2012). Between 2007 and 2014, a quarter of the 43,541 mothers in care proceedings in England returned to court for further care proceedings (Broadhurst et al., 2015, 2016). Internationally, too, the scale and patterns of repeat removals are worrying. The majority of removals—often at birth—are of infants (Broadhurst et al., 2016; Taplin

& Mattick, 2015). Intervals between successive maternal pregnancies are typically short (Broadhurst et al., 2015, 2016; Wright, Schuetter, Fombonne, Stephenson, & Haning III, 2012). To date, there has been no concerted service response to repeat removals or the needs of birth mothers following care proceedings (Broadhurst & Mason, 2013; Cox, 2012; Novac, Paradis, Brown, & Morton, 2006). Child removals have been linked to subsequent pregnancies in various high-risk samples. Novac et al. (2006) suggest that the rapid subsequent pregnancies of young homeless mothers often occur to replace lost babies. Grant, Graham, Ernst, Peavy, and Novick Brown (2014) found removing a child from the care of substance-abusing mothers increased the odds of a subsequent birth twofold.

Broadhurst and Mason (2013) highlight that mothers experiencing repeat removals have almost invariably suffered adversity during their own childhoods, including neglect, abuse, abandonment, and socioeconomic disadvantage. With adequate support, however, fewer mothers have subsequent births or subsequent substance-exposed births (Grant et al., 2014; Ryan, Choi, Hong, Hernandez, & Larrison, 2008), more mothers achieve substance abuse recovery, and more families are reunited (Harwin et al., 2011). Imagining a future with previous children (Broadhurst & Mason, 2014) or a new pregnancy (Kissin, Svikis, Morgan, & Haug, 2001) also provides mothers with a strong motivation for recovery.

The above research suggests a pattern of repeat "replacement" pregnancies (Grant et al., 2011, p. 2184), which could be prevented through appropriate intervention. The profiles of mothers are, however, divergent, with some recovering from difficulties after child removal, and others experiencing recurrent removals (Broadhurst et al., 2016). The findings highlight the need to differentiate qualitatively between mothers in recurrent care proceedings and the need to explore the mechanisms and personal meanings of repeat pregnancies for such mothers.

**Key findings/implications**

1. For mothers who have gone through previous care proceedings, managing grief about previous children lost to care constitutes a critical and live area of intervention during the new pregnancy.
2. Pregnant mothers who have repeatedly lost children to care can get in touch with the unborn baby's dependency on them, providing further opportunity for reflective parenting interventions.
3. Pregnant mothers at risk of recurrent care proceedings are in touch with feelings of extreme uncertainty with respect to their unborn babies' future care, meaning adequate support systems are essential for maximizing their chances of retaining care of the new-born baby. Pregnancy can motivate substance misuse recovery.

**Relevance to infant mental health**

Pregnant mothers who have repeatedly lost children to care are often deemed to be at high risk of losing their unborn babies to the care system after birth. Those infants who are removed at birth are likely to experience further and repeated caregiver separations. Understanding the states of mind of these mothers during pregnancy is vital to exploring their potential for recovery and to improving the chances of non-removal of subsequent newborns. Insights in this area are crucial to tailoring support for this group of mothers, which in turn is vital to improving infant mental health at the earliest stages after birth.

## 1.2 | Disenfranchised grief and identity

Although not widely discussed in the public domain, the grief that mothers experience when their children are removed is increasingly acknowledged (Aloi, 2009; Charlton & Oliver, 1998). This grief can remain unresolved for decades if it is socially unrecognized or maternally suppressed (de Simone, 1996; Henney, Ayers-Lopez, McRoy, & Grotevant, 2007; Novac et al., 2006). From the perspective of these mothers, professionals often pay insufficient attention to the effect of child removal on their well-being (Memarnia, Nolte, Norris, & Harborne, 2015). Indeed, Robinson (2002) argues that the grief of these mothers goes largely unacknowledged and can be labeled as "disenfranchised." "Disenfranchised grief" follows a loss that remains socially ignored and that cannot therefore be mourned openly by the griever (Doka, 2002). Responding to this lack of acknowledgment, mothers find different ways of dealing with their pain. In Broadhurst (2015b), one mother describes how: "it broke me, I couldn't wake up in the morning I was so full of drink and drugs after they took him" (p. 301). As a result, substantial harm may also arise for children in care who witness the ongoing emotional turmoil of their mothers during contact (Richardson, 2015).

In addition, the experience of losing a child to care constitutes an enormous challenge to these mothers' self-identities (Broadhurst & Mason, 2013). Memarnia et al. (2015) suggest that some mothers see themselves as part-time mothers who only assume their maternal identity during contact with their children. Renegotiating who they are outside of that contact is often a struggle.

As yet, it is insufficiently understood if rapid repeat pregnancies occur because of, or despite, the grief and identity-seeking of such mothers. Consequently, their mental states during new pregnancies are of considerable interest and importance.

## 1.3 | Pregnancy and prenatal maternal representations

Pregnancy is widely accepted as a period of enormous psychological and physiological change. Importantly, for mothers who become pregnant in a state of psychological vulnerability, pregnancy can constitute an emotional crisis in itself (Pines, 1993; Slade, Cohen, Sadler, & Miller, 2009). As the thoughts, feelings, and fantasies a mother holds of herself and her baby during her pregnancy are powerful in shaping the emerging mother–baby relationship, such an emotional crisis can have long-term repercussions for both (Fraiberg, Adelson, & Shapiro, 1975; Raphael-Leff, 2010). Widely labeled "prenatal maternal representations," these thoughts, feelings, and fantasies are thought to arise from a mother's memories of her "early relationships, her fantasies, hopes, fears, family traditions, myths, and personal experiences" (Pajulo, Helenius, & Mayes, 2006, p. 232).

Numerous studies have demonstrated the negative impact on prenatal maternal representations of certain psychosocial risk factors. Domestic violence (Huth-Bocks, Levendosky, Theran, & Bogat, 2004), an unplanned pregnancy (Pajulo et al., 2006), prenatal depressive symptoms (Ahlqvist-Björkroth et al., 2016; Pajulo, Savonlahti, Sourander, Piha, & Helenius, 2001b), interpersonal trauma (Schwerdtfeger & Nelson Goff, 2007), low socioeconomic status, single motherhood, a family psychiatric history, a history of alcohol or substance abuse, antisocial behavior, loss, separation or abortion, and the absence of social support (Ammaniti, Tambelli, & Odorisio, 2013; Pajulo et al., 2001b; Smaling et al., 2015) are all associated with more negative prenatal maternal representations. Prenatal maternal representations might be an indicator of a mother's future ability to accurately understand and hence to respond to her infant's needs and emotions, given that they influence postnatal mother–child interactions (Smaling et al., 2016) and postnatal attachment classifications (Benoit, Parker, & Zeanah, 1997; Fonagy, Steele, & Steele, 1991) in both low-risk and high-risk samples. For mothers who have themselves suffered child abuse and neglect, prenatal representations are concordant with subsequent mother–child attachment styles, with 83% of dyads rated as insecure (Berthelot et al., 2015). Importantly, two studies show that prenatal maternal representations are more negative among mothers whose children have subsequently been removed and placed into foster care (Conte, Mazzoni, Serretti, Fundarò, & Tempesta, 1994; Pajulo et al., 2012).

## 1.4 | Birth mothers' voices

The above research on prenatal maternal representations focuses on analyzing formal features of interviews, for example, narrative (Ammaniti & Tambelli, 2010), coherence (Fonagy, Steele, Steele, Moran, & Higgitt, 1991), positivity and negativity (Ammaniti & Tambelli, 2010; Ilicali & Fisek, 2004), or a mother's ability to think about her own and her baby's needs (Slade, Patterson, & Miller, 2007). That is, rather than reporting "what" mothers said, what was assessed was "how" it was said. Both the formal aspects and the content of these mothers' representations can be influenced by past relationships (Schechter et al., 2005). Thus far, however, only one study has thematically explored prenatal maternal representations—that of Sadler, Novick, and Meadows-Oliver (2016) who undertook a thematic analysis of pregnant adolescents' responses to the Pregnancy Interview (Slade, 2007). This found that themes mirrored the particular developmental challenges of these very young mothers, in terms of the array of emotions during pregnancy, and their changing identities. Baradon, Fonagy, Bland, Lénárd, and Sleed (2008) also used a thematic analysis of maternal representations (albeit postnatally) in mothers in mother-and-baby-units in UK prisons—a unique high-risk population. They, too, found that certain themes distinctly reflected the unique contextual attributes of this maternal sub-group.

## 1.5 | Aims

The above review illustrates that the perspectives of pregnant mothers who have experienced repeat child removals have seldom been the focus of research. Their prenatal representations are, nevertheless, both clinically and theoretically relevant. The current study therefore aimed to analyze thematically the prenatal representations of pregnant mothers who had experienced repeat removals and who were, as such, at risk of further care proceedings. More specifically, it aimed to analyze these mothers' representations within three relevant categories highlighted in the literature: the mothers' representations of themselves as mothers, of their unborn babies, and of the current

and future mother–baby relationship. As evidenced above, analyzing maternal representations thematically can highlight idiosyncrasies in unique maternal sub-groups. Broadhurst and Mason (2014), moreover, have advocated the use of birth mothers' self-report data in the quest to respond to the "scant coverage" (Broadhurst, 2015b, p. 301) of their experiences.

## 2 | METHODS

### 2.1 | Setting

This study was undertaken alongside a Lancaster University led evaluation of a pilot program within the Family Drug and Alcohol Court (FDAC), a new and innovative problem-solving court (see Harwin et al., 2011). The FDAC pilot program provided timely support to pregnant women who had previously had one or more children removed. Holistic support lasted for 2 years, irrespective of the initiation of care proceedings, making it unique in England (Broadhurst, 2015a). As part of the ongoing clinical assessment, key-workers undertook a range of interviews with participating mothers, which doubled as research data collection tools.

### 2.2 | Ethical approval

The current study was undertaken by the first author while a postgraduate student at the Anna Freud National Centre for Children and Families and University College London, supervised by the second author. It required ethical clearance separate from the ethics granted by the Research Ethics Committee at Lancaster University, and thus retrospective consent from mothers for use of their interviews. The study was ethically approved by the University College London Research Ethics Committee (9209/001).

### 2.3 | Participants

Five pregnant women were opportunistically sampled from the FDAC pilot on the basis of consenting to participate in the study. One mother consented to the use of her interview but not her background information.[1]

The women (mean age 32.35, $n = 4$) had between two and six children each who had previously been removed. The children were not living with them at the time the interviews were recorded, but were living in adoptive, kinship, emergency, or long-term foster placements. For three of the mothers, the main concern during previous care proceedings had been substance or alcohol abuse, while for the remainder, concerns included emotional abuse and neglect, domestic violence from a partner, criminal activity, or other difficulties compromising their capacity to parent.

Three mothers had subsequent positive outcomes through the Early FDAC, keeping their baby after birth, one was additionally reunited with her children who had previously been placed in foster care, and one was going to have to go through care proceedings if she was to keep her baby.

At interview, the mothers were between 30 and 39 weeks pregnant ($N = 5$) and had known their key worker (the interviewer) for between 2 and 9 months ($n = 4$).

### 2.4 | Data collection

Interviews were undertaken and audio-recorded by the interviewee's respective key-worker at an FDAC center or the mother's home. All key-workers adhered closely to the interview schedule, while allowing space to explore topics of personal importance to the mother being interviewed. The current study was a secondary analysis of these routinely collected interviews, each of which lasted between 16 and 64 min.

The "Pregnancy Interview-Revised" (*PI-R*) is a 22-item semi-structured interview developed by Slade (2007), which asks about a mother's emotional experience of her pregnancy, her view of her baby, and the developing mother–child relationship. The *PI-R* tries to evoke a mother's thoughts and feelings about her own parenting, the father of the baby, and her own mother.

### 2.5 | Data analysis

Thematic analysis (TA) (Braun & Clarke, 2006) was used to analyze the *PI-R* qualitatively. TA is a qualitative method that helps identify, analyze, and report patterns within a dataset. TA is also a theoretically versatile method of data analysis (Braun & Clarke, 2006), allowing analysis within pre-set categories of interest. The digital qualitative data analysis software NVivo 11.4.0 (QSR International Pty Ltd., 2016) facilitated analysis of the data.

In line with Braun and Clarke (2006), the following steps were taken to conduct the thematic analysis: listening to the audiotapes and transcribing data verbatim; intensive study of the transcripts; and attribution of codes across the entire data set. The resulting 520 initial codes ranged from descriptive codes (e.g., "getting injunction on father") to

[1] $N$ is used for full sample, while $n$ is used to take account of this restriction.

**TABLE 1** Themes organised within categories A–C

| Themes within categories A–C | |
|---|---|
| **A** | **Mothers' representations of themselves as mothers and of their pregnancies** |
| **1** | Uncertainty and fear of losing the baby / Uncertainty but hope of becoming a mother |
| **2** | Not wanting to be like their own mother |
| **3** | Experiencing recovery and pregnancy as two interdependent processes |
| **B** | **Representations of the baby (and other children)** |
| **4** | Struggling to imagine the baby |
| **5** | The omnipresence of previous children |
| **C** | **Representations of the relationship with the baby** |
| **6** | Pleasure at starting to have a connection with the baby |
| **7** | Noting the baby's dependency |

analytic codes (e.g., "experience of abandonment"). Subsequently, all codes were redistributed to any of the pre-set categories that they fitted (Mother/Baby/Relationship), as well as to any of the additional categories (Recovery/Previous Children), which were created after careful study of the initial codes. Codes and their associated text extracts were then combined to create candidate themes that had become noticeable through the amount of text involved, repeated reference, or relevance to the sample. The resulting six themes were summarized in a global thematic map and checked for the extent of the text extracts and their recurrence across the data set. After rereading the entire data set, one theme was added, completing the final version of results. While double coding was not possible due to time restrictions, the second author oversaw and verified the coding.

## 3 | RESULTS

Despite their small number, the interviews elicited a wide variety of responses, reported in terms of seven main themes. Five themes lay within the pre-set categories of interest, while two themes about the mothers' recovery and previous children were on the borders. Including these in the findings proved to be essential, as they highlighted distinctive representations within this unique sample. Table 1 presents an overview of the themes.

The themes are presented in their respective categories and supported with text extracts[2]. All names have been changed and all identifying details have been removed from the narratives to ensure anonymity. Where appropriate, attention has been paid to negative cases, as data that seemingly contradicted identified patterns can enrich discussion and improve the quality of the findings (Mays & Pope, 2000).

### 3.1 | Mothers' representations of themselves as mothers and of their pregnancies

A prevalent theme for mothers was uncertainty about whether they could keep their baby and become a mother again. Fear of losing their baby to care proceedings was omnipresent. At the same time, some mothers had developed hopeful feelings about their pregnancy: might they be able to keep the baby this time? This double-theme presented as two sides of the same coin (fear vs. hope), and is best illustrated through quotation.

#### 3.1.1 | Uncertainty and fear of losing the baby: "Will I be allowed to keep my little one?"

The uncertainty and fear of losing care of the baby seemed to play on most of the mothers' minds. Rochelle described the state of not knowing about her baby's future and her powerlessness in the process: "I was worried about what happens after when the baby is born. That's what I'm worried about, is, what's gonna happen, where's my baby gonna go? And what plans have people got for my baby?" Her positive feelings were overshadowed by the fear of potentially losing the care of her baby: "I've had like good feelings, like, excited, but then something always overclouds it, 'cause I know what's coming. Because I know Social Services are gonna give me a hard time, I know I'm gonna have to go to court." Julie also feared losing her baby ("I don't want to lose my child") but was weighing up the final outcome in the light of her past substance misuse and her recent recovery:

> *regardless of how much work I put into myself and how much I'm showing that I'm really maintaining my, my changes and stuff like that, erm, I do have that sort of feeling, sometimes, of too, too little too late, (…) that 'have I really just pushed the boat out that bad that I can't get back to shore to be able to give myself that (.) chance.*

Amina, in turn, expressed the uncertainty through the voice of the father of the baby:

[2] Transcription notations and crosstalk have been removed from quotes for accessibility. For brevity, some text extracts have been shortened, with '(…)' indicating omitted text.

> *He was happy but he was scared, 'cause, (…) was thinking that, erm, the social care might take him again. With, like they took the other children. (…) we didn't know what's gonna happen*.

Finally, Nicky shared what the reality of these fears looks like:

> *being told for the first time by the social worker that, erm, they're going to be putting my child on a child protection due to my older children and my youngest child. Due to past concerns, they'll be doing the same with this child*.

There were, however, also instances of looking at the mothers' uncertain situations from the opposite perspective: that of hope.

### 3.1.2 | Uncertainty but hope of becoming a mother: "A chance for me to be a Mum again"

Within this theme, pregnancy was repeatedly referred to as an "opportunity" or "chance," despite the uncertainty around it. Tentatively, Julie summarized her hopes: "cause obviously where, I don't have (…) [my children], erm, with me, I had feelings, and, of sort of like, erm, I might gonna be given the opportunity to be a Mum to this baby." Julie then imagined in detail what it could be like to care for her baby. Her descriptions of caregiving read like a long-harbored wish, maybe highlighting the opportunities missed with previous children:

> *the opportunity to be a Mum, erm, but in the right mindset. (…) I just want to (…) watch them ride their bike for the first time. To hear the first words out of their mouth. To be there when they fall over and they hurt their knee and to be able to say that it's okay*.

For Amina, too, not currently caring for her other children seemed to play a role in hoping to become a mother to her unborn child:

> *it was like a chance for me to be a Mum again and - 'cause I feel like, even I see my children, (…) I'm not a Mum. I'm just a Mum, like, for 2 hours, today. And - but this one, if I have a chance with the things that I've been doing, offered me a chance for me to be a Mum again*

In contrast to these hopeful accounts, Nicky seemed to have given up on the idea of keeping her baby. Being asked what she imagined the hardest time in the first 6 months of the baby's life would be, Nicky responded: "Social services getting involved. And putting him in care."

Despite the above uncertainties, all the mothers were able to imagine themselves as mothers of their babies. The most unifying idea about imagining themselves as mothers was being different from their own mother as parents.

### 3.1.3 | Not wanting to be like their own mother: "She was no mother at all"

Mothers showed different degrees of insight about, and elaboration of why and how they wanted to be different from their own mothers. Regardless of this, however, it was striking to read how adamant most of the mothers were about this, often shown in the vehemence of their words. Being asked in what ways they imagined themselves to be like their own mothers as parents, the mothers responded, "I won't be nothing like my Mum" (Rochelle), "Honestly, hopefully bloody none of it" (Julie), and "Never. (…) No. Never like her" (Helena). Amina found it more difficult to condemn her mother's parenting outright: "She wasn't a bad Mum. Yeah, I don't think I wanna be like her, but she wasn't a bad Mum."

The mothers also described not having relationships with their own mothers, be it because of the pregnancy or for other reasons. Julie recounted her relationship with her mother as "just, not happening. Nothing" and Rochelle said "I haven't spoken to my mum since last year, [month]? So, yea, she, I don't have a relationship with her and to be honest with you, I don't really want her involved in my, my child's life."

The mothers made sense of wanting to be different from their own mothers by describing different disappointments. Julie recounted:

> *… my Mum was physically violent, erm, she was quite detrimental and condescending, erm, and she was no mother at all (…) my Mum would give me [a] good hiding when she told me not to go across the road (…). She never talked with me to explain that sort of stuff, she just told, and when it didn't happen, she'd become physically abusive*.

Other mothers recalled similar experiences of being humiliated or betrayed by their mothers, feeling as if their mothers did not support them during a difficult time or describing their mothers as putting them into care. Only

one mother reported a good relationship with her own mother and hoped to parent like her.

Throughout the above themes, the mothers made reference not only to wanting to do something different but also to working for it, for example, "with the things I've been doing" (Amina) or "showing that I'm really maintaining my, my changes" (Julie). The next theme relating to the mothers' recovery was in line with these ideas and was particularly important in that it prevailed despite the *PI-R* itself not probing for "recovery."

### 3.1.4 | Experiencing recovery and pregnancy as two interdependent processes: "cause it's trying to give up one thing, and then it's changing to do another thing"

Two mothers repeatedly referred to their recovery from using alcohol or substances when commenting on their pregnancies. Pursuing recovery while going through the stages of pregnancy seemed a powerful experience that posed challenges but also offered rewards. Helena noted the physical interplay between pregnancy and recovery:

> *…just a lot of pressure when I'm trying to, like, recuperate from abstinence of alcohol. So, as far as that's gonna be a lot more pressure on my body, 'cause it's trying to give up one thing, and then it's changing to do another thing. (…) but I've managed it.*

Recovering while being pregnant seemed to have brought mental clarity. Julie observed: "To actually go through this pregnancy pretty much from very early on, stable on prescription medication has been, it allowed me to see things a lot clearer, yea, and feel things." For Helena, who tried to get her children back through recovering from alcohol dependency, becoming pregnant meant that her recovery had an even greater focus: "I was trying to give up alcohol, and I think having known I was pregnant and having no children by my side has actually been more focused and wanting it."

Recovery was not a process confined to pregnancy, however, but one that, it was hoped, would continue beyond the baby's birth. For Helena, being in recovery during pregnancy seemed to promise the prospect of normality after her baby's birth.

> *Just carrying on at being clean and not drinking (…) 'Cause there'll be more normality, more what people do. Like, what, the way I was living is not normal. That's not a normal person's daily lifestyle. I thought it was, but it wasn't.*

Helena also linked the prospect of keeping on "the straight road" to having the energy to meet the newborn baby's needs: "I'd be a lot more recovered from no alcohol. Should be able to put my brains and effort into [it]." Julie, too, saw recovery as a process that would continue after birth and considered how caring for a newborn would interact with this:

> *just 'cause I've had a child don't mean to say I [will] be cured, do you know what I mean? Recovery is a life-long process, (…) but having a newborn baby, there's obviously, it will become a time where I would need to probably work on that heavier stuff just that little bit more because of having a new baby, there'll be extra emotions, extra feelings, um, sleepless nights, and things like that.*

She summarised the challenges of this time compellingly: "It's gonna be hard, however, for the benefits that I will get from it, it will be no contest."

## 3.2 | Representations of the baby (and previous children)

### 3.2.1 | Struggling to imagine the baby: "Not until he's born"

Descriptions of the baby were thin across the five interviews, meaning that no coherent theme of what the baby would be like could be identified. With the exception of one interview, the mothers' images of their babies were marked by brevity or ordinariness. They hoped and imagined that their baby would be "healthy," "happy," and "safe." Beyond these general wishes, there was a tendency to imagine the child as "independent" (Rochelle), gaining "independence" (Julie), and able "to look after himself" (Nicky).

Most of the mothers struggled to imagine their child at some point during the interview. Rochelle simply deemed it impossible to imagine her baby as yet:

> *…I don't know if you can really imagine it. I don't, I don't really imagine what she's going to be like, 'cause I don't know what she looks like or anything, so it's a bit hard for me to say what she's going to be like, 'cause I don't know* [smiles] *what she's gonna be like. (…) I don't know until* [laughs], *until she gets here.*

Imagining their baby before s/he was born seemed to be a struggle. When asked if she had a relationship with the baby now, Nicky responded: "No, not just yet. Not until he's born." The struggle to imagine this baby, or anything to do with his/her future, also unfolded in an exchange between Amina and the interviewer:

> Interviewer: *If you had to think of five years from now and [baby] is 5 years old, and you had three wishes for [baby], what would they be?*
>
> Amina: *Oh. I don't know.*
>
> Interviewer: *Take your time.*
>
> Amina: [laughs] *I don't know. Aw.*
>
> Interviewer: *What'd your wishes be?*
>
> Amina: [sighs].
>
> Interviewer: *For [baby].*
>
> Amina: *I don't know. That one I don't know. I really don't know.*
>
> Interviewer: *No?*
>
> Amina: *I don't know.*
>
> Interviewer: *Right, we'll come back to that.*
>
> Amina: [laughs] *I don't know.*

The absence of an image of the baby was not only apparent from single responses but also cumulatively over each interview. The difficulty of achieving a clearer image of the baby from the mothers' responses was possibly also linked to the next theme, the omnipresence of the mothers' previous children in their interviews.

### 3.2.2 | The omnipresence of previous children: "My children, they're not with me"

The omnipresence of the mothers' previous children was a second theme that emerged, despite the absence of prompting through the *PI-R*. If measured by the extent of text, this was the most consistent theme, given that references to previous pregnancies, to other children, or to their absence were as constant as they were spontaneous. Examples included, "well, I often think about my daughter (...), and how she is like. So maybe she might be a bit like [her]" (Rochelle imagining the baby) or "I just have to think of all the other kids as well and how they're gonna feel" (Helena, describing her reaction to her pregnancy).

For some mothers, the pain of missing their children was the reason they talked about them. Amina described what it felt like being absent from her children on their birthdays:

> *Especially when it's the children's birthday (…) I try to call them. The phone was switched off all day. (…) Every time when you reach their birthday, that's the, that's the time. I feel like somebody stabbing in my heart (…), I wanna know what they're doing, where they are.*

Connected to missing previous children was the strong wish or fantasy to be reunited with previous children and the new baby. Asked about three wishes she had for her baby, Helena responded without hesitation: "To have his Mum healthy, his Dad around and the rest of his siblings home with him" and "as soon as he's born (…) my other kids get to see him." Amina, too, dreamed of a reunion:

> *…ever since I found out I was pregnant, I keep having [a] dream, like I was asleep, somebody was knocking on my door and then when I opened the door there was the woman standing there with my children. (…) when the children saw me, they run, they hug me and say to me 'we came to return your children back'.*

Taken together, descriptions of the babies' characteristics were thin, whilst unprompted references to previous children were ubiquitous. Nevertheless, the mothers did give evidence of starting to connect with the babies they were carrying.

## 3.3 | Representations of the relationship with the baby

### 3.3.1 | Pleasure at starting to have a connection with the baby: "I get bursts of excitement"

Throughout the interviews, the mothers made references to enjoying the early connection with their unborn babies. As with all themes, there was great diversity in the mothers' descriptions and experiences and their reference to such interactions. At the basic level, however, experiencing the babies' movements seemed to bring pleasure to all

of them. Rochelle recounted: "I get bursts of excitement, like, all the time. Like, when the baby moves and stuff. And, like, I talk to her and stuff like that, but in my belly." Similarly, Julie remembered: "When I first started to feel the baby move, that was a really nice experience as well actually. Yea it was, it was a beautiful experience." Helena recalled that her relationship with her baby started when the baby started moving and Nicky described how feeling the baby growing inside her felt "wonderful." Finally, Amina summed up her pregnancy: "Carrying someone for 9 months, feeling that person moving, sharing things with that person, it's a gift."

While feeling the baby move and kick was the most common way of connecting and feeling pleasure about the baby, that first connection was not purely made through physical experience. Julie vividly described her emotions about seeing her baby during a scan:

> *I was expecting the normal scan and things like that but when me and [friend] was watching the monitor that you can watch the baby on and that, we was actually seeing the baby put his fingers in his mouth and sucking its thumb (…) I felt really emotional about that, in a nice way, (…) to be given, like, a little sneaky preview of what sort of, my baby will be like.*

What the mothers were describing was a physical connection with their unborn babies that they were able to feel and to talk about. It was, however, short of an emotional interaction and also short of imagining a future relationship with their babies once they were born. Throughout the data set, only one mother talked about the interactions she might have with her child. Nevertheless, in some instances, the mothers demonstrated a developing understanding of their babies' dependency on them, as illustrated in the following section.

### 3.3.2 | Noting the baby's dependency: "That's gonna feed into my baby"

In very diverse ways, the mothers in this sample showed a developing awareness of how their behaviors, bodily reactions, and emotional worlds would affect their babies during pregnancy. Julie, for example, linked her own emotional state to the baby's: "for example, I wouldn't be watching a horror film because I'm making myself scared and jumpy. And having anxiety feelings and things like that, that's gonna feed into my baby, which isn't good." Similarly, Rochelle linked her state of emotional and physical arousal to her baby's state of arousal and activity:

> *…not be around, like, loud shouty people, and stuff like that. And just relax, keep myself relaxed, 'cause when, if I'm relaxed, then she's relaxed. If I'm, like, upset, like I am now, she starts moving about.*

In a similar way, Helena understood that her baby's development and growth were reliant on her recovery. Being asked if she had any worries about the baby, she responded: "only at the beginning with the placenta. But obviously as he's grown, and I've remained no alcohol, obviously he's got a lot stronger."

The mothers also described moments, however, when noting the baby's dependency seemed more difficult. Amina spoke of a moment in which her own and the baby's needs were at a noticeable mismatch:

> *So I (…) call his name and talk to him and rub my belly and then he'd just listen and (…) even when he sleep[s], I feel bored, I don't have anything, I don't have anything to do, I wake him up, and he wake[s] up. Yea, well I patch [sic] him with my belly, doing this to him. I call his name and he just starts kicking.*

The way in which some mothers started linking their own behavior to their unborn baby's development was indicative of the formation of a relationship with their baby forming in their minds. Julie pinpointed why making this link during pregnancy was so important: "*Because if I can't do it with my baby inside of me, then you can't do it once a baby arrives.*"

## 4 | DISCUSSION

The current study responded to the paucity of research capturing the views of birth mothers at risk of repeat care proceedings. It aimed to explore thematically how mothers, pregnant with a baby they were at risk of losing, imagined themselves as mothers, their babies, and their relationships with their babies. Within those categories, the interviews demonstrated that the mothers feared losing their babies while hoping to become mothers; that they did not want to be like their own mothers; that they struggled to imagine their babies but felt pleasure at their babies' movements, and could occasionally sense their babies' dependency. Nevertheless, the study identified some noteworthy themes outside these specific categories and reporting them recognizes some contextually important themes for this sample: the omnipresence of children removed from their mothers' care and the interdependence of pregnancy and substance recovery. As has been shown previously

(Sadler et al., 2016), semi-structured interviews designed to assess mothers' reflective functioning (Slade et al., 2007), such as the *PI-R* used here, provide the necessary adaptability and sensitivity to elicit themes reflecting the contextual challenges faced by unique maternal samples.

## 4.1 | Hope and fear

The double-theme of fear about losing the baby and hope about becoming a mother reflected the mothers' awareness of their external realities. Some mothers focused on the opportunity that the FDAC support offered them, hence the hope of becoming a mother to their baby. For some mothers, however, this hope could also be understood as their attempt to ignore the difficulties and obstacles to motherhood that they faced, e.g. substance use, parenting capacity, and so on. In contrast, some mothers exclusively displayed fear that their pregnancy would result in another episode of care proceedings. This fear was of course realistic but could also serve the function of attempting to prevent yet another loss by not investing emotionally in a baby they were at risk of losing to social care. Others, however, managed the careful balancing act of showing hope and fear, and were able to reflect on both possibilities. Even without the prospect of care proceedings, pregnancy is a time of immense uncertainty that provokes feelings of anxiety and helplessness (Slade et al., 2007), and tolerating this uncertainty is a mentally challenging process (Feldman, 2013). The fact that some mothers were able to contemplate both possible outcomes can be seen as a capacity to tolerate uncertainty and was thus an enormous achievement during this highly anxiety-provoking time. Interestingly, those mothers who had the capacity to contemplate both hope and fear were also the ones who remained with their babies after pregnancy. This has both theoretical and clinical implications. The mothers' ability to remain balanced in the face of the immense uncertainty around their pregnancies might have indicated at least some future capacity to be sensitive to the environmental and internal factors potentially impacting on their infant's well-being and their own caregiving capacity. With regards to this capacity, then, when working with pregnant mothers at risk of care proceedings, supporting them in the difficult process of tolerating the uncertainty around whether they can keep their babies might be a key intervention in increasing parental reflective functioning.

## 4.2 | Identity and grief

The mothers in this sample appeared preoccupied with their maternal self-identity, reflected in the themes of the hope of becoming a mother, fear of losing their baby, and the constant references to previous children. Previous studies showed that child removals severely challenge mothers' maternal self-identity (Broadhurst & Mason, 2013; Memarnia et al., 2015; Novac et al., 2006). The current study highlights that pregnancy and the prospect of keeping the unborn baby effectively re-activate this identity struggle.

Similarly, it has been widely reported that child removal triggers complicated maternal grief (Henney et al., 2007). The mothers' painful references to previously lost children might be an indicator of pregnancy stirring up this grief. Nevertheless, the mothers also dreamed of a reunion with their children. This is a potentially hopeful finding, as imagining a future with their children might be a motivator for mothers to seek and use support in repeat care proceedings (Broadhurst & Mason, 2014). Nevertheless, it is important to hold in mind the alternative interpretation: that an exaggerated sense of hope might be indicative of mothers ignoring or minimizing the difficulties that lie in the way of caring for their children.

By intertwining the themes of hope, fear, and previous children, the interviews suggested that pregnancy reactivates the two major phenomena following child removal found in previous research: negotiating self-identity and grief. There are no particular indications that the mothers' grief was disenfranchised, that is, unacknowledged. It is possible that the empathic support that FDAC aims to provide counterbalanced the mothers' potential perceptions of their grief being unrecognized. Alternatively, the realistic chance of keeping their current baby might have temporarily abated the intensity of the mothers' grief, a mechanism alluded to in Grant et al. (2011, p. 2184) idea of mothers imagining a "replacement" baby. Indeed, listening to some of the mothers' quotes (e.g., "this one (…) offered me a chance for me to be a Mum again") lends qualitative support to Grant et al. (2011)) statistical and Novac et al.'s (2006) anecdotal findings about "replacement" babies. Together, the findings suggest that being attentive to mothers' indirect references to struggles with grief and self-identity is likely to be an important part of effective clinical support for mother–infant well-being in this highly vulnerable group.

## 4.3 | Substance misuse

Although only three mothers in the sample presented with past or current substance and alcohol misuse, their reflections on how their recovery process connected to their pregnancies presented a striking theme. The mothers were aware of a range of interactions: recovery could be a challenge as it heightened pressures on their bodies and minds,

but could also mentally support their pregnancy through providing clarity at a time of multiple changes. Broadhurst and Mason's (2014) study on birth mothers' turning points found that such newfound clarity could prove instrumental in making use of psychological support.

Indeed, pregnancy and the prospect of keeping their babies appeared to provide the mothers with a strong motivator for continuing recovery. This finding mirrors reports by Kissin et al. (2001), Pajulo et al. (2001a), and Taplin and Mattick (2015), which link pregnancy to mothers' increased motivation to refer to services or to attempt abstinence. It has been theorized that as a mother's capacity to regulate her own affect increases, both her desire to invest in her child might increase, and the reward derived from drug use might, in turn, diminish further (Suchman, DeCoste, Castiglioni, Legow, & Mayes, 2008). The link between pregnancy and substance recovery is especially noteworthy here in mothers who had experienced repeat child removals, as it echoes Broadhurst and Mason's (2014) finding that the combination of child removal and a new pregnancy was what motivated these mothers to "get things right this time" (p. 1575). Clinically, it offers professionals the possibility to harness mothers' potential willingness to recover. The fact that one mother did not touch on this part of her story at all, however, highlights that supporting mothers with the appropriate space and language to discuss the interdependent processes of recovery and pregnancy might need to be an inherent part of this clinical support.

### 4.4 | Imagining the baby

Although the mothers started to note their babies' movements and dependency, most struggled to imagine them. Pines (1972) notes that it is not unusual only to appreciate the reality of the baby at birth. Combined with the uncertainties in relation to their babies' futures, it was not surprising that the mothers found it difficult to form an image of their babies. Nonetheless, the absence of a mother's prenatal representations of her baby can sometimes indicate a lack of mental space for the child after birth (Vizziello, Antonioli, Cocci, & Invernizzi, 1993). This could also be understood in the context of most the mothers giving clear accounts of having experienced depriving and abusive relationships with their own maternal caregivers, increasing the conflict about imagining a baby they will be expected to mother.

What helped these mothers take pleasure in their babies, however, was feeling the baby move inside them. For mothers who have experienced abuse and violence, being able to take pleasure in those fetal movements, rather than interpreting them as aggressive or persecutory, might indicate a growing resilience and acceptance of the baby soon to be born (Huth-Bocks et al., 2004).

Related to the expected baby was the mothers' general tendency to imagine their baby to be "independent." While this possibly reflected the mothers' difficulty in thinking about their babies' complete dependence on them as emotionally available caregivers after birth, there were the subtler moments in which some of the mothers appreciated their babies' dependency on them. Understanding the baby's dependency on the mother is a core feature of parental reflective functioning (Slade, 2005). This finding was particularly important, as mothers' comments portraying a mismatch between their babies' and their own needs are already widely reported (Baradon et al., 2008; Sadler et al., 2016).

Listening to mothers actively making choices that might benefit their babies (e.g., not watching a horror film) revealed that their early understanding of their babies' dependency could be quite subtle. For professionals who spot them, they provide unique opportunities to reinforce reflections on the baby's dependency and hence increase the mother's reflective capacity.

### 4.5 | Limitations

The current study relied on a small sample, thus limiting generalisability. The findings offer important preliminary observations, however, that might provide future directions for research and practice. As in all qualitative research, the researcher's subjectivity can influence the findings and the absence of full double-coding presents a limitation. Nonetheless, some of the themes identified here resonate with the broader literature and others are novel findings, lending credibility to the study's methodology. Finally, the fact that the interviews doubled as assessment tools is likely to have made a difference to the content the mothers shared. Slembrouck (2011) highlights that when parents are interviewed in relation to their children in care, they can feel provoked to account for themselves to redeem their "moral worth and credibility" (p. 51) as parents. An emphasis on trust with the keyworker/interviewers might, however, have made the interviews less intimidating. The mothers' readiness to give consent retrospectively could be seen as testimony to this trust. Nonetheless, from an ethical perspective, seeking informed consent prospectively would be highly advisable for any future studies.

## 5 | CONCLUSION

The current study outlined seven prenatal representations of pregnant mothers who had previously lost children to

care and who were again at risk of entering care proceedings with their unborn baby.

The study's findings are clinically relevant in that they showcase not only the need of such mothers for interventions but also some important pointers for what such interventions might involve, for example, facilitating processes of grief, identity-seeking, recovery, and tolerating uncertainty. From a policy perspective, the results also indicate that this clinical support would ideally be provided timely at the point of post-removal due to otherwise unaddressed levels of grief and struggles with self-identity.

In a context in which the voices of women in general (Reinharz & Chase, 2003) and birth mothers in particular (Broadhurst & Mason, 2014) often continue to be rendered invisible, one of the study's strengths lies in presenting and emphasizing the voices of a unique sample of high-risk mothers scarcely represented before in research. By highlighting both the depth and variety of these mothers' experiences, the findings enhance the understanding of their mental states beyond existing narrative-based findings, and contribute to a much-needed 'maternal perspective on separations between mothers and their children' (Sanger, 1995, p. 28). By drawing on qualitative data on a socially complex phenomenon, the findings further help to replace 'speculation with observation' (Becker, 1996, p. 59).

Together with previous research, the findings might potentially assist in informing the decisions of policymakers, courts, rehabilitation, and social and mental health services. This is particularly important considering that such mothers often feel powerless and lack a collective voice (Charlton & Oliver, 1998).

While some initial suggestions for clinical interventions arise from this research, future studies focusing on mothers' experience of repeat removals are urgently needed to refine interventions and to improve outcomes for both mothers and their babies. In this regard, adding a thematic analysis of maternal representations to the more common application of reflective functioning scales might enhance and refine our understanding of at-risk mothers' capacities to think about and care for their children.

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