The Impact of Severe Mental Illness on Mothering: Perceptions of Clinical Psychologists

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ABSTRACT

A large portion of adult women who suffer from severe mental illness (SMI) are mothers. Unfortunately, mothers with SMI have historically been considered as incapable of caring for their children. The impact that SMI has on mothering, particularly in the South African context, remains underexplored in literature. In particular, the perceptions of individuals working therapeutically with these groups have been largely neglected and overlooked. This exploratory study had a dual focus which was both to draw attention to the impact that SMI can have on mothering and the mothering identity, *and* to explore the perceptions and experiences of clinical psychologists working with these individuals. This study followed a qualitative research approach underpinned by the interpretivist design in order to address the aims of the research and answer the research questions. Purposive and snowball sampling techniques were used to select a sample of seven clinical psychologists who have experience working with mothers with SMI. In order to generate the data, semi-structured interviews guided by an interview schedule were employed, and a thematic approach to data analysis was utilised. As a theoretical framework, the Grounded Theory of the Psychological Experience of Mothering (Barlow & Cairns, 1997) was drawn on, in conjunction with relevant psychoanalytic theories, to guide the research methods, data analysis and presentation and discussion of findings. The impact of SMI on mothering and the mothering identity is intricately interweaved with contextual factors, as well as the internal and intrapersonal processes that occur in the individual mother. The findings revealed the complex and nuanced nature of this phenomenon, and the duality that is present in the identity of the mother, as well as the psychologist, which has to be negotiated in treatment. The unique South African context introduces further complexities which have to be both managed by psychologists and mothers with SMI.

Key words: mothering, severe mental illness, clinical psychologist, dual identity

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LIST OF ACRONYMS

HPCSA	Health Professions Council of South Africa
MHCPs	Mental Health Care Professionals
SMI	Severe Mental Illness

CHAPTER ONE: INTRODUCTION TO THE STUDY

This chapter introduces the study by first orientating the reader to the phenomenon on which this study is based, and then explores the key concepts related to this phenomenon. Thereafter, the rationale and problem statement of the study are presented, drawing attention to the reason this study was conducted, and justifying the choice of the specific topic selected. The research purpose is then presented followed by the research questions which this study aimed to answer. Thereafter, an overview of the research methodology is discussed followed by a summary of the contents of the research report.

1.1 Introduction

A substantial number of adult women who suffer from severe mental illness (SMI) are also mothers (David et al., 2011; Rampou et al., 2015). Historically, women with SMI have been considered by mental healthcare professionals (MHCPs), families, and communities as incapable of caring for their children, often resulting in loss of custody, separation, or in extreme cases, sterilisation (David et al., 2011). Emerging literature draws attention to the needs of this population, and shows that often SMI can disrupt parenting and has the potential to negatively impact the child (Awram et al., 2017; Brockington et al., 2011). The impact that SMI has on mothering, especially in the South African context, remains underexplored in literature. In particular, the perceptions of individuals working therapeutically with these groups have been largely neglected and overlooked (Montgomery et al., 2011). Mental health care professionals, such as clinical psychologists, who work with this patient group arguably provide valuable, experience-based insights into the way in which SMI can impact mothering. This study had a dual focus – on the one hand, the study focused on a specific group of MHCPs, namely clinical psychologists, drawing attention to the perceptions and experiences of these professionals. On the other hand, the focus was on a secondary population, namely mothers with SMI. The perceptions of clinical psychologists were used as a vehicle to gain insight into how the mothering role is impacted by SMI.

1.2 Conceptualisation and Key Concepts

There are three key concepts that need to be defined in order to orientate the reader to the focus of the study. Firstly is *severe mental illness*. Severe mental illness is described in literature as a psychiatric diagnosis that severely impairs day-to-day functioning, interferes with

participation in life activity, and has resulted in at least one psychiatric hospital admission (Zumstein & Riese, 2020). For this study specifically, the researcher needed to consider that in resource scarce contexts such as South Africa, many individuals who struggle with SMI often face extended periods without hospital treatment or in-patient care (Robertson & Szabo, 2017). The researcher was aware not to exclude this population. Therefore, the specific focus for the current study was on individuals who have been diagnosed with psychiatric disorders by a professional including, but not limited to, schizophrenia, psychotic disorders, mood disorders and bipolar disorders; and who are currently under psychological and/or psychiatric care. These diagnoses have been included as they are commonly classified as 'severe' (Johnson, 1997; Rampou et al., 2015). In order to delineate this concept further, SMI has been defined as a chronic, long-term illness rather than acute presentations such as post-partum onset of mental illness. This delineation is important as the chronicity of mental illness can often be more predictive of life disruption than the diagnosis itself (Ackerson, 2003; Rampou et al., 2015).

The second key concept is *clinical psychologists*. Clinical psychologists are specifically trained to intervene with mental, behavioural, and cognitive disturbances and are able to diagnosis and assess psychopathology (Health Professions Amendment Act, 2007). Clinical psychologists' theoretical underpinnings means that they have unique knowledge about developmental psychology and psychopathology, as well as how to work with individuals and families (Health Professions Amendment Act, 2007). The scope of practice of clinical psychologists will be further expanded on under the literature review and research methods section of this report.

Finally, the last concept that requires defining is the term *mothering*. Mothering is increasingly being understood as an evolving, dynamic, and interactional process that has a variety of influences (Barlow & Cairns, 1997). For this study, a mother is defined broadly as an individual who is responsible for caring for, raising, or nurturing a child, and who engages in the practical and psychological tasks to do so (David et al., 2011; Rampou et al., 2015). Mothering can be defined not only as a role but also as an identity, a process, and a function (Barlow & Cairns, 1997). Mothering as an experience is expressed both within the individual (intrapersonally) and between the individual and the child (interpersonally) (Barlow & Cairns, 1997). While many individuals can mother, the secondary population of mothers in this study will be further defined as women who are parenting biological children. This delineation has been made given the genetic element of SMI and how this might be a factor that may influence the internal fantasies of the mother, and fears that are brought into the mothering role (Johnson, 1997;

Lautenbach et al., 2012). Given the focus of the study and the above definition, the specific term 'mothering' has been mainly used throughout the discussion. When referring to literature or specific studies, more generalised terms such as 'parent' has been used.

1.3 Rationale and Problem Statement

There is an abundance of broad research that highlights how mothering with SMI has complex challenges that patients and MHCPs have to navigate. Research has focused widely on the experiences and needs of mothers with SMI, specifically in terms of parenting issues, from the mothers' perspectives (Cremers et al., 2014; Diaz-Caneja et al., 2004; Harrington, 2016; Montgomery et al., 2011; Mowbray et al., 2000); the role of MHCPs in supporting mothers with SMI and in intervening with their children (Acri & Hoagwood, 2014; Awram et al, 2017; David et al., 2011); and the negative effect mental illness can have on parenting ability, specifically pertaining to children's wellbeing (both in childhood and the long-term effects) (Bee et al., 2013; Brockington et al., 2011; Mowbray et al., 2006; Murphy et al., 2017; Van Santvoort et al., 2015). The impact that SMI has on mothering within the South African context, however, remains unknown and under-researched. Furthermore, the perspectives of clinical psychologists working with this population group are underrepresented in the existing South African literature. Rampou et al. (2015) have begun to draw attention to the research gap in South Africa on the topic of parenting experiences of mothers living with mental illness, as well as the need for holistic mental healthcare for parents with SMI. Moodley et al. (2019) conducted a study on mentally ill women committing filicide and du Toit et al. (2020) focused on risk factors for perinatal suicide. Voges et al. (2020) also examined the issue of postpartum psychosis. These four studies seem to be the only published articles known to the researcher on this specific topic in South Africa, and mainly focus on peri and postpartum onset of illness and risk. A focus on the impact of mental illness which is severe and chronic, on the mothering role specifically has not, to the researcher's knowledge, been studied in the South African context. Research that focuses on the perspectives of clinical psychologists who work with this population is particularly scarce. The experiences and theoretically-informed perceptions of clinical psychologists about how SMI can impact mothering remains a topic that has not been explored widely in literature, both locally and internationally. Developing knowledge in this area is important because the needs of both mothers with SMI as well as the professionals working with them is largely unknown.

The professional knowledge that clinical psychologists have about mothering, as well as the capacity of clinical psychologists to work therapeutically with mothers and specifically, mothers with SMI, means that their perceptions provide important insights into the needs of mothers with SMI in South Africa. Available research typically has drawn attention to the perspectives and experiences of the mother who is patient, or of adult children who have grown up with mothers with SMI (Montgomery et al., 2011; Murphy et al., 2017). However, because of their training and work in the field, clinical psychologists can potentially provide a unique, in-depth, and theoretically-informed perspective on how SMI can impact mothering both interpersonally and intrapersonally. This is in contrast to the absolute and rigid narratives that have derived from literature, anecdotes and collective beliefs regarding mothering in the context of SMI (Eliezer et al., 2022). Gaining insight into the perspectives of clinical psychologists about the impact of SMI on mothering could be particularly valuable in addressing the research gap and developing knowledge in this field. The clinical perceptions also have implications for practice. Historically, women with SMI have been considered unable to mother, and mental healthcare services were developed based on this notion (e.g., removal of children from mothers with SMI as opposed to intervening therapeutically with this patient population) (Brockington et al., 2011; Creamers et al., 2014).

Furthermore, this study serves as a springboard for further research into this topic in South Africa. The need to develop the knowledge base in this area is underpinned by the fact that the South African context introduces unique complexities for mothers with SMI. Firstly, the burden of disease is deepened by psychosocial issues such as poverty, ineffective social welfare services, and paucity of mental healthcare resources (Achoki et al., 2022). Secondly, the influence of the multifaceted intersectional identities (including race, class, ability, relationship status) of the patient can have profound relevance for the individual's experience (Robertson & Szabo, 2017). The need to expand on research in this field is also underpinned by the potential vulnerability of this population of patients, who are not only vulnerable because they are mental healthcare users, have children and likely experience poor quality mental healthcare, but also because they are women and are thus at risk for additional adversity (e.g. exposure to gender based violence) (Brockington et al., 2011; Jacobs & Coetzee, 2018). There are also potential consequences of poor understanding of the needs of this population, for example, the consequences that ineffective service delivery for mothers can have for the children in their care, such as the exposure to unmanaged and untreated symptoms (David et al., 2011; Kamis,

2020). Broadly, the study has relevance for the state of mental healthcare in the country which has previously been a neglected field of healthcare (Jacobs & Coetzee, 2018).

1.3 Research Aims

The aim of this study is primarily exploratory in nature, as the focus was to explore and understand what the impact of SMI is on mothering, specifically from the perspectives of clinical psychologists (Fouché & de Vos, 2011). This study aimed to understand how clinical psychologists perceive and understand the effects of SMI on the mothering capacity and role. The study was therefore also descriptive as the findings present a detailed description of these perceptions (Fouché & de Vos, 2011). To achieve these aims, clinical psychologists were individually interviewed to access their thoughts and experiences of working with patients who present with SMI and who are also mothers, so that an understanding could be developed on the issue of mothering in the context of SMI. The study aimed to gain insight into the impact that SMI has on mothering as a whole, both in terms of the intrapersonal (what happens internally for the mother) experiences of this role as well as the interpersonal experiences (what happens between the mother and the child) (Barlow & Cairns, 1997). Importantly, this study aimed to focus on the mother and mothering practices, rather than the impact that maternal SMI can have directly on the child. This ensures that the study is able to contribute to the research gap, but also expands on the existing literature which has predominantly given attention to the impact of maternal SMI on the child (Bee et al., 2013; Brockington et al., 2011; Mowbray et al., 2006; Murphy et al., 2017; Van Santvoort et al., 2015). The secondary aim of the study was to explore the experiences of clinical psychologists working with this population, and understand how clinical practice is shaped by perceptions of the impact that SMI has on mothering. Studies have shown that MHCPs' attitudes towards parenting with mental illness has significant impact on the way in which patients are treated and the interventions they receive (Dolman, et al., 2013; Krum et al., 2014; Strand & Rudolfsson, 2020). The perceptions of clinical psychologists therefore do not only allow insight into the impact of SMI on mothering, but how the juncture of SMI and mothering are treated in clinical psychology practice.

1.4 Research Questions

In order to achieve the aims of this study, the research questions had to incorporate the dual focus of the study. As such, the primary research questions and sub-questions were:

1. What are the perceptions of clinical psychologists regarding the impact of severe mental illness on mothering?
    a. What are clinical psychologists' perceptions on the capacity for women to mother when diagnosed with a severe mental illness?
    b. What are the perceptions of clinical psychologists about how mothers manage the mothering role *and* their severe mental illness?
    c. What do clinical psychologists perceive to be the needs of mothers with severe mental illness to effectively fulfil their mothering role?

2. How do the perceptions of clinical psychologists regarding the impact of severe mental illness on mothering impact clinical practice?
    a. How do the attitudes and notions about mothering with an SMI influence decisions around therapeutic interventions and treatment plans for this patient population?

1.5 Overview of Research Methods

This study followed a qualitative research approach underpinned by the interpretivist design in order to address the exploratory and descriptive aims of the research, and to answer the research questions. The qualitative approach and methodology allowed for a concentrated and in-depth exploration of the experiences of participants of the impact of SMI on mothering (Christensen et al., 2015). As such, the knowledge generated from this study is grounded in the individual, lived experiences of participants, with a focus on the context in which these occur.

In keeping with the research approach and design, the methods for sampling, data collection, and data analysis were selected in order to comprehensively capture and portray the data. Non-probability sampling techniques, specifically purposive and snowball sampling, were used to select a sample of clinical psychologists who have experience working with mothers with SMI. These sampling techniques allowed the researcher to purposefully select participants based on a predetermined inclusion criteria who were anticipated to be able to provide rich data pertaining to the topic (Rubin & Babbie, 2010). These sampling methods were congruent with the qualitative approach. The final sample included seven clinical psychologists. In order to generate the data, semi-structured interviews guided by an interview schedule were employed, which allowed for an in-depth exploration of the impact of mothering on SMI (Greef, 2011).

An analysis of the data was conducted through a thematic analysis guided by Braun and Clarke's (2006) steps. This allowed for an accurate and intensive analysis of the raw data in a way that would capture the meaning participants ascribed to their experiences (Clarke et al., 2015). The co-construction of meaning that occurs between the researcher and participants in qualitative research was acknowledged, and as such, issues of trustworthiness had to be considered. In order to maintain the trustworthiness of the study, the research findings utilised thick descriptions, and researcher reflexivity was thoroughly interrogated, in keeping with the qualitative and interpretive nature of the study (Creswell 2013; Kaplan, 2015). The research was also conducted with consideration of ethical issues, including voluntary participation and confidentiality. This study was approved by the Human Research Ethics Committee (non-medical) at the University of the Witwatersrand.

1.6 Content of the Research Report

This report is divided into five chapters. The first chapter has set the scene for the research by describing the problem statement and rationale for the study. The research questions, and research aims and objectives have been described, and an overview of the research methodology has been presented. This chapter aimed to orientate the researcher to the research topic and the study undertaken. In Chapter Two, the literature pertinent to the study is presented to draw attention to the theoretical concepts and existing research that is available regarding the topic of the impact of mothering with SMI, as well as the role and experiences of professionals working with them. The theoretical framework that underpinned this study is also discussed. In the third chapter, the methodology used in this research, with a focus on the research approach and design, as well as the method of sampling, data collection, and data analysis are presented. A justification of the choice of methods is provided, followed by an interrogation into the trustworthiness of the study, the ethical implications, and the positionality of the researcher. In the fourth chapter, the findings are presented which emerged from the thematic analysis of the data, and thus, this chapter aims to answer the research question(s). These findings are discussed within the context of the available literature on the topic. Finally, in Chapter Five, the research report is concluded, and the contributions, clinical implications, and limitations are discussed, alongside recommendations for future clinical practice and research.

CHAPTER TWO: LITERATURE REVIEW

In this section, the literature and research pertinent to the phenomenon of mothering with SMI is presented. Firstly, SMI is revisited to provide a more comprehensive discussion of this concept. Thereafter, in order to position the phenomenon in context, the state of mental healthcare in South Africa is discussed which highlights the socio-historical issues that are intrinsic to this context. The notion of mothering and motherhood is then expanded upon with a focus on the expectations and representations of mothering, the psychological theories underpinning mothering practice, and the concept of mothering in the South African context. The available research on the impact of SMI on mothering is then presented to position the study in relation to the existing body of literature. The treatment needs of mothers with SMI are then elaborated on with attention drawn to the available research on the perceptions of MHCPs working with this population. Finally, the theoretical framework underpinning this study is presented.

2.1 Severe Mental Illness (SMI)

Severe mental illness is defined as a debilitating group of diseases that can significantly impair functioning in all areas of life. Severe mental illness was a term previously used to encompass a specific group of diagnoses, such as Schizophrenia and Bipolar Mood Disorders, because of the nature and severity of the symptoms typically associated with these disorders (Ruggeri, et al., 2018). These symptoms include, but are not limited to, delusions and hallucinations, avolition (lack of motivation), deterioration in self-care, significant mood lability, and decline in participation in activities of daily living (Barlow & Durand, 2015; Johnson, 1997). Ruggeri et al. (2018) highlight the drawbacks of only delineating diagnoses such as Schizophrenia and Bipolar Mood Disorders and the symptoms associated with them as 'severe', noting that other psychiatric disorders can have equally debilitating symptoms that can also markedly affect an individual's functioning. For example, the symptoms associated with profound personality disorders can result in considerable behaviour disturbances, and cause difficulties in interpersonal relationships, self-concept, emotional regulation, and impulse control (APA, 2013; Barlow & Durand, 2015). A more widely accepted conceptualisation of SMI is that it is typically associated with persistent or chronic presentations of psychiatric diagnoses (regardless of the diagnosis), the symptoms of which can profoundly disrupt an individual's ability to participate in occupational, social, and self-care activities (Zumstein & Riese, 2020).

The severity of the illness pertains more to the extent of disruption to the individual's functionality, rather than the diagnosis itself. In this understanding, personality pathology and other psychiatric disorders, not only mood and psychotic disorders, can also be considered severe (Ruggeri et al., 2018; Zumstein & Riese, 2020).

Historically, SMI was considered to be completely incapacitating, and many individuals with these diagnoses were believed to be incapable of independence. As a result, individuals with SMI were often institutionalised, excluded from work and social contexts, and ostricised from families and communities (Brockington et al., 2011). This inevitably impacted on the success in, and fulfilment of, social roles (e.g. mothering) because individuals had no autonomy, were unable to earn an income, and had poor social support (Drake & Whitley, 2014). Today, individuals diagnosed with SMI typically tend to have episodic presentations of symptoms at different stages in their life. Fortunately, if an individual has adequate support, and adheres to treatment, the number of episodes reduces, the length between episodes increases, and inter-episodic functioning remains relatively stable (Barlow & Durand, 2015). Importantly, because of the severity of symptoms, the demands of SMI can be particularly overwhelming for an individual struggling with an SMI diagnosis. In order to manage their illness, they often have to adhere to a strict and cumbersome treatment regime, which may include regular follow-up appointments at the clinics, participation in therapies, and daily medication in-take (Ball et al., 2005; Barlow & Durand, 2015). Furthermore, hospital admissions are also frequently indicated in SMI, often disrupting an individual's routine and daily life (Zumstein & Riese, 2020). The demands of SMI further place individuals at risk of exclusion from occupational and social contexts and make it particularly challenging for them to effectively fulfil social roles and responsibilities (Boardman, 2011). It is however, generally accepted that individuals with SMI are able to participate in social, occupational, and educational activities and have the capacity to live independently if they receive effective mental healthcare, have access to support systems, and are managed well on medication (Drake & Whitley, 2014).

A shift in the approach to mental illness from a primarily biomedical perspective to a biopsychosocial perspective has reformed treatment for individuals with SMI and has meant that social and psychological interventions are equally prioritised along with medical interventions (Tripathi et al., 2019). Thus, the way in which SMI is approached and treated currently has potentially positive effects on the mothering role for women with SMI. Unfortunately, compliance to treatment and insight around diagnosis, symptoms, and necessary

treatment remain a profound challenge in mental healthcare. In some cases, individuals who are diagnosed with an SMI tend to relapse often, have poor inter-episodic functioning, and do not remain compliant to treatment (Barlow & Durand, 2015; Johnson, 1997). This is often because the symptoms of SMI can be particularly disruptive to the individual and can significantly distort reality, making the capacity for insight impaired (Johnson, 1997). The complexities of SMI are also underpinned by the sociohistorical context of mental healthcare, and this is especially relevant in the South African context.

2.2 The State of Mental Health and Mental Healthcare in South Africa

Mental illness in South Africa is prevalent, with research illustrating that one in six South Africans have mental health struggles, but only an estimated 27% of these individuals receive psychiatric treatment (Booysen et al., 2021; Pillay, 2019). Despite South Africa's progressive legislation that is geared towards protecting mental healthcare users from abuse and discrimination, the field of mental healthcare is profoundly neglected when it comes to resource allocation and state funding. Infrastructure and service development are, as a result, not prioritised, perpetuating the vulnerability of mental healthcare users in the country (Burns, 2011; Lund et al., 2012; Moodley et al., 2022). Inaccessible or unavailable community-based services, outdated infrastructure, unqualified or ill-trained professionals, and high caseloads characterise the state of the mental healthcare system in South Africa, and often prevent successful and effective treatment of mental healthcare users in the country (Burns, 2011; Lund et al., 2012; Moodley et al., 2022). Additionally, South Africans seeking psychiatric care and treatment often face long waiting lists, medication shortages, and lack of access to specialised services such as neuropsychiatry and eating disorder in-patient treatment (Booysen, et al., 2021; Schneider et al., 2016).

Deinstitutionalisation of mental healthcare users, which refers to the integration of patients back into communities and families rather than placing individuals in care facilities, has been a reformative response in South Africa to outdated mental health services (Engelbrecht & Kasiram, 2012). Deinstituionalisation has created pressure on mental healthcare professionals to treat patients quickly and effectively (Mkhize & Kometsi, 2008). For mental healthcare users that have social roles and responsibilities, such as mothers, the pressure is often more pronounced. Importantly, deinstitutionalisation has increased the prevalence of children among psychiatric patients as individuals with mental illness have been able to participate more openly and inclusively in social activities and relationships (Boardman, 2011; Burr et al., 1979).

Apartheid's legacy of inequality underpins the broad systemic failures, and the disjunction in coordination of state sectors, such as the social welfare and legal systems, and this prevents collaboration and comprehensive, holistic service delivery in the South African state sector (Mkhize & Kometsi, 2008). High rates of HIV/Aids, substance abuse, domestic violence, and intergenerational trauma further complicate the context of mental health and mental healthcare in the country and are strongly correlated with poor psychological outcomes, or precipitate and worsen psychiatric symptomatology (Jonsson, 2013). Pertinent to the current study is that research shows that women are disproportionately affected by these factors and are far more vulnerable to adverse social circumstances (Moultrie & Kleintjies, 2006). Additionally, systemic psychosocial issues, such as poverty, homelessness, unemployment, and lack of education increase the risk of adverse mental health outcomes (Khumalo et al., 2012; Pillay, 2019). The complexity of the South African context is underpinned by the interrelation of these factors, as many South Africans are affected by a multitude of psychosocial adversities, which compound the difficulties already experienced by mental healthcare users who are faced with lack of access to treatment and poor-quality care (Booysen et al., 2021).

Resources that are available are primarily concentrated to urban areas, and large hospitals, limiting the reach of available services for many South Africans. Many South Africans are still facing the consequences of Apartheid's segregation policies, and for South Africans living in rural areas, mental healthcare services are almost non-existent (De Kock et al., 2015; Moodley et al., 2022). This often means that the public healthcare system is based on a predominantly reactive model of care that treats mental healthcare users only after functioning is significantly impaired (Docrat et al., 2019; Schneider et al., 2016). The context in which mental healthcare is positioned in South Africa, and the factors that constrain effective treatment and prevent access to care, means that prevention and early intervention programmes are unobtainable (Booysen et al., 2021).

An estimated 80 to 85% of South Africans rely on the state for their healthcare needs (Docrat et al., 2019); however, for individuals with medical aid, and access to financial resources, the mental healthcare system looks vastly different. The disparity of the distribution of resources, and specifically with regards to mental healthcare professionals, between the public and private sectors in South Africa is profound (Moodley et al., 2022). The experiences of the majority of mental healthcare users in the South Africa, as well as the MHCPs who treat them, therefore occur within the context of an already over-stretched and under-resourced public health system,

which is encumbered by an array of psychosocial and socioeconomic challenges (Mkhize & Kometsi, 2008).

Psychological services in the state healthcare system in South Africa are particularly limited, and both studies which have been conducted over two decades ago, Rock and Hamber (1994), and more recently, De Kock and Pillay (2016), have highlighted that psychologists in South Africa primarily practice in the private sector, and the complement of clinical psychologists in the state sector is concentrated to urban areas. Mashigo (2017) estimated that there are only 1.4 psychologists per 100 000 patients in South Africa. Psychological services, especially in the public sector, are strained, and individuals requiring more specialised psychological services, such as mothers with SMI, often bear the brunt of the paucity of resources (David et al., 2011). Low levels of mental health literacy among South Africans, as well as the prevalence of stigma makes access to mental healthcare more challenging (Mkhize & Kometsi, 2008; SAHRC, 2017).

The dire state of mental healthcare in South Africa contextualises the field in which mothers with SMI receive treatment, and in which clinical psychologists work. Given the interpretivist nature of the current study, outlining the context in which the participants practice, and therefore in which their perceptions are shaped, is important for a more nuanced understanding of the findings (Kivunja & Kuvini, 2017; Pervin & Mokhtar, 2022). The South African context also has diversity of religious and cultural beliefs, which are likely to further shape the participants' perceptions and experiences, as well as affect how the phenomenon of mothering with an SMI is viewed, which will be expanded upon in the following section.

2.3 Mothering and Motherhood

The conceptualisation of mothering and motherhood continues to shift and develop as gender norms, cultural and religious beliefs, and political and social ideologies progress (McKinney & Meinersman, 2022). The notion of mothering has received considerable attention from psychological theories which have placed emphasis on the importance of the mother in the development of the child (Louw & Louw, 2016). Societal representations and expectations of motherhood have also imposed beliefs about what this identity means for women. In South Africa, motherhood also holds unique meaning. It is important to first critically examine the concept of mothering and the mothering identity before understanding how motherhood might be reconstructed in the context of SMI. To position this section in the conceptualisation of

mothering utilized for this study, it is crucial to restate the definition of mothering. Mothering is defined broadly as caring for, raising, or nurturing a child; and a mother is a person who engages in the practical and psychological tasks to do so (David et al., 2011; Rampou et al., 2015).

2.3.1 Expectations and Representations of Motherhood

Mothering can be a fulfilling, emotionally powerful, and symbolic experience for many individuals (Hine et al., 2019). Becoming a mother is a transformative process that requires a constant negotiation of internal and external needs (Frizelle & Kell, 2010). As such, mothering can be a physically and emotionally demanding process, and sexist and patriarchal ideologies often mean that mothers have to balance childrearing and household responsibilities with relational, social, and occupational demands (Frizelle & Kell, 2010; Louw & Louw, 2016; Walker, 1995).

Childrearing is often considered a natural and expected part of being a woman, and many women who are childless are often questioned, criticised, or judged as being 'incomplete' (Akujobi, 2011). Motherhood is typically considered as a core feature of womanhood and has become an exemplification of feminine identity. Sex-role stereotypes predicated on the belief that motherhood is an expected and necessary part of being a woman have prescribed a life trajectory for many women in which childrearing and childbearing are both the primary aim and the primary focus (Russo, 1979). Russo (1979) describes this as the concept of the 'motherhood mandate' to draw attention to societal, community, and family expectations that often propel women into motherhood. These expectations are not only based on the notion that biologically, women are 'designed' to have children, but in socially constructed perspectives which are assigned to the feminine identity (McKinney & Meinersman, 2022). The feminine identity and thus women, are typically associated with, and routinely portrayed as, gentle, nurturing, intuitive, and sensitive. As a result, women are often deemed more suitable for caregiving tasks, as opposed to men (Forcey, 1994). These representations indirectly suggest that all women, and therefore mothers by proxy, intuitively possess characteristics and skills that allow them to be an effective parent (Baraitser, 2008).

More recent, feminist literature (Beyer, 2019; Gimenez, 2018; Kawash, 2011) begins to challenge the notion that the wellbeing of the child relies solely on the mother, however, the general discourse in society about what it means to be a successful mother can be dominant and

imposing (Frizelle & Kell, 2010; Hine et al., 2019). Narratives around mothering are extremely prescriptive, leave little room for individual choice, and create profound pressures for women to be successful, competent parents. This is important to note for this study considering that SMI is also exceptionally overwhelming to manage and can exacerbate the pressures already associated with mothering (Hine et al., 2019). For mothers with SMI, having to look after their children, whilst following up at their local clinics, having prolonged admissions, and managing treatment regimens can prove significantly challenging, which can then exacerbate the disruption and the effect that SMI has on the mothering role (Cremers et al., 2014; Rampou et al., 2015). The representations of motherhood and womanhood are further entrenched by psychological developmental theories, which place further emphasis on the mother as exclusively responsible for child rearing, and for the emotional and psychological nurturance of the child.

2.3.2 Psychological Theories of Mothering

There has been a great deal of research and theory development that has drawn attention to the importance of mothering and mothering practices, particularly in the field of developmental psychology (Watts, 2009). The more traditional psychoanalytic theories of mothering are primarily based on the child and mother-child relationship and stress the importance of this relationship in shaping the child's psyche (Wolitzky, 2006). These theories, however, are important as they elucidate the rigid and exhaustive expectations of mothers and highlight a tendency for mother-blaming in psychoanalytic and psychological practice (Chess, 1982). The theory of the 'good enough mother', which is one of the foundational psychoanalytic theories (Winnicott, 1960), has been excluded from this discussion as it is introduced as a core feature of the theoretical framework underpinning this study later in this chapter. For the purposes of this discussion, only the core tenets of the other seminal theories in psychoanalytic psychology are presented which position the clinical psychologists' frame of reference in a theoretical backdrop.

2.3.2.1 Object Relations

Klein's (1932) theory posits that the mother is the primary person responsible for nurturing and nourishing the child, and that the mother is the most significant object (person) in the child's life (Segal, 1978; St. Clair, 2000a). In Klein's theory, the significance of the parent-child relationship is anchored in the idea that this early relationship is internalised and enables an infant to develop mental representation of the self and others (Ogden, 1983; Segal, 1978). This

sets the foundation for the development of the self in relation to the world and others. Klein believed that the availability, responsiveness, and quality of care provided by the mother profoundly influences the child's emotional and personality development (Britton, 1992; Segal, 1978; St Clair, 2000a).

2.3.2.2 Attachment and Mentalisation

The Attachment Theory (Bowlby, 1969) is a core pillar of developmental psychology. According to this theory, an essential task in the beginning of life is to create a bond of emotional connection with the caregiver, and this typically happens with the mother, the primary attachment figure (Louw & Louw, 2016). Bowlby (1969), a seminal author in Attachment Theory, emphasised the necessity of the attachment figure's accessibility and responsiveness to yield emotionally meaningful mother-child interactions that surpass the need for physical proximity required in basic caregiving practices (Shore & Shore, 2008). This means that more practical caregiving tasks, such as feeding, bathing, and dressing, are only the most rudimentary responsibilities of the mother. The quality of the early mother-infant relationship has a profound influence on future relationship development, and as such, serves as a template for relational patterns across the lifespan (Holmes, 1993; Morse et al., 2003). According to the Attachment Theory, the early relationship with the mother can shape both the perception of self, and the experience of the other (Morse et al., 2012). The mother's ability to be responsive, attuned, nurturing, and engage in positive interactions with their child (such as communicating and playing) are fundamental for the way in which their child will form an attachment. This relationship necessitates a stable, present, and self-regulating mother with the ability to mentalise (Jurist & Meehan, 2009).

Mentalisation, and the concept of reflective function, is fundamental for the child's ability for self-regulation, and capacity to competently navigate stressful life events, and effectively interact with and process the social environment (Fonagy et al., 2002; Fonagy & Campbell, 2016). The mother's ability to mentalise is therefore fundamental for the development of the child as a socially competent, empathic, and regulated individual. Mentalisation refers to the ability to think about and understand interpersonal and intrapersonal dynamics and their corresponding mental states (Ensink & Mayes, 2010; Fonagy et al., 2002; Raphael-Leff, 2018). Essentially, this refers to the ability to think about one's own behaviour, and the behaviour of others in relation to underlying beliefs, desires, and intentions. In this process, the infant needs to interact with a maternal mind that is mature, benign, and reflective, and one that can

recognise and accurately interpret signals from the infant (Ensink & Mayes, 2010; Fonagy & Campbell, 2016). Essentially, a mother needs to identify the feelings of a baby and think about them as being related to a need or desire and respond accordingly. Furthermore, this process necessitates an ability to tolerate the infant's unmanageable feelings. In order to be able to provide this for her baby, a mother needs to be able to think about her own feelings, and attribute them to her own needs, desires, and experiences (Raphael-Leff, 2018). If the mother is able to engage in her own process of mentalisation, she will be better able to understand and manage the feelings of her infant (Ensink & Mayes, 2010). If the mother responds to her infant in a way that escalates or joins in the infant's distress, potentially for example, when she is struggling with an SMI (Brockington et al., 2011), the infant experiences his/her own emotions as contagious, hard to regulate, and dangerous (Fonagy et al., 2002; Fonagy & Campbell, 2016). According to this theory, the mother has a crucial role to play in the healthy emotional development of the baby, but also needs to possess healthy emotional and relational skills herself to effectively mother.

2.3.2.3 Container/Contained

Bion's (1985) theory of Container/Contained also brings attention to the significance of the mother-infant dynamic. In Bion's theory, the capacity of the mother is particularly integral, as the child's emotional development is based on the mother's ability to appropriately engage in the early relationship with the child. For Bion, a primary function of the mother is to use her mind, reverie (referring to a state of being receptive and attuned to the child's emotional state), and capacity to mentalise, to help an infant make sense of and manage his/her emotions and experiences (Symington, 1996). Bion (1985) believed that infants often have raw sensory experiences that might feel intolerable, and which are not yet processed to be understood as feelings. The mother's role is to metabolise these raw sensory experiences for the infant, make sense of them, and give them back to the infant in a meaningful form (Symington, 1996; Waddell, 1998). Through this process, the infant introjects something that either dissipates his/her distress and gives the child the experience that the world is benign and that feelings can be thought about, tolerated, and managed, or intensifies the infant's anguish and gives him/her a perception of the world as destructive and dangerous (Ivey, 2009; Waddell, 1998). In the former, the infant begins to develop meaningful emotional relationships with the object (initially the mother), and later, with others. In the latter, the infant needs to protect him/herself and does this by withdrawing and limiting meaningful relationships and shared emotional experiences (Bion, 1985; Waddell, 1998). The successful functioning of the mother as a

container contributes to the infant's eventual capacity to understand and regulate his/her own powerful emotional states. Being a container, however, requires a mother to have an intuitive sense of the infant's distress, and be able to process this distress within her own mind, and with the infant, without becoming overwhelmed herself (Symington & Symington, 1996).

The discourse around mothering identifies several core elements that constitute the 'ideal' mother, such as the ability to be attentive to the physical and emotional needs of the infant; the capacity for reflective functioning; maternal mentalisation; sensitivity, warmth and nurturance; as well as effective discipline, tapered supervision and autonomy granting (i.e., the capacity to provide a safe environment with appropriate boundaries in which exploration can occur) (Cowling & Van Gordon, 2021; Hine et al., 2019; Jenkins, 2019; Louw & Louw, 2016; Murray et al., 2019; Slade & Sadler, 2018). These skills outlined in the literature are predicated on the theoretical frameworks discussed above and call for a mother to possess a heightened and astute awareness of the extent of her child's dependence on her (Hayes, 1996).

The common thread across all these theories is that the mother plays a crucial role in the healthy development of the child, and that the quality of the early mother-child relationship is the most important predictor of successful emotional, cognitive, physical, and psychological development. However, it is fitting that the term 'mother' is used in these theories, given the expectations and representations of motherhood and what the term 'mother' is often associated with in society. More contemporary interpretations of the psychoanalytic theories acknowledge that the individual being described as the mother can refer to any other (primary caregiver) in the child's life (Kenny, 2014). In the South African context, this is particularly relevant as many children are raised by other family members, who may still be successful and 'ideal' caregivers for the child and foster healthy psychological and emotional development (Kenny, 2014; De Villiers, 2011). For the current study it is important to consider that the mothering role is strongly defined by cultural and contextual factors, and 'ideal' mothering practices might not be applicable across all cultures (Murray et al., 2019).

2.3.3 Mothering in South Africa

Seminal psychoanalytic theories, such as those discussed earlier, are predominantly based in Western ideologies about motherhood and mothering practices. It is important to consider what practices are acceptable and 'normal' in different cultures that may shape mothering practices when attempting to gain insight into how issues such as SMI may affect mothering.

In the South African context, there is a diverse set of cultural and traditional contexts that shape the way in which individuals may approach mothering. As Frizelle and Kell (2010) assert, mothering is "an identity that is actively negotiated within a web of social interactions against a backdrop of wider cultural expectations" (p. 27). Arguably, this perception is in contrast to the perception of Barlow and Cairns (1997) which asserts the importance of a mother's ability to create an internal model of mothering based on her own meaning, and independent of external influence (Barlow & Cairns, 1997). It is important to consider here, rather, how normative narratives about what it means to be a 'good' mother may pathologise different mothering practices based on cultural beliefs and practices (Frizelle & Kell, 2010; Walker, 1995). For example, in some cultures it is considered normal for children to develop independence as early as possible, and as such mothering approaches are geared towards this (Akujobi, 2011). More traditional psychological ideologies might view this as inappropriate autonomy granting which may put the child at risk for a pattern of pathological self-reliance (Hauser Kunz & Grych, 2013).

Additionally, many of the theoretical frameworks and ideologies that underpin mothering practices have an assumption that all families are nuclear, and that a child is cared for by a biological mother (Bozalek, 1997). In South Africa in particular, this is often not the case, and many children are cared for by grandparents or other family members. A more community-based approach to childrearing confronts and challenges the concept that mothering occurs as an exclusive, one-on-one relationship between a child and his/her biological mother (Sudarkasa, 2004). Notably, the African proverb 'it takes a village to raise a child' (Reupert et al., 2022) reinforces that childrearing is a considerable task, and insinuates that it is a responsibility that should not, and cannot, be assigned to only one person. In many traditional African cultures, family members are viewed as resources in the parenting process, and motherhood is a collective identity (Sudarkasa, 2004). Some authors, such as De Villiers (2011), however, are of the opinion that care of children by other family members in a more collectivist parenting approach can be disruptive to attachment with a primary caregiver and as such, has negative consequences for the wellbeing of the child. The South African context is unique in that the intersection of a mother's identity is charged by the sociopolitical climate of the country, meaning that many mothers may have no choice but to leave children with alternative caregivers, for example, if they have to go work or fall ill and are unable to care for their children (Frizelle & Kell, 2010; Spjeldnæs, 2021).

The intersectionality of race, class, and gender in motherhood creates a complex and challenging landscape for mothers to navigate, even outside of the context of SMI. Black women in South Africa who are mothers and living in low-income rural areas are the most significant victims of systemic barriers that are likely to prevent access to healthcare, employment, and education (Moultrie & Kleintjies, 2006; Nkosi & Van Der Wath, 2012). The intersectionality of social identity and the implications of this in South Africa are interrelated. The sociohistorical context of South Africa also means that black women are more likely to live in poverty. The sociocultural and sociohistorical climate of South Africa has also perpetuated single mothering, meaning that women are more likely to raise children without support of a partner or father (Moore, 2013; Perrot, 2017; Spjeldnaes, 2021). The mothering identity is the focus of this study, however, her experiences of mothering with an SMI will inevitably be influenced by psychosocial issues that she already faces as a result of her race, gender, class and relationship status. The compounding effect of social identity therefore has relevance for the way in which the identity as a mental healthcare user, and as a mother, is navigated. This is fundamental to consider when exploring the impact of SMI on mothering.

2.4 The Impact of SMI on Mothering

Women who are mothers and have an SMI are required to mediate the contradictory elements of their dual identity both as a parent and as a mental healthcare user (Banerjee et al., 2021). For women trying to be an 'ideal' mother, this can prove to be a monumental task. SMI can affect mothering in a multitude of different ways, both in terms of the mother's capacity to parent, as well as the mother's ability to manage and negotiate the demands of both her children and her mental illness (Mizock et al., 2019; Van der Ende et al., 2016). The prevalence of SMI among mothers elucidates the need for research to be concentrated to this area of mental health and suggests that the extent of the impact of mothering with SMI on both mothers and children is significant (Banerjee et al., 2021; Dolman et al., 2013; Montgomery et al., 2011).

2.4.1 Prevalence of SMI amongst Mothers

The prevalence of SMI amongst mothers draws attention to the prominence of mental illness in families and foregrounds the significance of this research topic. Importantly, adult women have the highest rates of mental illness among the South African population (Rochat et al., 2015). South African statistics regarding the number of mothers with SMI is limited, with the focus mainly on post-partum onset of illness (Fisher et al., 2012). International literature,

however, indicates that a significant portion of individuals with mental illness are parents, and that women with SMI are far more likely to be parents than men with SMI (Lacey et al., 2015; Mizock et al., 2019). A recent study by Mayberry and Reupert (2018) showed that up to 45% of adults in the mental healthcare system are estimated to be parents. In the United States of America (USA), it was estimated that 3.8% of parents had SMI (Stambaugh et al., 2017). Another study from the USA indicated that 38.5% of female patients who were admitted to psychiatric hospitals were mothers (Benders-Hadi et al., 2013). Leijdesdorff et al. (2017) found that worldwide, up to 23% of children live with a parent with a mental illness, whereas another study estimated this prevalence rate to be slightly higher at 28% (Maybery et al., 2009). It is significant that women tend to be more affected by SMI than men, and that they are also more likely to be the primary caregivers for their children (Mizock et al., 2019; Mowbray et al., 2011). These prevalence rates espouse the theoretical assumptions and societal expectations of mothering in which the woman is typically considered the exclusive caregiver, highlighting the pressures affiliated with the mothering role, and situate these in the context of SMI.

2.4.2 The Impact of SMI on Mothering Skills and Behaviours

There is an abundance of research available on the effect that SMI has on parenting and children (Brockington et al., 2011; David et al., 2011; Deutsch & Clyman, 2016; Khang et al., 2008; Montgomery et al., 2011; Tchernegovski et al., 2018; Van der Ende et al., 2016). Parent-child relationships and the stability of the family environment have been shown to be significantly poorer in families with parents with SMI, comparative to those without SMI (Van Loon et al., 2014). The symptoms associated with SMI can affect the way in which parents might engage with their children, as well as their capacity to be consistent, attentive, and emotionally available to their children (Brockington et al., 2011; Deutsch & Clyman, 2016; Khang et al., 2008). Symptoms such as fatigue, low energy, poor motivation, and hallucinations and delusions may make it hard for a mother to engage in play, communicate with a child, or participate in day-to-day parenting activities (Strand et al., 2020). Deterioration in self-care or preoccupation with distorted thoughts and experiences may make it hard for mothers to move beyond a self-focused state to a consideration of the needs of the infant. These SMI symptoms, particularly when they are untreated or unmanaged, affect a mother's ability to provide environments that are stimulating for the child, maintain a routine in the home, and assert healthy boundaries and limits (Brockington et al., 2011; Strand et al., 2020). These are important elements of creating a safe environment for a child to explore, learn, and develop a healthy sense of themselves and others (Louw & Louw, 2016).

Studies have shown that mothers with SMI may also struggle with mentalisation and separating their own distress from that of their child's (Strand et al., 2020). This may engender a difficulty in attunement and thus recognising and appropriately responding to their child's emotional needs (Kamis, 2020; Mowbray et al., 2002). In psychoanalytic terms, being a container for a child's difficult feelings becomes challenging (Waddell, 1998). Furthermore, a mother who is having to manage her own mental illness, may struggle to be present for a child's learning needs (e.g., help with homework), physical needs (e.g., bathing), and emotional needs (e.g., comfort when distressed) (Brockington et al., 2011; Deutsch & Clyman, 2016; Kahng et al., 2008; Voges et al., 2020). Importantly, the nature of SMI means that individuals often require prolonged hospitalisations, regular clinic follow-ups, and allied interventions, all of which affect a mother's ability to be consistently available for her child (Strand et al., 2020). Furthermore, as Hayes (1996) posits, a child's needs should supersede that of the mother's, creating a difficult predicament for women with SMI who need to ensure their own wellbeing for the sake of themselves and their child. The side-effects of medication, such as fatigue, poor concentration, or sedation, may also prevent a mother from being able to effectively interact with her child, and fulfil a parenting role (Rampou et al., 2015).

The disruptions to behaviour and caregiving as a result of SMI affect the mother's ability to form an attachment with the child and develop an appropriate parent-child relationship. To bond with a child, and form an attachment, the mother needs to be physically and mentally present, available, and engaging with the child (Brockington et al., 2011). A mother who is distracted, out of touch, and inconsistent because of an SMI which affects their behaviour and personality, is unlikely to be able to form a healthy, reciprocal, and connected relationship with her child (David et al., 2011). In more serious cases, erratic and disorganised behaviour, unpredictable symptoms, and mood swings can result in neglect or displaced aggression directed towards the child (Ackerson, 2003; Brockington et al., 2011; Patrick et al., 2015). Unsurprisingly, maternal mental illness has an effect on the child's emotional, physical, and psychological development and wellbeing (Kamis, 2020; Miklush & Connelly, 2013; Schepman et al., 2011).

2.4.3 The Impact of SMI on the Child

The impact that SMI can have on a child can be both directly related to the disruption to care and exposure to an unpredictable parent, and to social adversity and psychosocial stressors that accompany SMI (Gladstone et al., 2011). There is some debate on whether having a mother

with mental illness is a predictor of transient and short-term adjustment difficulties, or long-term mental health challenges and developmental delays (Angelini et al., 2016; Gladstone et al., 2011; Kamis, 2020; Van Loon et al., 2014). The extent of the disruption to caregiving is likely to mediate the outcome for the child. Mothers who are compliant to treatment regimen are less likely to be incapacitated in their parenting role and as such, the effect of the SMI on the child is less pronounced (Van Loon et al., 2014). For mothers who have unmanaged SMI, the concomitant consequences of long periods of separation due to hospitalisation, exposure to erratic behaviours, and constant change in caregivers can profoundly impact a child's emotional and psychological wellbeing (Kamis, 2020).

Overall, however, it is widely agreed that children of parents with mental illness are far more at risk for psycho-emotional and developmental difficulties than children without parents with mental illness (David, et al., 2011; Miklush & Connelly, 2013). In instances where containment and attachment are impaired as a result of the behaviour and parenting disruption associated with SMI, a child is likely to experience a range of difficulties including emotional dysregulation, poor interpersonal functioning, academic struggles and behaviour disturbances (Fonagy & Campbell, 2016; Singleton, 2013). The disruption to caregiving and associated consequences, as well as a genetic predisposition, also makes children of mothers with SMI more likely to develop psychiatric disorders themselves (Schepman et al., 2011; Singleton, 2013). Interestingly, research has also shown that children of parents with SMI are at an increased risk for physical injury and medical troubles such as asthma and malnutrition (Pierce et al., 2019).

The psychosocial adversities linked with both womanhood and SMI, particularly in the South African context, also affect the children of these mothers. For example, mothers with SMI who are affected by poor employment and education opportunities are also likely to live in poverty or experience homelessness, and the children that they care for will also be exposed to these difficulties (Campbell & Poon, 2020; Dobener et al., 2022). These adversities are also risk factors for poor mental health outcomes in children (Louw & Louw, 2016). Attuned, 'good enough' caregiving is likely to mitigate many of the effects that psychosocial adversities might have on a child, and reduce the risk of poor psychological, emotional or physical outcomes (Dobener et al., 2022; Louw & Louw, 2016). The context in which many mothers have to parent, however, is brought to light here, and the pressures associated with parenting in such harsh contexts and in the face of social adversity are profound. Mothers who are living in

poverty may not be able to provide for the physical needs of the child, and if they are able to find employment, they may struggle to balance their child's emotional needs (e.g., to interact and play with the primary attachment figure) with their employment responsibilities (Rampou, et al., 2015). The cyclical nature of this phenomenon is also emphasised, as mothers with SMI are affected by psychosocial adversities (such as poor access to healthcare, education, and employment) which are likely to worsen their symptoms, which then makes it harder to participate in societal activities and fulfil their mothering role (Dobener et al., 2022; Montgomery et al., 2011). Parenting capability by mothers with SMI is therefore "jeopardised by the complex interplay of mothering, mothering contexts, illness, service needs and resources" (Montgomery et al., 2011, p. 2). Additionally, children who grow up with mentally ill parents and thus are also more likely to develop mental illness themselves, often also become parents, perpetuating the cycle (Dolman et al., 2013). As Raphael-Leff (2018, p. 18) suggests, the health of children "predicts the health of the future", and as such, the consequences of SMI are not only relevant for the immediate wellbeing of the child, but for the long-term wellbeing of society.

The impact that SMI has on the child is fundamental to consider; however, literature in this area appears to focus primarily on how SMI affects the mother in relation to her child, with a lack of focus on the needs, identities, and challenges the mother faces as an individual (Shor & Moreh-Kremer, 2016). The gap in this literature supports the need for the current study. The effect of SMI on maternal identity and self-perception is prominent, and for the purpose of this study, an exposition into the research surrounding the identity of the mother within the context of SMI is crucial.

2.4.4 The Impact of SMI on Maternal Identity and Self-Perception

Mental illness has an effect on social identity, as it may disrupt an individual's ability to participate in social roles and result in a fragmentation in the sense of self (Hine et al., 2019). The mothering identity is already considered as something that has the propensity to provide a woman with purpose and fulfillment, and research shows that mothers with SMI equally desire to fulfil the parenting role (Dolman et al., 2011). Literature suggests, however, that mothering with SMI can reduce parenting confidence, and contribute to feelings of incompetence and a sense of failure among mothers (Mizock et al., 2019; Shor & Moreh-Kremer, 2016). Hine et al. (2019) found that being a 'good' mother can feel exceptionally difficult for mothers when their mental illness is unmanaged. The prescriptive theories impose expectations on mothers

about what it means to be successful and effective, which many mothers with SMI, and those living in difficult social circumstances, struggle to live up to (Hine et al., 2019).

Mothers with SMI often compare themselves with the societal representations, and cultural and family expectations of motherhood. When they are unable to meet these, due to the limitations caused by their illness, they are often left with feelings of inadequacy, poor self-esteem, guilt, and fear (Dolman et al., 2013; Hine et al., 2019; Van der Ende et al., 2016). These feelings are likely to be exacerbated when a mother is attending to the demands of her mental illness (Rampou et al., 2015). Additionally, Hine et al. (2019) showed that mothers who have SMI often experience a disconnect from other mothers, and that they feel socially isolated in communities, further entrenching a sense of loneliness and shame. In the context of collective mothering often inherent in South African communities (Sudarkasa, 2004), this loneliness and shame is compounded. Mothers with SMI may have a desire to be competent but may be vulnerable to the criticism that they receive from friends, family, the community, and healthcare professionals, which often becomes internalised (Hine et al., 2019; Shor & Moreh-Kremer, 2016). The stigma that mothers with SMI often face in society is based on the incongruency between the representations and expectations of mothering, and the stereotypes linked to SMI (Heron et al., 2021).

2.4.5 The Role of Stigma and Societal Attitudes Towards SMI in Mothers

Stigma surrounding mental illness is still pervasive, despite the fact that advocacy for mental health awareness has increased exponentially since the 20th century (Corrigan et al., 2012; Pescosolido et al., 2021). Even without the additional societal implications related to parenting with SMI, having a mental illness leads to prejudice and discrimination (Reupert et al., 2020; Stuart, 2016). Individuals with SMI have historically been considered unable to look after themselves, and as such, the ability to effectively care for a child has been largely questioned by society (Heron et al., 2021; Lacey et al., 2019; Reupert et al., 2021). Individuals with mental illness are often considered to be dangerous and ignorant, and have as a result, been deprived of opportunities and autonomy (Lacey et al., 2019). The stigma of mental illness is compounded for mothers with SMI, as the perceived juxtaposition of parenting with SMI results in reduced social support, experiences of judgement and criticism from others, and an increased risk of loss of custody of a child (Montgomery et al., 2011).

The children of mothers with SMI are often exposed to the same social isolation, stigma, and discrimination that their mothers face (Dolman et al., 2013). Eliezer et al. (2022) argued that some children may be stigmatised if they have a mother with SMI, as they might be perceived by society as being 'contaminated' by their parent. The effect of stigma on children of mothers with SMI can lead to poor self-esteem, bullying, and poor interpersonal relationships (Dobener et al., 2022). The ramifications of stigma are also cyclical for mothers with SMI – mothers who are excluded from social and occupational contexts are likely to have minimal support from families and communities, and struggle to ensure financial stability. This may make it hard for mothers to remain psychiatrically stable, as well as provide for, and care for a child, which then perpetuates the perception that mothers with SMI are incapable and unstable caregivers (Dobener et al., 2022; Reupert et al., 2021). The capacity of the mother to parent with an SMI is therefore inextricably linked with the level of social support and inclusion they receive in their environments (Montgomery et al., 2011). This includes psychological support (David et al., 2011), and therefor underpins the reason for the specific focus of this study. Finally, stigma is a profound barrier to care for mothers with SMI, who often avoid seeking treatment or disclosing their parental status to professionals because of shame, fear, and judgement (Engqvist et al., 2011; Montgomery et al., 2011). Treatment and support for mothers with SMI therefore needs to be based on their unique experiences and challenges that they face as a patient population.

2.5 Treatment and Support for Mothers with SMI

The majority of studies focusing on mothering with SMI have recommendations regarding treatment programmes that would benefit both the mothers and their children (Brockington et al., 2011; David et al., 2011; Heron et al., 2021; Hine et al., 2019; Mizock et al., 2019). Unfortunately, mothers with SMI often face barriers to care that are embedded in socioeconomic contexts and role responsibilities. The perceptions of MHCPs on mothering with SMI also introduce complexities to the care and treatment provided to this patient population. As this study is focused on a specific group of MHCPs, it is important to first foreground the nature of the scope of practice of clinical psychologists in order to position their role in working with mothers with SMI.

2.5.1 Psychotherapy and Psychological Support

This study focuses on a specific group of MHCPs, and it is therefore salient to foreground the therapeutic framework that generally guides clinical psychologists in practice. Importantly, the

scope of practice of clinical psychologists is broad, and includes assessments as well as therapeutic interventions for individuals, groups, and families (Linden & Hewitt, 2018; Turel et al., 2020). Typically, in a psychiatric setting, clinical psychologists provide psychotherapeutic interventions to patients and their families (Linden & Hewitt, 2018). The scope of practice of psychologists specifically in South Africa, includes assessment, diagnosis, and treatment of mental illness, as well as therapeutic interventions addressing behavioural, mental, cognitive, and health disorders (Health Professions Act 56 of 1974). Clinical psychologists in South Africa are trained in a variety of modalities and are equipped to work at both tertiary level institutions and community clinics (Health Professions Act 56 of 1974). Psychotherapeutic interventions are underpinned by several key assumptions about what successful therapy entails.

Traditional psychoanalytic approaches highlight the importance of the clinical psychologist maintaining a neutral and objective stance with the patient (Lemma, 2015). However, more recently, the intersubjective nature of the therapeutic relationship has been given attention which emphasises the emotional contributions of the clinical psychologist that are an inevitable part of the dyadic and shared process of therapy (Lemma, 2015). Intersubjectivity acknowledges that both the patient and the clinical psychologist are charged with their own beliefs, perceptions, experiences, and social identities, and that these invariably play a role in the therapeutic interaction (Aponte, 2022; Nissen-Lie et al., 2022; Zeller-Steinbrich, 2018). For psychologists working with mothers with SMI, intersubjectivity suggests that clinical psychologists will inevitably be affected by their own parenting status, beliefs, and perceptions about 'good' parenting practices, and their own experiences of being a child (Derry, 1994; Nissen-Lie et al., 2022). Often referred to as countertransference, the clinical psychologist's own internal difficulties, unresolved conflicts, and unprocessed experiences can be triggered in a therapeutic interaction. If this is unmanaged and unacknowledged in the therapeutic space, countertransference can influence a clinical psychologist's capacity to remain objective and may affect his/her emotional response and reaction to the patient (Lemma, 2015; Nissen-Lie et al., 2022). Ideally, clinical psychologists should be aware of their own desires and agendas in therapy to provide a patient with a non-judgmental space in which they can explore their thoughts, feelings, and experiences (Ivey, 2011). This allows for patients to present a narrative of their life, and establish cohesion in their experiences, a salient process to begin working through more challenging experiences (Lemma, 2015).

Importantly, the theoretical underpinnings of developmental and psychoanalytic psychology, such as attachment and mentalisation theory, container/contained, object relations theory, and 'good enough' parenting also guide a therapeutic approach (Lemma, 2015). Just as a mother is required to be attuned, warm, and present to her baby for optimal bonding and development, the clinical psychologist needs to use the same skills in the therapeutic relationship to ensure a successful outcome for the patient (Gabbard, 2018). Although a contentious perspective, Slochower (1994) argues that in the therapeutic interaction, the clinical psychologist's role is as the mother, and the patient's is as the baby. In this way, the clinical psychologist also becomes the container for the patient and uses his/her ability to mentalise to think about the patient's experiences and help them symbolise and make sense of their difficult emotions and experiences (Ivey, 2011). Furthermore, just as the mother's relationship with the baby embeds mental frameworks and prototypes of relationships, the patient-clinical psychologist relationship can modify the patient's relational patterns through new and corrective experiences in the therapeutic relationship (Gabbard, 2018; Lemma, 2015; Shore & Shore, 2008). A clinical psychologist can play a significant role in modelling new ways of relating, thinking, and regulating for a patient, and can help patients develop their own capacity to manage and think about their feelings and ways of relating in the world (Ivey, 2011; Lemma, 2015). This assumes that a clinical psychologist who utilises skills that a mother might use in an interaction with an infant (such as attunement, emotional sensitivity and responsiveness, reflective functioning, and warmth) may model a way of interacting for the patient who is a mother (Raphael-Leff, 2018). The therapeutic relationship in this way becomes a vehicle of change for the patient (Cowling & Van Gordon, 2021; Hine et al., 2019; Jenkins, 2019; Lemma, 2015; Slade & Sadler, 2018; Slochower, 1994).

For mothers with SMI, the therapeutic relationship might provide a containing and safe space to explore issues of parenting in the context of SMI and could be valuable in terms of developing skills and capacities to both manage their mental illness and enhance their parenting capacity. Clinical psychologists are central in work with mothers with SMI, because of their unique knowledge about emotional and psychological functioning, developmental issues, and personality structure (Linden & Hewitt, 2018). They can therefore play a fundamental role in responding to the mental healthcare needs of mothers with SMI.

2.5.2 What is Needed for Mothers with SMI

Mental healthcare services have typically been structured around the assumption that individuals with SMI do not have children, are single, and live with some level of support. This is underpinned by stereotypical perspectives about individuals who struggle with mental illness (Banerjee et al., 2021). Treatment of individuals with SMI also is commonly focused on psychiatric stabilisation, especially in more resource limited contexts, and less on psychological and occupational rehabilitation (Robertson & Szabo, 2017). There is a deficit of services that are aimed at treating mothers with SMI, and addressing all aspects related to their care needs, and this is especially true in the South African context (Brockington et al., 2011; Rampou et al., 2015). An abundance of research suggests specific treatment and intervention programmes that are needed to support this patient population which might be useful for application in the South African context to reduce the burden of disease for mothers with SMI and their children (Brockington et al., 2011; David et al., 2011; Heron et al., 2021; Hine et al., 2019; Mizock et al., 2019).

Literature reveals that treatment and support for mothers with SMI need to be holistic in that it includes a focus on the mother and her experiences in managing her illness, the mother's identity as a parent, parenting approaches, and child and family focused interventions (Heron et al., 2021). Importantly, the needs of a mother in terms of her treatment might differ depending on her process of recovery, and the course of interventions should be non-linear (Heron et al., 2021). For example, a psychiatric intervention focused on reducing symptoms and ensuring a return to premorbid functioning is typically prioritised as the first point of care for a mother who is experiencing severe symptoms. Thereafter, as a mother's capacity to engage in more complex treatment programmes such as psychotherapy, focus may be shifted to issues of self-esteem, confidence, symptom management, and individual-specific therapeutic goals (Heron et al., 2021).

A prevailing theme in the literature regarding the treatment needs of mothers with SMI is that parenting needs to be incorporated as a target area in intervention (Brockington et al., 2011; David et al., 2011). Literature illustrates that mothers with SMI require education, training on parenting practice, and support to manage their demands (Brockington et al., 2011; David et al., 2011). Interventions that focus on promoting a positive self-concept with regards to the mothering role, managing this role in the context of SMI, and parenting skills are needed to support mothers with SMI who desire to fulfil their parenting role (Mizock et al., 2019). This

may involve providing an individual or group space in which mothers with SMI can discuss their experiences and connect with other mothers (David et al., 2011; Hine et al., 2019; Radley et al., 2022; Reupert et al., 2017). Furthermore, research illustrates that mothers with SMI desire more parent-friendly experiences when they attend clinics or are admitted to hospital (Rampou et al., 2015). Importantly, literature also indicates that interventions targeted towards the family support have also been shown to be necessary (Radley et al., 2022). This may involve educating the family, including the child, on SMI and treatment, and enhancing the family support for the mother (Heron et al., 2021). Mothers could also benefit from empowerment to discuss their illness with their children and families (Reupert et al., 2015). Importantly, the literature suggests that treatment programmes should consider that the 'parent' status of patients should have priority when treatment is implemented (Heron et al., 2021). There are a variety of recommended interventions for mothers with SMI, however, there are often barriers to care affecting the success and effectiveness of such interventions.

2.5.3 Barriers to Care

Many of the barriers to care have already been addressed throughout this discussion, including under-resourced and overstretched mental healthcare contexts and stigma, which limit the treatment opportunity available to mothers and reduce access to care (Lacey et al., 2019; Moultrie & Kleintjies, 2006). Interestingly, the literature suggests that mothers with SMI are at increased risk for losing custody of their children because of the pervasive stigma pertaining to the capabilities of these mothers to parent (Heron et al., 2021), suggesting that the parenting role and wellbeing of the child is a foregrounding factor for interventions. Some literature, however, suggests that the fact that an individual is a parent is often overlooked in treatment interventions and that the parenting skills and experiences are not the focus of many psychiatric interventions. Furthermore, the identity of the parent and their perception of their role is often disregarded (Eliezer et al., 2022; Mizock et al., 2019). This has been identified as another barrier to care for mothers with SMI, who may either fear treatment because of the risk of judgement, or in serious circumstances, loss of custody of their child, or experience a complete disregard for their parenting status (Eliezer et al., 2022; Mizock et al., 2019). Chandra et al. (2019) found that in some instances, treatment of mothers with SMI might prioritise the children over the mother, and interventions may be primarily directed towards the wellbeing of the child. Additionally, Eliezer et al. (2022) showed that interventions that did address the parenting role, focused on practical issues of parent functioning, rather than support of the

parenting role. In interventions that are provided, the focus is often on social welfare interventions, the needs of children (e.g., in terms of therapy), or the focus is on mothers with young children (Mizock et al., 2019).

In South Africa, the barriers to care for mothers with SMI are rooted in the socio-economic context of many of these women. Rampou et al. (2015) found that mothers who had insufficient financial resources often had to decide between supporting their children in terms of their practical needs or using the money for clinic visits. Additionally, mothers with SMI in South Africa were shown to have poor financial support and involvement from the biological fathers of the children, and as such often are single mothers. This makes it difficult for mothers to attend clinic appointments or consent to long hospital admissions because of the pressure to care for children at home (Rampou et al., 2015). This may result in a lack of necessary medication and subsequent relapse. These issues are embedded in broader systemic barriers that are present in the mental health context in South Africa as described in the beginning of this literature review, as well as a lack of integrated, holistic care from different sectors (Chandra et al., 2019). Finally, research suggests that the views and attitudes of MHCPs working with parents with SMI also can result in barriers to care, as often a mother's status as a psychiatric patient may result in a disregard and neglect of her needs as a parent (Heron et al,. 2012).

2.5.4 Perceptions of MHCPs Working with Parents with SMI

Literature on the perceptions of MHCPs on parenting with an SMI has significant relevance for this study, particularly considering the aims of this research. The available literature on the topic is mainly based on the perceptions of psychiatrists, nurses, and allied professionals (e.g., social workers, support workers, occupational clinical psychologists, and clinical psychologists) (Krum et al., 2014; Strand & Rudolfsson, 2020). None of the available studies focus solely on the perceptions of clinical psychologists. Strand and Rudolfsson (2020) conducted a study on MHCPs' perceptions of parenting with psychosis. Their study focused on participants who were social workers, psychiatric aids, and nurses. They found that these professionals perceive that parents with SMI struggle to provide a stable, safe environment for their children, as well as maintain focus on their child's needs. Krum et al. (2014) found that some MHCPs went as far as saying that parenting and mental illness are "diametrically opposed" (p. 98). Their study focused on the ideas of nurses, psychologists, social workers, and psychiatrists. Studies that focused on the experience of mothers with SMI identified

that the attitudes of MHCPs towards mothers with SMI about their parenting ability are often unfavourable, stigmatising, or negative (Dolman et al., 2013; Engqvist et al., 2011). Chandra et al. (2019) also found that mothers often experience uncompassionate and judgmental MHCPs. These attitudes could be underpinned by the concern around the risk to the children involved, both in terms of the physical and psychological impact that SMI in a parent can have on children (Krum et al., 2014). Krum et al. (2014) highlight how MHCPs, such as clinical psychologists, may find working with this population quite challenging, as they are torn between their allegiance to the patient, as well as their concerns about the impact that SMI can have on children. In contrast, Radley et al. (2020) found that MHCPs (unspecified) do not always believe that psychiatric illness means that an individual will be a poor parent. However, some MHCPs view the parent status as a separate issue from the psychiatric needs of the patient and consider this issue more suited to be addressed by social welfare services than psychiatric services (Eliezer et al., 2022). Similarly, Chandra et al. (2019) suggested that some MHCPs are unwilling to address the psychological needs of mothers with SMI, and as such focused more on the psychiatric rehabilitation of these individuals. Eliezer et al. (2022) found that despite the different attitudes and approaches of multidisciplinary team members towards their interventions with mental healthcare users, there was no difference among different professionals regarding parenting issues. This suggests that even though MHCPs such as clinical psychologists might have a unique lens in which they could view issues of mothering, their attitudes regarding parenting with SMI may not differ significantly from their colleagues from other professions.

The available literature on perceptions of MHCPs' perspectives provides a backdrop to explore the perceptions of clinical psychologists on mothering with SMI as well as how these perceptions might influence clinical practice. Furthermore, the literature review illustrates the gap in the research regarding the specific perceptions of clinical psychologists working with mothers with SMI. Interestingly, a key assumption previously underpinning psychoanalytically inclined psychotherapy, as discussed earlier, is that the clinical psychologist becomes the 'mother' and the patient, the 'baby' in the therapeutic space (Slochower, 1996). This type of assumption has since been reviewed after it received much criticism because it positions the clinical psychologist as all-knowing and as someone with authority and power (Slochower, 1996). Overall, MHCPs often do not regard mothers with SMI as experts in parenting, and as such, judgement, discrimination, and 'top-down' treatment prevails (Banerjee et al., 2021). Given that therapeutic practice has long been underpinned by an assumption in which the

patient, in this case the mother, is viewed as a child, it is unsurprising that mothers might not be considered 'experts' in mothering, and that their beliefs and perceptions may be undermined by MHCPs. This may be further perpetuated by the fact that clinical psychologists, and other mental healthcare professionals, are theoretically oriented by developmental theories that are based on the assumption of what it means to be an 'ideal' mother (Linden & Hewitt, 2018). These theories shape clinical psychologists in practice, but do not guide actual mothers in the same way (Baraitser, 2008).

Interestingly, an older study by Derry (1994) showed that clinical psychologists who are mothers experience more empathy and compassion when working with mothers and are more sensitive to mothering experiences and expectations. Derry's (1994) study did not focus on working with mothers with SMI but does provide an interesting perspective on what factors might affect a clinical psychologist when working with mothers, such as social identity of the psychologist. Interestingly, Baraitser (2008) criticises psychoanalytically inclined clinical psychologists, who use the mother for representational value, but then abandon her, rather than helping her to gain insight into the complexities and nuances that underpin her mothering identity. As Baraitser (2008) suggests, a mother "theoretically remains a shadowy figure who seems to disappear from the many discourses that explicitly try to account for her" (p. 4). In order to avoid letting the maternal object disappear in this discussion, and in the focus of the study, the theoretical framework calls for her experiences to be central.

2.6 Theoretical Framework

Barlow and Cairns (1997) assert that seminal theories in psychology and related fields generally place disproportionate emphasis on the mother-child interaction, and what occurs within the dyad of the mother and child. Winnicott's (1960) famous statement illustrates this, in which he said, "there is no such thing as an infant" (p. 39). This assertion suggests that the existence of the infant is contingent upon his/her relationship with his/her mother, and that one cannot understand the infant without also understanding the mother. The mother and the infant cannot entirely be separated, however, for this study, the theoretical framework needs to draw a delicate balance between acknowledging the existence of the infant, whilst still drawing attention to the experiences of mothers within the context of SMI (Barlow & Cairns, 1997).

The theoretical framework employed for this study is underpinned by the Grounded Theory of Mothering as a Psychological Experience developed by Barlow and Cairns (1997). This theory

was selected because the focus of the study is the impact of SMI on *the mother*, rather than the impact on the child, which has been the predominant focus of research in this field (Brockington et al., 2011; David et al., 2011). Barlow and Cairns (1997) offer a helpful framework for understanding the continuous and unfolding internal experiences of mothering, which they conceptualise as "expanding the self" (p. 236). The population of MHCPs used for this study, however, engenders the need for a more psychoanalytically-oriented theoretical framework, which, as evident in the findings, inform the perceptions of a large portion of clinical psychologists. This is fundamental in order to account for the dual focus of the study, which includes the experiences of psychologists. In order to account for this, Barlow and Cairns theory has been drawn upon, with an integration of relevant psychoanalytic literature that contributes to the understanding of the mothering experience. Winnicott's (1960) theory of the good enough mother has therefore been integrated alongside Barlow and Cairns' (1997) theory of Mothering as Psychological Experience. Although Winnicott's theory positions the needs of the infant as having greater importance than those of the mother, the theory has been central in shaping the psychological community's understandings and expectations of what it means to be an effective mother (Lehman, 2015; St Clair, 2000b). Additionally, seminal authors in the field of psychoanalytic maternal studies, including Raphael-Leff (2018) and Baraitser (2008), have been drawn on to provide a holistic and comprehensive theoretical framework in which the findings can be positioned and understood. Barlow and Cairns' (1997) theory has therefore been used as an organising theory and has been supplemented with psychoanalytic, maternal literature. The complex nature of this phenomenon, and the interrelated components that are highlighted in this study, calls for a multifaceted and intricately integrated theoretical backdrop. The psychological experiences of the mother therefore draw the discourse away from the manifestation of her as an object who is a container responsible for fostering the internal world of the child, and one who is expected to receive, survive and manage the infant's intolerable feelings (Baraitser, 2009), and directs the focus towards the intrapersonal of mothering process that is just as pertinent.

A Grounded Theory of Mothering as a Psychological Experience

Barlow and Cairns (1997) propose that that there are two overarching elements, each with four separate processes of expanding the self in mothering. These elements elaborate the internal processes a mother has to undertake in the mothering identity. A summary of these elements with the four separate processes can be found in Table 1 below, adapted from Barlow and Cairns (p. 236).

Engagement		Immersion	
"Establishing the Intention to Mother"	Underlying reason for becoming a mother including both internal and external influences.	**"Renegotiating Relationships"**	Reorganising relationships to prioritise the needs of thechild.
"Encountering the Ghosts of Mothering Received"	Reflection of own experiences of being a mother and how these experiences will influence future mothering.	**"Preserving the Self: Preserving the Child"**	Balancing own needs andneeds of the child.
"Committing to New Life Circumstances"	Accepting and taking on new mothering responsibilities.	**"Self-Constructed Mothering"**	Developing individualised approach to mothering.
"Engaging in the Process of Self-Socialization"	Developing adaptive mothering skills and accessing support.	**"Replenishment"**	Developing confidence and sense of mastery in mothering role.

Table 1: A Grounded Theory of Mothering as a Psychological Experience, adapted from Barlow and Cairns (1997).

Engagement

The first element of expanding the self in mothering is *engagement*, which the authors describe mainly happens in the first year of having a child (Barlow & Cairns, 1997). The first process under engagement is referred to as "Establishing the Intention to Mother" and refers to the reasoning and decision-making surrounding becoming a mother, which can include poor childhood experiences and the need to recreate a positive family experience, as well as socialisation, cultural norms, or pressure from external parties (Barlow & Cairns, 1997). Importantly, as illustrated earlier in the literature review, the intention to mother is often not a subjective, informed choice *by* women, but something that is often expected *of* women in society. This study does not focus on the processes that occur before an individual with SMI becomes a mother, however, "Establishing the Intention to Mother" has implications for this study, as it draws attention to the societal expectations of womanhood, and the way in which these abject expectations have the propensity to denude the agency, choice, and desire in the mothering experience (Baraitser, 2008). This may compound a sense of disempowerment for mothers with SMI who, as a result of stereotypes, often already and lack agency in their environments (Baraitser, 2008; Heron et al., 2021).

The second process, according to Barlow and Cairns (1997), is referred to as "Encountering the Ghosts of Mothering Received" which refers to the mother's reflection of her own experiences of being mothered, how this is brought up when she is about to become a mother, and how this prepares her to be a mother herself and influences on her own mothering practices. This second stage is consistently expressed in maternal studies, as individuals will inevitably draw on their internal representations of what it means to be a mother, which they have learnt from their own experiences of being a child (Murray et al., 2019; Slade & Sadler, 2018; Verahge et al., 2016).

Raphael-Leff (2018) asserts that mothering prompts arousal related to the implicit procedural and autobiographical memories that are linked to the mother's own identity. These memories are reactivated particularly in the close contact, intimate interactions with the infant, when the mother is responding to the raw, intense, and unrestrained emotions and needs of the child. In these interactions, the mother's "schemas of sensations, affects, actions, arousal and motivation" (Raphael-Leff, 2018,p.22) engrained as a result of her own parenting experiences, and which inform the nature of interactions with the other, are triggered. For mothers who have more positive early experiences, these intimate interactions with the infant can draw the mother into a process of primary maternal preoccupation, in which she becomes acutely aware of, and sensitive to the child's needs, at the exclusion of other elements of her life (Winnicott, 1963). For mothers with very poor childhood experiences, such as many mothers with SMI, these intimate and emotionally intense interactions with the infant evoke distress memories and traumatic experiences (Barlow & Durand, 2015; Raphael-Leff, 2018). These may be experienced by the mother as particularly overwhelming, and she may respond, mostly unconsciously, by repudiating the infant, or distancing or disconnecting herself from caregiving (Raphael-Leff, 2018). Importantly, these memories are likely to heighten the mother's internal distress, and threaten her own internal coping structures, putting her in an emotionally compromised position (Raphael-Leff, 2018). For mothers with SMI who are already vulnerable, this could be particularly risky to their psychiatric stability and mental wellbeing.

The mother's own experiences of caregiving are psychically integral to her own mothering practices, and thus, "Encountering the Ghosts of the Mothering Received" does not only suggest a conscious process of reflecting on one's own caregiving experiences, but the way in which these experiences are unconsciously elicited, and the impact that this can have on the mother (Barlow & Cairns, 1997; Raphael-Leff, 2018). Importantly, just as the

intersubjectivity occurs between a clinical psychologist and a patient, in which the identity of the clinical psychologist inextricably enters into the therapeutic space (Lemma, 2015), the same intersubjective process occurs in the mother-infant dyad (Baraister, 2008), drawing attention to the importance of considering the identity of the mother as something that has to be negotiated in mothering.

Thirdly is "Committing to New Life Circumstances" which refers to the process where new mothers become aware of, accept, and begin to commit to the new demands and responsibilities of mothering and the life changes associated with these responsibilities (Barlow & Cairns, 1997). Supporting this, Darvill's et al. (2010) study on psychological factors affecting women's experience of motherhood found that women identified that transformation is imminent when a new child arrives in the family and that accepting and understanding this was a significant part of moving into the mothering role. Baraitser (2008) asserts that the independence of a woman prior to becoming a mother is lost after having children, and that narratives around mothering experiences suggest that returning to this level of independence is unfeasible, often leading to a significant amount of maternal despair. She further argues that the delineation of the self is blurred through parenthood, as the self is fundamentally altered by the presence of an 'other', namely the child. Committing to new life circumstances therefore does not only involve a more conscious process of awareness, and acceptance of new demands of mothering, but a more implicit yielding of an independence and singularity in lieu of a more receptive, interdependent relational dynamic with another (Baraitser, 2008; Barlow & Cairns, 1997). Essentially, the mother needs to make room for the other in her own life. Baraitser (2008) uses the concept of the 'third', which is traditionally considered as an intrusive or external factor that impedes on the exclusivity of the mother-infant relationship (Britton, 1989; Fink, 1995; Jacobs, 1999), to draw attention to the way in which the child can be considered the third in relation to the mother's life. The infant presents as something which confronts the mother's own individuality (Baraitser, 2008), demanding the mother to, as Barlow and Cairns (1997) suggest, commit to and accept new life circumstances. The being of the mother therefore becomes inextricably linked with the needs of the infant, and her identity is constructed and shaped based on societal, cultural, and social norms about what constitutes a mother (Baraitser, 2008). Making room for the other, and giving up of the self can result in a sense of loss, and mourning, a process that can be experienced as overwhelming for many mothers (Baraitser, 2008; Darvil et al., 2010). In the context of SMI, this may be especially challenging.

Lastly in engagement, is "Engaging in the Process of Self-Socialization" which refers to the process of developing and using a range of important mothering skills and being able to proactively use these skills to adapt to the new role (Barlow & Cairns, 1997). Winnicott's (1963) theory of good enough mothering has widely influenced expectations of what these mothering skills entail, and what it means to be an effective mother (Lehmann, 2015; St Clair, 2000b). In Winnicott's theory, the mother's competency and proficiency play a pivotal role in the successful development of the infant. Inadequate maternal care, and a lack of maternal devotion, can result in deficits in the child's emotional and psychological development; for example, a difficulty with intimacy, poor self-esteem, and an unstable sense of self (Nayar-Akthar, 2019; Winnicott, 1963). The mother's role, in this context, is to provide a warm and stable environment that enables the child to take risks, learn from experiences, and explore the world with a sense of security and support (St Clair, 2000; Winnicott, 1963). In order to provide this environment, a mother does not need to be perfect but 'good enough'. This notion acknowledges that the child might experience frustration, disappointments, and sadness in the parent-child relationship but asserts that these are equally healthy for growth (Lehmann, 2015). Nonetheless, mothers are expected to maintain a delicate balance between impingement, failure, and presence (Baraitser, 2008; Winnicott, 1963), which can be difficult to achieve.

Ultimately, the good enough mother uses a variety of skills, also portrayed by other psychoanalytic theories, such as attunement, reflective function, presence, sensitivity, and responsiveness (Baraitser, 2008). Unfortunately, the good enough parenting concept has implications for mothers who are particularly struggling in their parenting role, as these skills require a mother to suspend her own emotional distress, and contain her own rage, aggression, and despair, in order to effectively contain the uncontained emotions of the child (Raphael-Leff, 2018). Winnicott (1963) suggested that caregiving is a natural and intuitive process for women, one that enables identification, anticipation, and accommodation of the child's needs. As such, the process of self-socialisation, for Winnicott, would come naturally to a mother who is adapting to the mothering role. Mothers with SMI, who may often be at the mercy of their symptoms, may find this particularly difficult. However, Barlow and Cairns (1997) draw attention to the importance of accessing support from communities and professionals, for mothers to be able to evaluate, modify, and change their skills and approaches based on the needs of their child.

Immersion

The second main category of expanding the self is Immersion, which is described by Barlow and Cairns (1997) as a more continuous, long-term process that involves more "day-to-day, year-to-year realities of child rearing" (p. 239). Four processes are included in Immersion according to Barlow and Cairns (1997). Firstly is "Renegotiating Relationships", which refers to the process of reorganising and reprioritising relationships (e.g., work, friendships) in order to accommodate the child's needs. In order to do this successfully, the mother needs to consider finances, the needs and temperaments of her children, and support from those around her (Barlow & Cairns, 1997). Importantly, this process highlights the way in which a woman's life can substantially change when having a child, and the impact that the disruption to a woman's career, relationships, and life plans can have on the maternal psyche (Baraitser, 2018). For a mother, who shifts from being an independent individual, to someone who is fully relied on by a child, the process of reproritising relationships offers little flexibility. Importantly, in the South African context, where a collective approach to mothering is prevalent (Sudarkasa, 2004), and where many women struggle with employment and poverty (Moultrie & Kleintjies, 2006), renegotiating relationships may not be a straightforward and simple process. Nonetheless, this theory draws attention to the significant tasks that mothers must go through in their mothering identity (Barlow & Cairns, 1997).

Secondly in Immersion is "Preserving Self: Preserving the Child" which refers to a process in which the mother balances her own needs and feelings and those of her child. Winnicott (1963) believed that a mother's primary obligation as a parent is to prioritise the needs of the child, suggesting that a balance is not possible. Barlow and Cairns (1997), however, highlight that the mother's own needs will inevitably need room in the relationship. Baraitser (2008) discusses this as an intersubjective space between the mother and the infant, where the mother's own identity, needs, and experiences do not need to be lost in sacrifice of the child. However, this is often not the case, and mothers often face a hopeless endeavor in which they attempt to maintain their autonomy and individuality in their mothering identity. This unfortunately often gets lost in the onslaught of the child's needs, and the all-consuming nature of their demands (Baraitser, 2008; Frizelle & Kell, 2010). This can often evoke a sense of anger, despair, hopelessness, and inadequacy in a mother (Baraitser, 2008). Barlow and Cairns (1997) draw attention to how difficult it is to balance needs, suggesting that often the mother either completely self-sacrifices for her child, or is unable to recognise or meet the needs of her child entirely. Darvill et al. (2010) argue that sometimes as early as the first trimester the mother has

a “shift in focus from themselves to the needs of the foetus” (p. 357). The needs of the mother are pertinent to consider in the context of SMI, which cannot always assume a position of less prominence because of the potential consequences of SMI.

The third process is “Self-Constructed Mothering” which refers to the process of developing one’s own way of mothering and developing a relationship with the child that is not solely based on external influences (Barlow & Cairns, 1997). Interestingly, Blegen’s et al. (2012) study on experiences of motherhood when suffering from a mental illness found that managing to become the mother they desired to be was a significant area of concern for mothers with mental illness. This would be important to consider when looking at the third process of “Self-Constructed Mothering” in relation to this study. Importantly, the good enough parenting practices that are expected from mothers (Winnicott, 1963), as well as the internal relational dynamics that are triggered in the face of parenting (Baraitser, 2008), make it particularly challenging for mothers to develop a relationship with the child that is not affected by external influences.

Finally in Immersion, is “Replenishment” which Barlow and Cairns (1997) describe as the process where mothers seek to “regain their positive energy that had been depleted by the challenges of trying to mother according to a philosophy which was not their own” (p. 242). This process occurs by accepting, understanding, and coming to terms with their own limitations and difficulties, but also appreciating the rewards that mothering can have. Importantly, replenishment can be particularly challenging for a mother who is unable to meet her own needs, because of the accommodations she is required to make for her child, as illustrated above (Baraitser, 2008; Raphael-Leff, 2018). Furthermore, a mother is likely to struggle with feelings of guilt, shame, and blame when she is struggling to meet the needs of her child, and when she is unable to find fulfilment in her maternal experiences (Baraitser, 2008). For a mother with SMI, replenishment may be hard to achieve, particularly if she is overwhelmed by the intensity of external and internal pressures regarding her mothering, as well as societal stereotypes regarding her SMI. This process does, however, offer an opportunity to consider the way in which a mother with SMI might accept her limitations, whilst still finding fulfilment in her mothering role (Barlow & Cairns, 1997; Dolman et al., 2011).

2.7 Conclusion

The literature review has provided a comprehensive exploration into the issues pertaining to SMI and mothering and has contextualised these concepts in South Africa. By drawing attention to the research already available on this topic, the findings presented in this study can be discussed in relation to what is already known about the phenomenon of mothering with SMI. This data gathered through this study is presented through the lens of the theoretical framework integrated with psychoanalytic concepts, with an emphasis on the way in which SMI creates additional complexity to the already overwhelming experiences of mothering. The literature has also draw attention to important psychoanalytic theories, the role of clinical psychologists, as well as the research regarding the perceptions of MHCPs on mothering and SMI. This ensures that the dual focus of the study is maintained, positioning the clinical psychologists' perceptions in relation to the literature. These findings are discussed in the fourth chapter.

CHAPTER THREE: RESEARCH METHODOLOGY

This chapter begins by examining the qualitative research approach and interpretivist research design that underpins this study. Thereafter, an exploration of the sample and sampling methods are presented, with emphasis on the characteristics of the participants used in this study. A detailed account of the data collection and analysis process is subsequently provided, with emphasis on the steps that were taken to ensure the trustworthiness of the study. This is followed by an overview of the ethical considerations that were observed throughout the study and concluded with an examination of the researcher's subjective position in relation to the topic.

3.1 Research Approach and Design

The exploratory and descriptive aims of this study have been achieved through a qualitative enquiry (Fouché & de Vos, 2011). The qualitative approach was selected for this study as the central focus was to generate data, and develop the knowledge base on the phenomenon of mothering with SMI, by exploring and understanding how participants perceive this phenomenon (Pathak et al., 2013). Qualitative research methods are suited to research in the field of mental health because they are able to produce valuable and novel insights and knowledge about multilayered, complex issues that are often poorly understood (Crowe et al., 2015). The topic of mothering with SMI by its nature is an experiential and subjective phenomenon and is therefore difficult to quantify. The qualitative research approach is therefore more suitable than an objective or statistical measurement of this phenomenon (Babbie, 2020; Creswell, 2014). The study focused on the unique perceptions of clinical psychologists who work with this population, and as such, a qualitative framework allowed for an in-depth, rich analysis of participants' perceptions and a nuanced understanding of the complexities of the phenomenon (Creswell, 2014; Doucet et al., 2010; Hennink et al., 2011). The research methods selected for this study, including the research instrument of semi-structured interviews and thematic approach to data analysis are also typical for qualitative research, further supporting the use of this research design (Creswell, 2013). Finally, qualitative research provides "contextualized understandings of subjective experiences" (Crowe et al., 2015, p. 616), which is important in the field of mental health, which is largely influenced by the interplay of social, cultural, and historical factors (Borcsa et al., 2021).

Qualitative research is inherently interpretivist, which is the paradigm under which this study fell. This is because the core tenet of this paradigm is that knowledge is not generated from external observation, but through lived experiences of individuals (Mack, 2010). In the interpretivist paradigm, an exploration into the meaning and significance individuals assign to their experiences is fundamental for understanding social phenomena (Creswell 2013; Kaplan, 2015). The interpretivist paradigm is typically used in research in social sciences, and particularly in research in the field of mental health (Doucet et al., 2010; Ng, 2020), and as such was appropriate for this study. Interpretivism also acknowledges that the meanings individuals attach to their experiences are idiosyncratically and subjectively constructed, and that multiple realities might exist, allowing for diverse perceptions (Levers, 2013; Mack, 2010). The value of the interpretivist design is emphasised in the findings, which illustrate the heterogeneity in perceptions and experiences of participants, whose responses were shaped based on their own personal and professional experiences, as well as the theoretical framework which orientates their work. Interpretivist research also requires the researcher to consider the whole reality implicated in the individual's experience, rather than only parts of it (Alharashsheh & Pius, 2020). This underpins the dual focus of the study, which is not only to draw attention to the impact of SMI on mothers, but the experiences of clinical psychologists in working with this population.

Additionally, it is worth noting that the context in which participants socially construct their perceptions and assign meanings to their experiences is also particularly valuable in the interpretivist paradigm. Interpretivism asserts that the socio-historical and cultural context play a central role in shaping the experiences and perceptions of individuals (Alharashsheh, & Pius, 2020; Kivunja & Kuyini, 2017). This includes the "circumstances, as well as times leading to the development of different social realities" (Alharashsheh & Pius, 2020, p. 41). This is important to consider for this study as societal understanding and representation of mental health has drastically changed since the 20th century, and individuals with SMI have historically not been considered capable of fulfilling social roles, such as mothering (Corrigan et al., 2012; Heron et al., 2021; Pescosolido et al., 2021). The shift in beliefs is equally relevant for the concept of mothering which is similarly interpreted based on cultural and societal specific expectations underpinned by gendered stereotypes (Frizelle & Kell, 2010; McKinney & Meinersman, 2022). The interpretivist research paradigm therefore positions the study in the current thinking around mental illness and mothering and draws attention to how this might shape the perceptions of participants (Alharashsheh & Pius, 2020). In justifying the choice of

this paradigm, the qualitative methodology employed in this study were considered, which were well-suited to examining and conveying the lived experiences of the participants (Doucet et al., 2010; Hennink et al., 2011).

From a qualitative and interpretivist research perspective, the knowledge gained about phenomenon is not generalised, but distinct to the lived experiences of individual participants, placing more emphasis on the context of the knowledge generated, rather than the capacity to abstract it to the general population (Alharashsheh & Pius, 2020; Creswell, 2013; Mack, 2010). Unfortunately, this is also a concomitant limitation to interpretivist research designs, because it is difficult to both reproduce and verify results and is thus criticised of being less impactful in terms of the universal applicability of the knowledge generated (Mack, 2010; Rahman, 2020). In order to address this limitation, this study has placed value on the in-depth and exploratory nature of the research, with emphasis on contextual factors engendering participants experiences, rather than in the generalisability of the findings (Creswell, 2013). Given the paucity of local research on this topic, drawing attention to the South African context, and the intersecting complexities unique to this context, is salient in this study. Additionally, the bias of the researcher is often critiqued as an element of qualitative interpretivist research that might undermine the validity and reliability of the findings (Mack, 2010). To address this, a section on researcher reflexivity is presented in this chapter. From the interpretivist paradigm, the researcher plays a role in data generation, and thus findings are a co-production of the knowledge from the participants and researcher (Schwartz-Shea & Yanow, 2013). In order to ensure transparency in the process, the sample and sampling methods also needed clear delineation and justification.

3.2 Sample and Sampling

The sample for this study were clinical psychologists in South Africa as the research aimed to gain insight into the perceptions specifically of this group of MHCPs. This population is large and therefore the researcher identified specific characteristics and inclusion criteria in order to delineate the parameters for the target population and sample for this study (Brink et al., 2014). The inclusion criteria ensured that the data generated would be relevant to the research focus and question(s). The target sample was clinical psychologists who have experience working in the field of mental health, as opposed to those who only have had experience working in other, perhaps narrower, settings such as geriatric care or forensics. Clinical psychologists were chosen as opposed to counselling or educational psychologists because of the scope of their

practice which allows them to work with patients with severe mental illness (Health Professions Amendment Act, 2007). Selecting clinical psychologists specifically, inherently meant that the participants in this study were all registered with the Health Professions Council of South Africa (HPCSA) as independent practitioners. There were no demographic requirements from participants in terms of age, race or gender. The following additional inclusion criteria were instated when selecting the sample which ensured that the data generated was both rich and relevant:

- The participants did not need to be currently seeing a patient who is a mother diagnosed with SMI but did have to have had experience working therapeutically with this population of patients. The participants did not have to be currently based in exclusively therapeutic settings, for example, participants who work in acute psychotic wards with patients who are mothers were also included in the sample as it was anticipated that they would be able to provide valuable insights into how SMI impacts mothering.
- The participants must have had at least three years of post-community service experience. This was to ensure that they have had sufficient experience in the field and would be able to provide rich data pertaining to the topic.
- The participants selected were required to be able to converse in English in order to reduce the potential for a language barrier during the data collection process, since the researcher, who was also the interviewer is English speaking (Laher & Botha, 2015).

Seven clinical psychologists who have experience working with mothers who have an SMI were selected to allow for an in-depth and rich exploration into the topic of interest (Laher & Botha, 2015; Vasileiou et al., 2018). The interpretive paradigm posits that knowledge is generated through a deep and comprehensive exploration into the subjective nature of human experience (Ahrens & Zaščerinska, 2014; Rahi, 2017). The smaller sample size allowed for this, and meant that there was sufficient opportunity to spend time with each participant and thoroughly gain insight into their perceptions and experiences (Kindsiko & Poltimae, 2019). Given the time constraints of the project, and the limitations on an individual researcher, a larger sample would have been counter-intuitive to an in-depth exploration of individual perceptions and experiences of each participant. The sample size therefore supports the depth of analysis that was required for this study, and aligns with the goal to contextualise, and not generalize, the knowledge that is generated. As such, a smaller sample size is further in keeping

with the qualitative, interpretivist nature of this study (Alharashsheh & Pius, 2020; Kivunja & Kuyini, 2017). Furthermore, Vasileiou et al. (2018) suggest that the complexity of the topic of inquiry can help determine a qualitative sample size, therefore, given the intricate nature of mental illness and mothering, a smaller sample size was anticipated to be more appropriate for this study. A larger sample size may have precluded a more nuanced understanding of the phenomenon (Vasileiou et al., 2018).

Small sample sizes have been critiqued in qualitative research for being insufficient for adequate data generation, and because they risk the validity of the findings (Laher & Botha, 2015). The value of determining sample size based on anticipated data saturation is increasingly being questioned for its applicability to qualitative research (Malterud et al., 2015; O'Reilly & Parker, 2013; Sim et al., 2018). Therefore, the concept of "information power" as proposed by Malterud et al. (2015, p. 2) can be drawn on to justify the sample size in this study and mitigate the potential limitation of a smaller sample size. The notion of information power suggests that the more relevant information that the sample can provide for the study, the less participants required (Malterud et al., 2015). This study includes a focused topic, pertaining to a specific group of MHCPs with unique knowledge about a particular group of mental healthcare users. As such, a small group of clinical psychologists were anticipated to be suitable "to offer sufficient information power" (Malterud et al., 2015, p. 2) as they hold the specific characteristics outlined in the research aims. The interpretivist nature of the study, along with the qualitative methodology also supported the sufficiency of information power, as there was a strong focus on the lived experiences of participants and thus, the data was generated through a comprehensive interaction with individual participants (Malterud et al., 2015; Schwartz-Shea & Yanow, 2013). Essentially, the study is not focused on whether findings are true or not, but on uncovering the meaning that the participants attach to their experiences and conveying these meanings in context (Faber & Fonscea, 2014; Vasileiou, 2018).

A smaller sample size called for non-probability sampling techniques. In this study purposive and snowball sampling techniques were employed to select participants (Brink et al., 2014). These sampling techniques were congruent with the qualitative approach of this research, and therefore were appropriate for use in this study (Rubin & Babbie, 2014). Furthermore, non-probability sampling techniques are appropriate in relatively new research in a specific context, such as this study (Orsmond & Seltzer, 2007). Purposive sampling refers to a process of strategically selecting individuals who meet the inclusion criteria of the study, and who are

anticipated to have unique and special knowledge about the research topic (Bryman, 2012; Sharma, 2014). Purposive sampling is prone to research bias, and thus the inclusion criteria and justification of the sample have been clearly delineated above (Sharma, 2014). Furthermore, it is important to draw attention to the researcher's own positionality in relation to the participants. The researcher's own experience as a social worker working alongside clinical psychologists, and the researcher's supervisor being a clinical psychologist herself, provided a starting point in selection of participants, as there was access to the population (Brink et al., 2014). Snowball sampling was then used to access participants through clinical psychologists who had already participated in the study who knew other individuals that were willing to participate or who met the inclusion criteria (Fouché & Delport, 2011).

In order to select participants, the researcher approached potential participants who were known clinical psychologists who met the inclusion criteria for the study and who were anticipated to either be willing to participate in the study, or who were anticipated to possibly know clinical psychologists who might be eligible and willing to participate in the study. The researcher guarded against selecting participants that might have confirmed her own preconceptions by ensuring to approach participants that were representative of different genders, differing level of experience, who have worked in different contexts, and who utilise different therapeutic/theoretical modalities (Stratton, 2021). An email was also sent out through the researcher's supervisor in the Department of Psychology at the University of the Witwatersrand to call for volunteers for the study. Participants who agreed to participate were provided, by email, with a participant information sheet (Appendix A) delineating the purpose and nature of the study and a consent form (Appendix B) for participation and audio recording of the interview. Table 2 provides a summary of the demographic details of the participants:

Participant Pseudonym	***Sex***	***Years' Experience***	***Therapeutic Paradigm***
Sharon	Female	10	Psychodynamic
Joyce	Female	4	Psychodynamic
Raadha	Female	3	Psychodynamic
Lindiwe	Female	5	Psychodynamic
George	Male	4	Psychodynamic
Matthew	Male	6	Psychodynamic
Trent	Male	10	Cognitive-Behavioural

Table 2: Summary of demographic details of participants.

3.3 Method of Data Collection

The method of data collection that was used for this study was semi-structured individual interviews, which are frequently used in qualitative studies and have been shown to be valuable for healthcare professionals conducting research (Jamshed, 2014; Robson, 2011). Semi-structured interviews are flexible and adaptive to the participants' responses, and thus provide an opportunity for participants to openly express their thoughts and experiences (Bryman, 2012; Hennik et al., 2011; Jamshed, 2014). Semi-structured interviews are beneficial for research that focuses on multilayered, complex phenomenon (Galleta, 2013) and were therefore considered appropriate for a study on the topic of mothering with SMI. Semi-structured interviews are also congruent with the interpretivist nature of the study, as they allow for an in-depth exploration into the perceptions and experiences of participants, with intensive focus on the constructed reality of individual participants (Bryman, 2012; Rahman, 2020). Semi-structured interviews are guided by the purpose of the research, and therefore maintain the general focus of the interview, however, they still allow for new avenues of inquiry during the data gathering process (Galleta, 2013; Jamshed, 2014). This was valuable for this study as the researcher could identify potential areas of information brought by the participants that required more exploration and that needed to be expanded on (Bryman, 2012). Given the unique knowledge that participants have on the impact of SMI on mothering, based on their theoretical orientation and professional experience, a semi-structured approach to the interviews meant that there was flexibility to uncover the more subtle and nuanced elements of their experience (Galleta, 2013). Due to the in-depth nature of the study, the researcher anticipated a relevant limitation of this method of data collection, which is that these interviews are time consuming, and require participants to take time out of their schedules to participate. For this reason, interviews were arranged when suitable for participants (Robson, 2011).

Notably, all participants opted for online interviews conducted via Zoom or Microsoft Teams. This was not a requirement for the study, as the researcher did not want to exclude participants who potentially did not have access to the internet (Carter et al., 2021). Online interviews in research can be advantageous as they are cost efficient and overcome barriers such as distance and travel that might create additional pressure for participants and the researcher (Jowett et al., 2011). Given that the participants for this study were not limited to Johannesburg where the researcher resides, online interviews allowed for clinical psychologists from different parts of the country to participate, providing a more representative sample. There are, however, several limitations to online interviewing. Relevant to this study is that there is an increased

potential for misunderstanding, ambiguity and misreading of social cues. This is perpetuated by external factors such as network connectivity difficulties, which was experienced as a challenge in this study (Salmon, 2014). The researcher attempted to mitigate this by having a backup plan and being flexible in terms of the time and platform for the interviews (Carter et al., 2021; De Villiers et al., 2022). Online interviews are also less personal, and thus the rapport established with participants may be superficial, in comparison to face-to-face interviews in which non-verbal interactions supplement communication, portray warmth and attentiveness, and consequently enhance connection (De Villiers et al., 2022; Jowett et al., 2011). This may mean that participants may not always disclose their honest and personal feelings and thoughts, possibly compromising the richness of data generated (Carter et al., 2021). Given the emphasis on the individual experiences of participants in this study, this is a considerable limitation. In order to mitigate this, the researcher ensured to allow time at the beginning of the interview to briefly establish rapport with the participant and made sure to remain transparent and disclosing about the nature of the research (Carter et al., 2021; Salmon, 2014).

The semi-structured interviews were guided by an interview schedule (Appendix C) which was the research instrument for this study. The interview schedule provided a written set of schematic questions that guided the interview process. These questions were guided by the literature and theoretical framework relevant to this study, and as such were both driven by existing knowledge about the topic, as well as the theoretical constructs relevant to the phenomenon of mothering with SMI (Galleta, 2013). The questions were additionally generated based on the dual focus of this study, which was both to understand the impact of SMI on mothering, but also to gain insight into the experiences of clinical psychologists working with this population. The researcher was therefore able to identify the topics that needed to be covered in the interview to ensure that there was a line of direction that allowed the participant to convey their experiences related specifically to the topic of enquiry (Galetta, 2013; Robson, 2011). For example, the interview schedule began by broadly focusing on the topic of mothering and SMI, and then moved to exploring the impact of SMI in specific domains of mothering and the mother's identity, as illustrated in the literature review in Chapter Two. Finally, the interview schedule ended by moving focus to the participants' experiences and perceptions working with this population. The interview schedule was in keeping with both the qualitative approach of this study, and the interpretivist paradigm, in which the narrative of the individual participant is central to the development of knowledge, and thus, an opportunity to openly discuss this narrative is critical (Robson, 2011).

A thorough approach to generating the interview questions and producing the interview schedule also allowed the researcher to plan for any challenges that may arise in the interview process (Robson, 2011). The first interview served as a pilot interview to allow the researcher to evaluate whether the research instrumentation was effective and achieved its intended purpose of answering the research questions of the study (Strydom, 2011). Based on the pilot interview, the researcher was able to improve the interview process to ensure that rich enough data was gathered (Strydom, 2011). Specifically, the researcher noted that the participants did not always understand the questions and consequently questions had to be repeated or rephrased – this was then adapted for future interviews. It was also noted that the interview schedule resulted in very long interviews and therefore had to be condensed in order to gather the data within the allocated interview time. The pilot interview was still considered to hold enough information power, and thus was included in the data (Kiger & Varpio, 2020).

In summary, the procedure of this study was as follows. The topic was conceptualised based on the researcher's own interest in the field, as well as the lack of research available on this topic in South Africa. After consulting with the research supervisor, a research proposal was written up and submitted for ethical clearance. After ethical clearance was obtained (Appendix E), the researcher began contacting participants as per the purposive sampling strategy delineated in the sampling section above. The researcher ensured to ask participants if they knew anyone who would be willing to participate after each interview, which led to additional participants. An interview was arranged with participants at a time convenient with them – all participants preferred online interviews which were conducted via Microsoft Teams and Zoom. Once the interviews were completed, they were transcribed verbatim by the researcher in preparation for the data analysis.

3.4 Method of Data Analysis

The data generated from this study was analysed using thematic analysis, a common approach to data analysis in qualitative research. A thematic analysis is particularly valuable when attempting to understand a set of experiences or perceptions, underpinned by some level of shared meaning (Kiger & Varpio, 2020). It was therefore suitable for this study on the perceptions of a group of clinical psychologists who work with a specific population of mental healthcare users, namely mothers with SMI. Thematic analysis refers to a process of finding themes in data by coding important pieces of information in the raw data and identifying patterns (Kawulich & Holland, 2012). A thematic analysis was selected for this study because

it was easy to use, flexible, and allowed for an in-depth analysis of the raw data where rich descriptions of the clinical psychologists' perceptions could be uncovered and conveyed (Kiger & Varpio, 2020; Robson, 2011). Furthermore, a thematic analysis can draw attention to social and cultural contexts that shape experiences (Kiger & Varpio, 2020). This was important for the interpretivist nature of the study, in which the conjectural experiences of the participants, which are shaped by context, are the main source of knowledge (Mack, 2010).

The thematic analysis for this study was guided by Braun and Clarke's (2006) steps. The first phase of this process began after the data was transcribed and occurred when the researcher began to familiarise herself with the data by reading the transcripts several times and making preliminary notes based on potential patterns or areas of interest in the data (Braun & Clarke, 2006). After this, the researcher began identifying and labelling (coding) different parts of the data that seemed relevant to the research questions. The researcher then began identifying potential themes in the data by grouping or categorising the codes using a "central organising concept" (Clarke et al., 2015, p. 236). In other words, themes were searched for by grouping different codes together that had similar underlying ideas (Nowell et al., 2017). Outlier codes were reviewed, and examined to determine whether they offered unique perspectives, or if they were significant enough for further exploration (Nowell et al., 2017). If they were distinct and meaningful, they were re-evaluated and treated as separate from the original codes and a similar process was followed to ascertain the central organising concept (Braun & Clarke, 2006). As such, reviewing the codes was an iterative process until the point of code saturation, suggesting that no more new codes could be identified in the data (Braun & Clarke, 2006). The researcher then reviewed the themes and evaluated whether they accurately represent the perceptions of participants. The researcher continued this process to modify, remove, and develop new themes in order to ensure that the themes appropriately represented the findings (Braun & Clarke, 2006). The phases of this analysis process were not necessarily sequential and were often revisited to ensure that the findings adequately answered the research questions. The final themes represent the findings and are presented in the following chapter.

A thorough data analysis enhanced the information power of the sample, and thus ensured that enough data was generated from the small sample size, and that an in-depth meaning and insight was gained from the data (Blitz et al., 2018), as required by the interpretivist paradigm underpinning this study (Mack, 2020). Using a thematic analysis can be exclusively inductive, in that the participants inform the findings (Kiger & Varpio, 2020). For this study, however,

the theoretical underpinnings, such as Barlow and Cairns' (1997) theory of the psychological experiences of mothering, and the 'good enough mother' (Winnicott, 1959), were used as a lens through which the data was analysed. This helped maintain conceptual coherence and ensured a broader and more comprehensive analysis of the data, which helped maintain the dual focus of the study; the mothering experience and identity, and the experiences of clinical psychologists (Braun & Clarke, 2006; Kiger & Varpio, 2020). An example illustrating the process of thematic analysis used in this study is attached in Appendix D. Importantly, thematic analysis is often critiqued for being less rigorous than other more structured, methodological methods of data analysis (Kiger & Varpio, 2020). In order to address this, the trustworthiness of the study was considered in order to ensure the accuracy of the findings presented.

3.5 Trustworthiness

In order to ensure that the study can be considered good quality research, the four elements of trustworthiness, namely credibility, dependability, transferability, and confirmability were addressed. Firstly, the researcher attempted to ensure credibility, which means that the findings in this final research report are accurate representations of the experiences and perceptions of the clinical psychologists (Lietz & Zayas, 2010). The researcher has ensured that thick descriptions of the interpretations are presented in the next chapter, and that the interpretations are supported with direct quotations from the transcripts (Babbie & Mouton, 2011). Where the researcher was uncertain during the process, she validated interpretations with the participants directly (Babbie & Mouton, 2011). This study focuses on a small group of participants and because of the interpretivist, qualitative nature of the study, the emphasis is on the experiences and perceptions of the individuals (Creswell, 2013). For this reason, transferability, or the applicability of the findings to other contexts is difficult to guarantee and is not an aim of the study (Lietz & Zayas, 2010). Throughout the study, however, the context in which the research took place and the unique factors in this context have been highlighted (Babbie & Mouton, 2011). In order to ensure that the study can be replicated, the methodology has been clearly described and the researcher has worked closely with her supervisor to allow for an external moderation of the research process, including the data collection and interpretation of the findings (Lietz & Layas, 2010). These strategies were also utilised to ensure confirmability which means that the findings can be corroborated and are in keeping with the focus of the study (Babbie & Mouton, 2011). Overall, by using these strategies and working closely with the research supervisor, the trustworthiness of the study has been maintained. Furthermore, ensuring good quality research also meant a strict adherence to ethical research practices.

3.6 Ethical Considerations

This study does not focus on the experiences and perceptions of a vulnerable population; however, it is important to note that the clinical psychologists were talking about a potentially vulnerable population. It was therefore critical that the researcher remained sensitive when talking and writing about this phenomenon, particularly in the context that this population of patients are already subject to significant stigma and discrimination (Brockington et al., 2011). In order for the study to be conducted, ethical clearance from the Human Research Ethics Committee (non-medical) at the University of the Witwatersrand was required (Appendix E). There were several additional ethical issues that were considered during this study.

Confidentiality and Anonymity: The researcher could not ensure complete anonymity as she knew the details of participants, however, the data remained anonymous in the transcripts and the write up in Chapter Four to ensure that any information cannot be directly linked to individual participants (Babbie, 2014). Thus, final anonymity has been ensured. Pseudonyms have been used in the write up to ensure that the names of individuals or institutions cannot be identified in the final research report (Olgetree & Kawulich, 2012). Participants brought up cases or examples of patients they have seen when discussing their experiences which provided rich information, however, they were invited to keep confidentiality and anonymity of patients when discussing these cases. The identifying details of cases that came up have been excluded from the final research report and transcripts (Babbie, 2014).

Voluntary Participation and Informed Consent: The researcher ensured that participation in the study was completely voluntary and that participants felt that they could withdraw from the study at any point. It was emphasised that if participants withdraw from the study, there will be no consequence or negative response (Creswell, 2014). Withdrawal from the study was not possible after the write up of the findings, and this was brought to the attention of participants. Participants were also informed that they could choose not to answer questions that they did not want to. Voluntary participation was communicated to the participants both in the participant information sheet and verbally during the interview. Participants were also requested to provide written consent (Appendix B) for both participation in the study as well as audio-recording of the interview (Bryman, 2012). A participant information sheet (Appendix A) was also be provided to participants in order to ensure that they were fully aware of what participation entailed and what the nature and purpose of the study were (Olgetree & Kawulich,

2012). The participant information sheet also stated that the recordings and transcripts were to be secured and stored on a password protected computer that only the researcher has access to. Transcripts were also accessible by the research supervisor, but pseudonyms were used to ensure that the transcripts were anonymous. Participants participated in their professional capacity as clinical psychologists and not as representatives of the organisations in which they work. Furthermore, the focus of the study was also on their perceptions and is not related to the clinical context in which they work. Therefore, no permission was needed or obtained from the institutions in which the clinical psychologists work in. Finally, in order to further ensure the trustworthiness of the study, and uphold the ethical standards of this research, researcher reflexivity was an important part of the process (Dodgson, 2019).

3.7 Researcher Reflexivity

Importantly, qualitative researchers working from an interpretivist paradigm are not neutral or impartial observers during the research, and have a central role in each stage of the process (Mack, 2010). As has been suggested in earlier discussions, qualitative research involves the co-construction of knowledge between the researcher and participants, therefore highlighting the pivotal role of the researcher (Dodgson, 2019; Palaganas et al., 2017). Researchers therefore need to be transparent about their own biases, and acknowledge their own preconceptions, experiences, and perspectives which inevitably influence their interpretation of the data (Palaganas et al., 2017). In the field of mental health particularly, self-reflexivity in research is pertinent to avoid a 'top-down' discourse (Borcsa et al., 2021).

It is fundamental that I acknowledge my personal bias in this process, and evaluate my positionality on this topic, particularly considering that I have previously worked in mental healthcare settings alongside clinical psychologists and with mothers with SMI. My role as a social worker in these settings was predominantly to consider the wellbeing of the child, and thus, this study represented a significant shift in my own professional focus. My previous experience already meant that I had predetermined ideas about the capacity of mothers to mother with SMI, given that I was often responsible for contributing to this judgement. I had to be particularly aware of these predetermined ideas, and this study challenged me to adopt a different lens when looking at the phenomenon of mothering with SMI. I too had to maintain my focus, as the researcher, on the maternal experience, in order to ensure that the focus of the study was realised. This was at times challenging, as I found myself equally immersed in the narrative regarding the effect of maternal SMI on the child, something which has already been

comprehensively explored (Awram et al., 2017). Additionally, I had to consider that I am not a mother myself, and this may have implications for the way in which I view the findings, and specifically for how I might construct my own expectations about mothering.

We have all been children before, and thus, our representation about what it means to be an 'ideal' mother is engendered by our own, complex, and unconscious experiences of being mothered (Baraitser, 2008). A process of introspection about my own mothering experiences was thus a crucial part of my approach to the data generation and interpretation. Additionally, as a clinical psychologist in training myself, I found that I often aligned my views with participants, as my perceptions have too been shaped by my theoretical orientation, which is mainly psychodynamic. I was challenged in the research process by the need to consider how my alignment with participants might impact the way in which data was portrayed, and might reinforce societal and cultural expectations that already burden mothers and individuals with SMI (Raphael-Leff, 2018; Rampou et al., 2015). My own professional, personal, and theoretically-informed perceptions of how SMI can impact mothering therefore needed to be acknowledged, and where possible suspended, in order to ensure that I was able to accurately capture and present the findings (Dodgson, 2019).

The findings of the study are strongly based on my interpretation of the data (Berger, 2015). I have ensured to acknowledge these preconceptions and as far as possible avoid allowing them to influence the interpretation of the data. This was also important in maintaining the trustworthiness of the study (Creswell, 2013). I acknowledged that my interest in this topic arose from work in this field in my capacity as a social worker, however, being reflexive about my position in relation to this study was crucial at each step. I ensured that I worked closely with my research supervisor throughout the process to ensure that I was able to reflect on my own potential biases and preconceptions, and how they might affect the study (Dodgson, 2019).

3.8 Conclusion

The research approach and design, as well as the methods selected for this study were in keeping with the research aims and were selected because they aligned with the dual focus of the study, which was to explore and describe the impact of SMI on mothering, from the perceptions of clinical psychologists. A thematic analysis of the data ensured for an in-depth and rich analysis of the raw findings and allowed for the findings to accurately portray the perspectives of participants. As far as possible, the trustworthiness and ethical standards of this

study have been maintained and strategies to ensure this have been comprehensively integrated throughout each step of the research process.

CHAPTER FOUR: FINDINGS AND DISCUSSION

In this section the findings based on the thematic analysis of the data will be presented and discussed. These findings are based on the analysis of the data gathered from the semi-structured interviews with participants. The section will firstly revisit the research questions to position the findings in relation to what the study set out to explore. An overview of the themes and sub-themes will be illustrated followed by a presentation and discussion of the findings, with reference to both direct quotes from participants, and the literature.

4.1 Introduction

To draw attention to the relevance of the findings to the research topic, it is important to restate the research questions:

1. What are the perceptions of clinical psychologists regarding the impact of severe mental illness on mothering?
    a. What are clinical psychologists' perceptions on the capacity for women to mother when diagnosed with a severe mental illness?
    b. What are the perceptions of clinical psychologists about how mothers manage the mothering role *and* their severe mental illness?
    c. What do clinical psychologists perceive to be the needs of mothers with severe mental illness to effectively fulfil their mothering role?

2. How do the perceptions of clinical psychologists regarding the impact of severe mental illness on mothering impact clinical practice?
    a. How do the attitudes and notions about mothering with an SMI influence decisions around therapeutic interventions and treatment plans for this patient population?

The interpretation and discussion of the findings are presented in an integrative manner with reference to literature and direct quotes from the participants. This is important to provide a qualitative and descriptive narrative that draws attention to the experiences of participants and places them in context of other research (Creswell, 2013). Table 3 provides a visual representative of the themes and sub-themes that organise these findings:

Theme	Sub-themes	Sub sub-themes
Theme 1: Constructing and Restructuring Mothering Identities	Constructing the Mothering Identity without SMI	- *The Good Enough Mother* - *Transgenerational Transmission of the Mothering Identity*
	Restructuring the Mothering Identity with SMI	- *Distortion of Identity* - *The 'Not-Good Enough' Mother* - *So, Can She Mother?* - *Dual Demands and Confidence in Mothering*
Theme 2: Negotiating Duality in Treatment	Focus of Psychological Interventions	- *Focus is Always on the Baby* - *Focus on Mothering* - *Mothering the Mother*
	Personal and Professional Duality in Interventions	- *The Psychologist as a Parent, a Child, and Professional* - *Experiences of Working with Mothers with SMI*
Theme 3: Positioning Treatment in Context	The Healthcare System in South Africa	- *Lack of Family and Community Support* - *Deficit of Specialised Treatment Options in South Africa* - *What Do Mothers Need?*

Table 3: Visual representative of the research findings

4.2 Theme 1: Constructing and Restructuring Mothering Identities

The intricacy of the mothering identity is evident in the fact that it includes both an interpersonal process between the mother and the child, but also an intrapersonal process that occurs within the individual when she becomes a mother (Barlow & Cairns, 1997; Frizelle & Kell, 2010). As Sharon describes, becoming a mother involves giving up "*the identity as a single person*", a process which "*cannot be undone*". Sharon draws attention to the fact that the delineation of the self is often blurred in parenthood, where the self is fundamentally altered in the presence of the child as an 'other' (Baraitser, 2008). Narratives around the mothering role are particularly prescriptive and rigidly dictate ideal mothering practices, placing prominent pressure on mothers to conform to societal and cultural expectations of motherhood (Frizelle & Kell, 2010; Hine et al., 2019). Mothers are traditionally considered to be the primary caregivers, and are portrayed as nurturing, warm, and intuitive (McKinney & Meinersman, 2022), and this leaves little flexibility for mothers who have their own difficulties, personalities,

and parenting practices. The data illustrates how the participants construct mothering identities, which provide a point of comparison against which they determine the effect that SMI can have on this identity. These narratives are based on the theoretical underpinnings of psychological practice which inform participants' perceptions about what it means to be a mother. Importantly, the theoretical orientation of the majority of the participants is psychoanalytic, drawing attention to the specific body of literature shaping their perspectives. The findings reveal that participants restructure the mothering identity in the context of SMI, indicating that mothering can be substantially different in the context of SMI, and might deviate from theoretical, cultural, or societal mothering norms (McKinney & Meinersman, 2022).

4.2.1 Constructing the Mothering Identity without SMI

The literature elucidates how the mothering identity is in fact not only constructed by the mother herself, but is moulded by psychologically-based theoretical notions, external expectations, and internal representations developed out of one's experiences of being mothered (Barlow & Cairns, 1997; Cowling & Van Gordon, 2021; Hine et al., 2019; Jenkins, 2019; Murray et al., 2019; Slade and Sadler, 2018). Participants' responses are evident of how the constructions of mothering are influenced by these factors.

4.2.1.1 The Good Enough Mother

The concept of the 'good enough' mother, derived from Winnicott (1959), appeared to inform the participants' perceptions of what it means to be the 'ideal' mother, illustrating how theoretical frameworks can influence the narratives around mothering identity. The 'good enough' mother concept acknowledges that mothers can make appropriate failures in their parenting, but without necessarily compromising the emotional and psychological wellbeing of the child (Winnicott, 1959). The participants' use of the concept of the 'good enough' mother to structure their perspectives around mothering approaches is unsurprising, given the theoretical backdrop of psychological practice and how these influence both the understanding of, and the interventions with, patients (Linden & Hewitt, 2018; Turel et al., 2020; Watts, 2009). Participants utilised the term 'good enough' as an umbrella concept to describe that mothering should look like:

…Good enough kind of parenting because I don't think there's perfect parenting – Lindiwe

…Those are the skills that a mother needs to kind of use when raising a child, and you know, kind of being a good enough mom – George

… We also have to think about good enough parenting and good enough mothering…That's really what kids need, good enough mothering – Raadha

The term 'good enough' describes a mother who has all the essential characteristics of a mother who fulfils important mothering responsibilities. However, the clinical psychologists participating in this study used this term to specifically draw attention to the psychological and emotional needs of the baby, and the role of the mother in meeting these needs. Less focus was given to the practical and physical needs of the baby, and the general responsibilities of the mother in raising a child (David et al., 2011; Rampou et al., 2015). The participants' responses highlight how the mothering identity is far more nuanced and complex than simply meeting the physical needs of a dependent child. When describing what mothering responsibilities entail, participants said the following:

…initially really just coming down to attunement…of what the mother needs to be attuned with and towards the baby's needs – Sharon

But in terms of mothering, I perceive it as, you know, the primary kind of caregiving, which is, you know, the feeding, the anticipating their child's needs, the attaching, spending time, whether it's breastfeeding or formula feeding it is, you know, nappy changing – Lindiwe

So it's all the things that we require like comfort, care, shelter, feeding, bonding and closeness… – Joyce

… I'm using perhaps too psychologically, too psychological terms here, but something about mentalising, I mean the capacity to really think for the infant what may be going on, digest that, feed it back to them in a psychological way, in order to foster some kind of safety and security as it pertains to proximity, closeness in relationships – George

These participants place the psychological and emotional tasks of the mother at the centre of the parenting role. The participants' perceptions are espoused by literature that describe what

it means to be the ideal mother, including being attuned, reflective, sensitive, warm, and present (Cowling & Van Gordon, 2021; Hine et al., 2019; Jenkins, 2019; Louw & Louw, 2016; Murray et al., 2019; Slade & Sadler, 2018). Lindiwe places emotional and psychological tasks as part of "*primary caregiving*", indicating how these emotional and psychological tasks are just as fundamental to raising a child as feeding and nappy changing are. Raadha's statement echoed this, as she stated that "*actually the physiological needs of the baby are really only one part of what keeps the baby alive … but the rest is about the structuring of the mind*". In keeping with literature on the importance of the early child-mother relationship, participants' responses elucidate that mothering responsibilities surpass the basic and instrumental physical caregiving, and physical proximity needs of the infant, and require a more intricate and thoughtful relational interaction (Shore & Shore, 2008). This reflects what Barlow and Cairns (1997) considers part of "Engaging in the Process of Self-Socialisation". This not only requires the development and use of a range of mothering skills, such as those described above by participants, but also adapting and modifying these skills, and continuously evaluating them, based on the needs of the child (Barlow & Cairns, 1997).

Importantly, participants' responses also illustrate how demanding the 'good enough' mothering role can be, and the literature confirms this, noting that even outside the context of SMI, mothering is a high-pressure role underpinned by rigid and intense expectations (Frizelle & Kell, 2010; Louw & Louw, 2016, Walker, 1995). Matthew highlights that the "*emotional connection and psychological connection the child needs to have*" is far more "*taxing versus just meeting the physical demands*". This is because in order to form a bond with her child, the mother needs to be present, and be able to, as George highlights earlier, engage in a process of "*mentalising*". This necessitates that a mother has her own capacity to regulate her feelings, and reflect on her own thoughts, experiences, and emotions to think about those of her infant (Fonagy & Campbell, 2016; Jurist & Meehan, 2009). In order to engage in these relational interactions, utilise these skills, and form a healthy bond and attachment with her baby, a mother needs to be both physically and emotionally stable, present, and available (Jurist & Meehand, 2009; Raphael-Leff, 2018). As echoed by Sharon, there is therefore an expectation to be a "*stay at home mom*" or an "*involved and hands on mom*", and a deviation from this narrative is often judged or criticised. The expectations for mothering responsibilities mean that mothers often can feel like they should be the ones to "*bath the kid*", "*play with the child*", "*spend more time with the child*" (Trent). This places strain on a mother, whose endurance as described by Frizelle and Kell (2010) is already challenged by social and occupational

responsibilities. Trent asserts that even outside of the context of SMI, mothers might struggle to take "*five minutes to eat some dinner*". The disruption that having a child can have on a mother's own life is emphasised by Baraitser (2008) and Raphael-Leff (2018) who note the psychological impact that persistent interruptions to the mother's own need fulfilment can have on the maternal psyche.

Interestingly, Sharon acknowledges how tough mothering can be, and that often the assumption is that "*motherhood is beautiful*", insinuating an expectation that a mother find fulfilment and enjoyment in her parenting experiences (Baraitser, 2008). Trent also highlights how assumptions about mothering often portray this role as a positive, easy task for women. He notes that the mothering identity insinuates that "*moms should always be on and always be happy and be connected to the children at all times*". Participants' responses illustrate their appreciation for how overwhelming mothering can be, and how often childrearing is considered a natural part of womanhood, and that the assumption is that women intuitively possess skills to be an effective and good parent (Akujobi, 2011; Forcey, 1994). In reality, however, as Sharon describes, mothering is in fact "*flipping hard. You are sleep deprived, your body is filled with a million different hormones trying to keep this child alive*". Nonetheless, the external representations and expectations of both womanhood and motherhood have constructed norms and beliefs in society about what it means to raise and care for a child. Building the mothering identity therefore occurs in the context of normative beliefs and expectations about what it means to be a mother and a woman, as well as the theoretical frameworks (such as the attachment theory, container/contained, and 'good enough' parenting) that inform ideal mothering practices.

4.2.1.2 Transgenerational Transmission of the Mothering Identity

The findings indicate how the mothering identity is not only developed in the context of external expectations, but is also based on internal representations of one's own experiences of being a child, and of being mothered. Sharon succinctly describes this phenomena as a "*transgenerational transmission of identity*", or as Barlow and Cairns (1997) present it, a process in which the mother encounters "Ghosts of Mothering Received". In describing what their patients, as mothers, might base their mothering identity on, the participants said the following:

I suppose a huge part of that would be how they've internalised their own mother, you know, and then sort of how their identity as a mother would be represented – Sharon

There, there's fundamental things that are required or hoped for, but all of those things are psychological tasks for the parent themselves to be able to fulfil for the child based on their own history and their own experience of being parented and things like this. – George

Participants' perceptions reflect how the mother's own history of her mothering experiences play a significant role in shaping her mothering practices. As suggested in literature, the "*internal representations"* (Raadha) of mothering may either be consciously or unconsciously resisted or re-enacted (Murray et al., 2019; Slade & Sadler, 2018; Verhage et al., 2016). These responses are in keeping with what Raphael-Leff (2018) describes as the reactivation of implicit procedural memories linked to relational interactions from the mother's own childhood. Participants noted that mothers might push against their internal representations of mothering in an attempt to do something different for their own children, and that this results in them rejecting, rather than internalising and assimilating, their own experiences of being parented. In Barlow and Cairns' (1997) framework, the process of resolving one's own perceptions and experiences of their own mother is important in constructing their own mothering identity.

In emphasising the factors playing a role in the development of the identity of the mother, Joyce refers to the process as "*epigenetic*" noting the influence of "*the environment, the genetics and the experiences internally and externally*". The reciprocal and interrelated interaction between the environment and the individual is illustrated in Joyce's response, as the interaction with one's own mother also shapes the development of the mother's own personality, emotional, and psychological development (Hine et al., 2019; Murray et al., 2019). These factors are further mediated by genetic predisposition (Barlow & Durand, 2015). The way in which the mothering identity is developed is therefore not only based on external expectations of mothering (Frizelle & Kell, 2010), or internal representations of mothering (Murray et al., 2019), but a combination of these in conjunction with the mother's own personality, temperament, and behaviour. A mother with SMI is therefore likely to experience their mothering identity in a vastly different way than a mother without SMI. The findings illustrate how the mothering identity is reconstructed in the context of SMI due to factors such as poor

experiences of parenting themselves, prejudice regarding parenting with an SMI, and difficulties in their own psychological and emotional development.

4.2.2 Restructuring the Mothering Identity with SMI

Severe mental illness introduces a new angle of complexity to the mothering identity. Entering into the mothering identity already includes a process of renegotiation, reorganising, and reprioritising of one's life, and relational and occupational demands (Barlow & Cairns, 1997). Severe mental illness presents an additional demand that has to be negotiated and prioritised in this identity. As Matthew states "*with mental illness often what happens is our self-concept, and our self-esteem, our self-identity does get disrupted…to some extent*". Severe mental illness can potentially distort and disrupt one's identity (Heron et al., 2021) and this is equally true for the mothering identity. Participants indicate that SMI can affect a mother's parenting skills and competencies, their ability to manage their own needs and the needs of their child/ren, and their confidence in their parenting capacity. Importantly, participants' perceptions about the impact of SMI on mothering varied, and although most participants acknowledge that the effects of SMI on mothering can be detrimental, they also agree that with support, mothers with SMI can still be effective and successful parents. In constructing mothering in the context of SMI, participants again draw attention to the transgenerational transmission of identity, and how a distorted internal representation of mothering can precipitate SMI, and consequently affect parenting practices.

4.2.2.1 Distortion of Identity

Literature highlights that mothers with SMI are much more likely to have had difficult, abusive, or traumatic experiences of being parented themselves (Barlow & Durand, 2015). Participants describe how mothers with SMI might have had their own experiences of being parented by their own mother who also potentially had/has SMI. An interesting cyclical dynamic is introduced here, as participants illustrate the impact that mothering with SMI can have on a child, and position this in relation to the mothers that with SMI that they see in practice, who were once also children. This process is echoed in literature which suggests that children are at an increased risk for developing psychiatric disorders if they are raised by a parent with SMI, demonstrating the 'vertical transmission' of SMI (Barlow & Durand, 2015; Louw & Louw, 2016). In elaborating on this this, Joyce indicates how an "*impairment in a mother's own caregiving*" is expected to impact her development of important skills, such as emotional regulation and reflective functioning, and is likely to affect her personality, behaviour, and

relational patterns. These developmental deficits are also likely to predispose and precipitate her to a mental illness (Barlow & Durand, 2015; Jenkins, 2019). Consequently, it may be harder for a mother to integrate these skills into her parenting identity, as she has never had an opportunity in her own childhood experience to develop them (Dolman et al., 2013). As Barlow and Cairns (1997) posit, a part of developing and refining important skills as a mother, and being able to use these adaptatively and flexibly, requires the development of self-empathy, and a capacity to think about one's own experiences. This will be largely affected by the opportunities she has had in her own childhood (Barlow & Cairns, 1997), as Joyce also suggests. A mother who has had poor early life experiences is likely to be triggered in an interaction with an infant, where emotionally intense and demanding interactions evoke distressing memories, threatening a mother's internal resources (Raphael-Leff, 2018). Contrarily, if mothers have had positive experiences of mothering themselves, they are more likely to be able to engage in the 'good enough' parenting practices described above. This theme therefore draws attention to a salient aspect of the mothering identity in the context of SMI, which is that of her own childhood and the way in which it is integral to the presentation and course of her illness, and her parenting capacity.

The concomitant transmission of both SMI and the mothering identity therefore inextricably links these two phenomena. Lindiwe asserted that "*the mental illness is part of [the mother's] identity*". This statement draws attention to the way in which a mother is not always separated from her illness, and how SMI is perceived as part of a person and their identity. Although having an SMI and being a mother have opposite demands, and thus are considered a dual identity, the findings revealed that often one identity (i.e., either of a mother or a mental healthcare user) is overlooked in lieu of the other. There are opposing ideas presented in the literature regarding the integration of the mothering identity with SMI. Some studies indicate that often the mothering identity is not always acknowledged in a patient with SMI, and that this results in narrow, limited interventions, as well as a disregard for the expertise and knowledge of the mother as a parent (Banerjee et al., 2021; Brockington et al., 2011; Eliezer et al., 2022; Mizock et al., 2019). Conversely, authors such as Heron et al. (2021) and Lacey et al. (2019) posit that the mothering role of a patient with SMI is sometimes prioritised over her SMI, often at the expense of her individual needs. Interestingly, the research problem is exemplified here, as the child, and mother-child dyad, are commonly the focus of research and treatment, at the exclusion of the mother as an individual with an internal world and accompanying identity (Baraitser, 2008; Eliezer et al., 2022). This is further illustrated by

Lindiwe's description of SMI as "*staining*" something in the mother's identity which "*compromises her capacity to be present for her child*". Overall, the findings support that SMI and the mothering identity are considered by clinical psychologists as interrelated issues, and that SMI can profoundly, and often negatively, affect the mothering capacity.

4.2.2.2 The 'Not-Good Enough' Mother

The findings revealed how the 'good enough' mothering skills are often compromised by SMI. George's statement highlights the way in which mothering and SMI are often considered "diametrically opposed" (Krum et al., 2004, p.98), as he noted how SMI is often seen as "*completely incongruent with being a mother or a good enough mother*". Matthew went as far as stating that there is a "*universal concern*" about mothers with SMI and their capacity to be available for their child, drawing attention to the widespread enmity towards mothering with SMI. As highlighted by the literature (Forcey, 1994; McKinney & Meinersman, 2022) and the findings of this study, the mothering ideal embedded in societal expectations, representations of womanhood, and theoretical constructs of parenting, is particularly prescriptive. The context of SMI makes 'good enough' mothering particularly challenging to achieve. The following quotes illustrate the way in which 'good enough' mothering skills are compromised by SMI:

It's really difficult to ascribe mental states to a baby, if you don't even understand your own mental states – Lindiwe

...I think it's very difficult to imagine what a child might need if you don't have the capacity to mentalise for another mind – George

Notably, participants draw on similar issues raised in the earlier sub-theme, which is that SMI, just as experiences of one's own poor parenting, can impair a mother's capacity to use important skills, such as self-reflection and mentalising. This is because the symptoms of SMI often affect insight, emotional regulation, and orientation to reality (Zumstein & Riese, 2020). The participants suggest that mothers with SMI are therefore limited in their capacity for insight, emotional awareness, and perspective-taking for their child. In further supporting this, Sharon states that as a result of SMI, "*the mother will be impaired in getting in touch with the other's internal world*". The previous sub-theme, as supported by literature, indicates that mothers with SMI are likely to have had poor parenting experiences themselves, and as such are already compromised by a deficit in development of important emotional and relational

skills and self-empathy (Barlow & Durand, 2015). The presence of SMI is likely to further jeopardise her ability to adaptively utilise good enough parenting skills (Barlow & Cairns, 1997). Additionally, a mother with poor parenting experiences of her own is likely to be distressed in the face of an emotionally intense interaction with her infant, and might respond by disconnecting, or distancing herself from her child (Raphael-Leff, 2018). The findings highlight how the symptoms of SMI further entrench difficulties in using these skills, and the impact this has on parenting.

Importantly, participants do not only suggest that SMI is contraindicated to mothering because of the key skills that the mother might not be able to draw on, but also because the symptoms might compromise a mother's capacity to fulfil her parenting responsibilities. Participants highlight how symptoms of SMI, especially in the active phase, may significantly distort a mother's emotions, cognition and behaviour (Barlow & Durand, 2015). Participants described that symptoms like paranoia, mania, mood instability, or psychosis can affect a mother's ability to physically care for her child, instil and maintain appropriate boundaries and routines, and alter the way in which the mother interacts with her child. In describing this, participants said the following:

> *...in like a depression, the mom might become very withdrawn, might become very fatigued…may have very little motivation…that then actually prevents her from getting up and feeding the baby…* - Sharon

> *So her paranoid delusions kind of really just overtook her narrative and her, and her world in that it really took time away from being able to parent and to be present because it was always about what's going to happen to the child.* – Lindiwe

> *...the features of mania are such that this kind of mother wouldn't know, based on the symptomatology of mania, where the limit lies for a child.* – George

In these statements, the way in which SMI can overwhelm the mother, and impair her ability to meet the physical and practical needs of the child is illustrated. Sharon and Lindiwe also highlight how as a result of the more incapacitating symptoms of SMI, mothering can be impaired to the extent that the mother might be "*putting the baby in quite dangerous situations*" (Sharon), for example, if symptoms "*convince them to act in either suicidal or homicidal kind*

of ways" (Lindiwe). As illustrated in these statements, neglect and misplaced aggression directed at the child, precipitated and perpetuated by symptoms that result in unpredictable, paranoid and disorganised behaviour, and erratic moods, are highlighted in literature as the more severe consequences of SMI on parenting (Ackerson, 2003; Patrick et al., 2015). The participants appear to draw attention to a potential threshold in terms of symptomatology, where it is "*no longer a question of can the mom mother anymore, it's a question of can the mom survive anymore*" (Trent). These findings suggest that there are instances in which mothering and SMI are incompatible, and where the symptoms of SMI are so debilitating and disinhibit behaviour to the point where mothering is not possible, as confirmed by Brockington et al. (2011) and Patrick et al. (2015).

Overall, literature supports participants' statements about the possible impact that SMI can have on parenting skills (both in terms of physical and emotional responsibilities of the mother), indicating that SMI has the potential to impair a mother's capacity to recognise and fulfil both the physical and emotional care needs of the child (Brockington et al., 2011; Deutsch & Clyman, 2016; Khang et al., 2008; Mowbray et al., 2002). Compliance to treatment is fundamental in ensuring a mother's capacity to parent with SMI, and as such can significantly reduce the risk of more severely distorted parenting practices (Drake & Whitley, 2014; Van Loon et al., 2014). The severity and extent of the impact that SMI has on mothering is therefore affected by the presence symptoms, as well as compliance to treatment.

4.2.2.3 So, can she mother?

Participants assert that, despite the potential for SMI to impair a mother, with adequate support and assistance, as well as with compliance to treatment, mothers can still be effective in their parenting role. Lindiwe notes that she does not think "*that every mother with a mental illness cannot parent effectively*". Similarly, Joyce states that while she is often concerned, she does not think that "*[mothers with SMI] cannot bring up a baby, or care for a baby*" and that if neither the mother or child are in danger, mothers "*deserve the best opportunity to be allowed to develop the skills required to healthily and adequately bring up their child*". Echoing this, Raadha stated:

...you can never say that someone with a severe mental illness cannot be a mom, because even if they have a severe mental illness they may still be able to form solid attachments with

their kids and, you know, be able to provide that nurturing; even if it is intermittent, if they have support it can still be good enough.

Interestingly, the above quote suggests that good enough parenting can occur in SMI. George argued that if "*there's not too much of her own attachment that's impaired*", a mother can be an effective and emotionally attuned caregiver. The participant responses echo current thinking around mental illness which asserts that with support and compliance to treatment, individuals with mental illness often can participate effectively and independently in social contexts (Barlow & Durand, 2015; Drake & Whitley, 2014).

Unfortunately, literature indicates that individuals with SMI, as opposed to less severe psychiatric disorders, in particular have poorer prognoses because of the intensity of symptomatology, symptom-related impairment in their insight, and subsequent tendency to default treatment (Johnson, 1997). This was evident in Lindiwe's assertion that "*generally with severe mental illness there is a compliance issue*". This perspective was also put forward by Matthew who stated that often mothers with SMI will not seek treatment. The complexity of the phenomenon of mothering with SMI is illustrated by these findings, as it is suggested mothering can be successful in SMI, but only in the context of treatment compliance. Given the nature of SMI, however, treatment non-compliance is frequently an issue (Johnson, 1997).

Participants' responses are evidence that the phenomenon of mothering with SMI is not homogenous, and the effect of SMI on parenting relies on a multitude of interrelated factors. Participants' responses highlight how they identify concerns about parenting with SMI, and they appear not to generalise cases, but acknowledge that there are instances in which SMI can significantly distort parenting and that there is a threshold where the effect can be potentially harmful. Importantly, it is not only the nature of SMI that affects mothering, but the demands of mothering in conjunction with the demands of SMI that has an impact on the mothering identity.

4.2.2.4 Dual Demands and Confidence in Mothering

The earlier sub-themes suggest that being a 'good enough' mother requires a more sophisticated emotional and relational interaction with the child, and that this moves beyond instrumental caregiving. A prominent theme that is evident in the data was that participants assert that SMI and mothering both have unique demands. Individuals who are mothers and

have SMI are faced with a particularly challenging task of negotiating and balancing both of these demands. Balancing one's own needs, and those of the child, is highlighted as a fundamental process that a mother has to manage when entering into the mothering identity (Barlow & Cairns, 1997). The delicate negotiation of needs is not always achievable, and can result in the mother either self-sacrificing for her child, or not being able to recognise or meet her child's needs entirely (Barlow & Cairns, 1997; Hayes, 1996). As the previous sub-themes have suggested, SMI may make a mother more prone to the latter. Furthermore, as Sharon suggests, in mental illness "*one does need to be quite inwardly focused in terms of one's own treatment and mental health and wellbeing*". This makes it particularly difficult for a mother with SMI to suspend her own needs, and be fully receptive to the dependency needs of her child (Hayes, 1996). Participants describe how hard it can be for mothers to balance the child's needs with their mental illness:

And this is a narrative that I heard quite a lot of, 'I don't know how to take care of myself, how am I supposed to take care of this person' – Lindiwe

Well if I [mothers] can't keep my own self sane…sane in inverted commas…how the hell am I going to be able to raise a child if I can't even…look after myself – Matthew

The responses above speak to how SMI and mothering are both particularly taxing experiences, and if they occur concurrently, create an exceedingly demanding context for an individual to navigate. The child already presents with needs that may be experienced by the mother as all-consuming (Baraitser, 2008; Frizelle & Kell, 2010), and SMI replicates this. The presence of SMI requires a mother to be compliant to treatment, follow up at the clinic regularly, and manage their treatment regiments (Cremers et al., 2014; Rampou et al., 2015), but mothering as illustrated in previous sub-themes, requires presence, availability, and attunement. These potentially conflicting demands reiterate the sense that parenting and SMI is often perceived as "diametrically opposed" (Krum et al., 2004, p. 98), and that mothers experience these dual demands in the same way. These perspectives illustrate the way in which SMI becomes a 'third', or an intrusive external factor, in the mother-infant relationship (Britton, 1989; Fink, 1995; Jacobs, 1999), that introduces additional demands that would otherwise not be present. Essentially, SMI acts as another entity that demands a mother's attention, time, and energy, and thus alters the idealised exclusive dynamic of infant-mother relationship, where the infant's needs are central (Baraitser, 2008; Britton, 1989; Hayes, 1996; Jacobs, 1999). Interestingly,

participants also identify that the child can also be perceived as a 'third' in the mother's life (Baraitser, 2008). Sharon's quote illustrates this concept as she describes that becoming a mother is a "*loss of being her own independent person, and then giving up that narcissism in order to take care of your child and what that means when you do need to take care of your child and your own mental health as well*". From these perspectives, the triangular dynamic of SMI, the mother, and the child is illustrated, as both the child and the SMI can equally require the mother's focus, often precluding the other, and at the exclusion of the mother's own needs (Baraitser, 2008). Sharon's statement also highlights the loss that a mother often experiences after having a child, which requires a relinquishing of the mother's independent, individual identity and a receptiveness to an interdependent relationship (Baraitser, 2008).

It is clear from the participants' responses, that in the context of SMI, looking after oneself and mothering may feel like an impossible task. Interestingly, Barlow and Cairns (1997) speak to the necessity of 'preserving the self', as well as the child, suggesting that to some extent, the mother's needs are also relevant and pertinent in the mother-child relationship. In relation to SMI, this is particularly true, as the mother's capacity to meet her own mental health needs has direct implications for her mothering practices, as demonstrated in the previous sub-theme. To position these findings in the South African context, it is vital to reflect that the literature indicates that mothers with SMI are also disproportionately affected by single caregiving, marital discord, unemployment, HIV and poverty (Kamis, 2020; Moultrie & Kleintjies, 2006; Turner & Honikman, 2016). These factors are likely to further exhaust the capacity of mothers with SMI to effectively parent and manage the needs of their children without risking their own mental health (Hine et al., 2019).

As a result of the difficulty mothers with SMI might experience in recognising and prioritising their child's needs or looking after themselves and their children, the findings reveal that mothers with SMI can often experience "*an incredible sense of shame and guilt*" (George) linked to their difficulties in parenting and the effect that SMI has on their child. In describing this, participants said the following:

But when you already have those cognitive, you know, distortions and those thought processes, you're already thinking that 'that means it's because I'm failing, because I'm not a good parent.' So some of those things can really affect the way that the person is relating to something. – Lindiwe

So she feels she's an extremely bad mom for having a mental illness and that it's impacting on her children. – Matthew

The participants' responses highlight how managing an SMI can affect the confidence of mothers. Participants also identified that mothers with SMI who are in hospital or having to attend clinic appointments often sit with immense guilt that they are not present or available for their children, as supported by Rampou et al. (2015). As Lindiwe describes SMI can be a "*huge knock to their confidence*". These themes have been repetitively found in studies on this phenomenon which have shown that mothers with SMI often feel inadequate, guilty and incompetent, and experience a low self-esteem in relation to their parenting (Dolman et al., 2013; Mizock et al., 2019; Shor & Moreh-Kremer, 2016; Van der Ende et al., 2016). Preserving her own needs (Barlow & Cairns, 1997) and focusing on her own mental health as described by Sharon earlier, can be distressing for a mother who feels ashamed that her SMI is limiting her ability to be fully immersed in her parenting role. Furthermore, as Barlow and Cairns (1997) suggest, a part of the mothering experience includes developing a sense of confidence and mastery in the mothering role, which consequently might be particularly challenging for mothers with SMI.

The guilt and shame is exacerbated by the expectations of what it means to be a 'good enough' mother as described earlier in this chapter, with George asserting that mothers might feel "*not good enough in relation to what is expected*" of them by society. These findings are echoed by Hine et al. (2019) who posited that the imposing and prescriptive expectations about what it means to be a successful mother are seldom reachable for mothers with SMI who often compare themselves to these ideals. Sharon states that mothers with SMI may represent themselves as "*being a failing mother or not being a good enough mother*". In describing this further, Raadha said the following:

There can be this feeling of not being good enough and that can definitely add to a desire to maybe even distance from the baby, to not connect if they feel like they're not living up to that sort of ideal image of what it is to be a mom.

Raadha suggests that the consequences of the feeling of inadequacy can result in further relational distress between the mother and the infant, perpetuating the mother's sense of

inadequacy. Raphael-Leff (2018) argument supports this statement, as she notes that often in response to difficulties in parenting, mothers may withdraw or distance themselves from their children. For mothers with SMI who lack support, the potential consequences of this are profound. The discussion has demonstrated that mothers with SMI are confronted with an insurmountable task underpinned by unrealistic expectations, which is to be the ideal parent and effectively manage their SMI, and in the South African context, negotiate this duality in the face of additional psychosocial stressors. Importantly, participants also reflected that mothers with SMI desire to fulfil the parenting role (Dolman et al., 2011), and Sharon asserts there is an "*instinctual motivation that you want to look after your baby, and you want to be there*". The need for interventions targeting the unique needs and specific dynamics that present in this population is therefore pivotal, however, the duality also creates a difficult terrain that MHCPs have to navigate when treating mothers with SMI.

4.3 Theme 2: Negotiating Duality in Treatment

The findings represent the complexity that psychologists are faced with when working with mothers with SMI. Participants indicate how they are faced with the dilemma of their therapeutic responsibility towards their patient, and their ethical and moral responsibility toward the wellbeing of the child. The findings also reveal that the psychologists often feel that they are pulled in different directions in their treatment, as the line between interventions for parenting, and therapeutic work with the mother as an individual, often becomes blurred. Duality is therefore not only negotiated by the mother, but by the clinicians treating them who find it hard to delineate the focus of interventions. Interestingly, negotiating duality is further indicated in the findings as something that occurs internally for the psychologists, who have to balance their professional and personal thoughts and feelings about what it means to be a mother, which are underpinned by their own experiences in their personal lives, and of working with this population group. MHCPs treating mothers with SMI have to tread delicately in their interventions, ensuring that mothers feel able and willing to disclose their parent status and discuss their mothering experiences (Engqvist et al., 2011), and pursue, and remain compliant to treatment (Mizock et al., 2019).

4.3.1 Focus of Psychological Interventions

The findings reveal mixed perspectives about the focus of therapeutic interventions with mothers with SMI. Overall, however, it is evident that the focus of treatment with this population group, based on participants' responses, is almost always underpinned by the

duality of the parenting status and the SMI. Lindiwe states that her role as a clinical psychologist is "*to treat the symptoms and to help them [mothers] be in a good space with their mental illness, whether they are a parent or they are not a parent*", suggesting that at the core of interventions SMI is the primary treatment objective. Lindiwe's statement is indicative of the typical first point of care for a mother, given that mothers are more likely to present with complaints related to their SMI, rather than their parenting, to MHCPs (Heron et al., 2021).

The rest of the participants indicate that when they treat mothers with SMI in therapy, they almost always consider the fact that the patient is a mother, with George going as far as to say that "*the individual patient that might be a mother cannot be delinked from being a mother*". George's sentiments are echoed in literature, which suggests that the mothering identity should be central to all mental healthcare interventions (Brockington et al., 2011; David et al., 2011). However, importantly, George's statement also contradicts the literature suggesting that either the mothering identity *or* the SMI is overlooked by mental healthcare professionals (Eliezer et al., 2022; Mizock et al., 2019). However, the overall findings do draw attention to the fact that the identity of the mother as an individual is often not prioritised by MHCPs who may rather focus on the parenting, and wellbeing of the child. This is summarised by Sharon, who highlights that "*nobody, well not nobody, but … it's much less sort of taken into account what happens to the identity of the mother, especially a mentally ill mother*". Eliezer et al. (2022) and Mizock et al. (2019) have found a similar pattern, that the identity of the mother is often overlooked in the context of SMI, and that this may not always be considered or thought about in mental healthcare interventions. The findings reveal the way in which the clinical psychologists intervene with mothers with SMI, and illustrate how other factors are often considered more central in interventions.

4.3.1.1 Focus is Always on the Baby

The participants reflect that often when a mother with SMI is treated by a psychologist, the baby or child often become the main focus of intervention and treatment. In describing this, Raadha said "*most of my experience has been focusing more on the infant than the mother*". Rather than the identity of the mother, the participants highlight that the baby is always thought about in clinical psychologists' interventions, reflecting Winnicott's (1959) notion that the baby and mother do not exist as separate from one another. Participants justified their consideration of the baby, with Lindiwe stating that the reason this might be is because often the perspective of others is that these mothers are "*putting their children in danger*". George

highlights that often working with this population group might evoke *"an urgency"* in practitioners who might feel concern for the wellbeing of the child. The level of urgency is succinctly described by Sharon, who states that "*when that critical period of neurodevelopment is missed, we can't necessarily go back and try to fix it*". These perceptions are underpinned by the risk that SMI potentially has for the wellbeing and healthy development of the child (David, et al., 2011; Miklush & Connelly, 2013). The focus of the wellbeing of the child, as described by participants, is echoed in previous studies, such as Chandra et al. (2019) and Krum et al. (2014), which found that sometimes the child's wellbeing becomes the predominant focus when mothers present with SMI to MHCPs. The following quote further elaborates this:

But it's hard to not, I guess, consider the other person [baby] who is not here, who cannot change the environment in which they're growing in…there is a little bit of pressure to make sure you're helping this person so that the child on the other side can actually receive the help that they need. – Joyce

The pressure that psychologists might feel when working with this population group is illustrated by this quote, as Joyce indicates the high stakes involved in working with mothers with SMI, as interventions do not only affect the mother, but her child/ren as well. Sharon and George both delineate that the mother is their patient, and not the child; however, overall, the participants appeared to feel that psychologists have to consider that there is a "*vulnerable human in the space that's being impacted*" (Raadha). Given the theoretical underpinning of psychologists, in which the early years are often believed to be the most important (Louw & Louw, 2016), it is unsurprising that participants placed such emphasis on the child. Interestingly, George offers a more personal account, noting that "*it feels incredibly unlikely with all of us being children that have been parented, that we would be able to see a parent without somewhere, consciously or unconsciously, having the child in our minds*". Participants' responses are contrary to the opinion posed by Eliezer et al. (2022), who assert that sometimes the wellbeing of the child may be considered a social welfare issue, and not a psychiatric issue, by MHCPs. Importantly, literature suggests that the clinical psychologist should suspend their own desires and agendas in therapy (Ivey, 2011) which may be undermined by the need to ensure the wellbeing of the child.

The complexity of working with this population is highlighted by these findings, as psychologists may feel under pressure to think about another person during their interventions,

who is exceptionally vulnerable, but who sits outside the therapeutic space. Interestingly, in the therapeutic relationship between a mother with SMI and a clinical psychologist, the child becomes the 'third' who enters into the patient-clinical psychologist dynamic, and which demands the attention of the clinical psychologist (Britton, 1989; Jacobs, 1999), as illustrated by the above quotes. As such, the clinical psychologist's mind is relinquished from only being occupied by the mother (Britton, 1989; Jacobs, 1999) and space needs to be held for the child as well. Joyce's statement further espouses this notion as she states:

I take time to think about how the therapy process can help them or scaffold them to take care of their child so that it's not just about the individual, it's very much about the dyad…

The hierarchy of needs is also emphasised by the above quotes; just as mothers are required to suspend their own needs for their child in their relationship with their child (Baraitser, 2008; Barlow & Cairns, 1997; Hayes, 1996), the needs of the child are also often prioritsed by MHCPs. George describes that "*there might be expectations that are placed [on the mothers] to get better for the child because there might be grave concerns in the clinician's mind about the child at home*". This might compromise treatment of mothers, or might mean that MHCPs rush interventions or admissions in order to ensure that the mother is able to return to her child and be capable of parenting. The goal of psychiatric stabilisation over psychological rehabilitation (Robertson & Szabo, 2017) is demonstrated in these findings. George's statement illustrates how the preservation of the mother (Barlow & Cairns, 1997) is secondary to the wellbeing of the child.

The allegiance to the patient, and ethical and moral duty to care and protect children, makes working with this population particularly challenging and complex (Krum et al., 2014), and this is highlighted by these findings. Having to consider the child appeared to be an influencing factor in psychologists' approaches and interactions in therapeutic processes in participants' responses. Participants identified that considering the child also means that interventions need to address mothering practices.

4.3.1.2 Focus on Mothering

The findings reveal that the focus on the wellbeing of the child described above appears to direct psychologists' interventions with mothers, leading them to include parenting as a key component of therapy. This draws attention to a noteworthy concept identified in the literature,

which is that MHCPs often do not regard individuals with SMI as expert parents (Banerjee et al., 2021). Interestingly, although Trent describes that as psychologists they do not think "*okay, this is a mom now, we need to change tact*", the rest of the participants all indicated that the intervention is changed in the context of the mothering status. Importantly, the differing theoretical orientations is highlighted in the variation of these opinions, highlighting the way in which theoretical underpinnings influence and shape clinical psychologists' perceptions (Lemma, 2015). In describing what the focus might be for mothers with SMI in terms of parenting, participants said:

...working with mothers to…facilitate the process of becoming more attuned – Sharon

I think there would just be extra support in terms of the parenting guidelines – Lindiwe

If it feels like they haven't had exposure to psycho-education around parenting, mothering, caring for a child, then I would definitely provide that information – Joyce

In these statements, participants clearly illustrate how addressing parenting is part of their interventions with mothers with SMI, as opposed to the more intrapsychic and individually-focused dynamics that typically characterise the work of clinical psychologists (Lemma, 2015). Literature supports participants' integration of parenting into their interventions, as Brockington et al. (2011) and David et al. (2011) argue that mothers with SMI benefit from education, training on parenting practices, and support and guidance in terms of parenting approaches. According to participants, by focusing on the mothering practices, they are able to have an indirect positive impact on the wellbeing of the child, thus reinforcing how the child often takes precedence in the interventions.

Importantly, Sharon also states that working with the mother and her identity may mean unpacking what motherhood means to her in relation to her SMI. This draws attention back to the identity of the mother, the mothering process and the mother's experiences, and moves away from exclusively focusing on parenting and the wellbeing of the child. This is also indicated in literature as a fundamental component of therapeutic interventions with mothers with SMI (Heron et al., 2021). Given the intensity of balancing the mothering role with SMI as illustrated in previous sub-themes, a focus on the wellbeing of the mother and her

experiences of parenting with an SMI is essential (Heron et al., 2021). Interestingly, just as the mother has to manage the duality of the child's needs, and the needs in terms of her SMI, the psychologist is presented with the same task when working with the mother.

This section of the findings addresses one of the research questions, which illustrates the way in which the perceptions of clinical psychologists of mothering with SMI directly influences clinical practice. Participants appear to rely on their knowledge about what it means to be 'good enough' as a mother which guides them in how to equip mothers with skills to parent when they have an SMI. The 'good enough' mothering theory therefore underpins not only the way they perceive mothering practices, but how they structure the therapeutic approach (Winnicott, 1959; Lemma, 2015). Participants suggested that they did not only rely on psychoeducational and direct 'teaching' approaches in therapy to facilitate the development of parenting skills in their patients, but rather that these skills develop through the therapeutic relationship.

4.3.1.3 Mothering the Mother

The findings show that participants felt that their role in therapy with mothers with SMI, with consideration of the child in mind, would be to help the mother develop 'good enough' parenting skills. The way in which these skills are communicated does not only happen in a direct, informative way. Rather, participants highlight that they need to model behaviour and relational interactions with the mother in order to help her internalise these patterns of interacting that can be applied with their children. Just as a mother is required to be attuned, warm, and present to her baby to establish an emotionally meaningful connection, the clinical psychologist needs to use the same skills in the therapeutic relationship (Gabbard, 2018). Lindiwe went as far as stating that her role as the clinician is to "*mother the mother*" and that in this way, more space is created "*for that mother to mother*". Lindiwe introduces an interesting perspective on the nature of the therapy-patient relationship, and how this might be transformed when the patient is a mother. She described that in therapy, the person sitting across from you is "*always a child*", supporting the controversial notion suggested by Slochower (1994) which is that the clinical psychologist-patient relationship is equivalent to that of the mother-baby. George further elaborates on this notion stating:

...holding true to a modality that thinks about the fact that as a fundamental truth of being a clinical psychologist means that actually the patient that you meet… you're mothering them.

This approach is often criticised for undermining the experiences and knowledge of the patient, which may be experienced as even more disparaging for mothers who already feel ashamed and inadequate about their mothering abilites (Dolman et al., 2013; Mizock et al., 2019; Slochower, 2013). Importantly, the participants framed this perspective around how the therapeutic relationship could offer a safe, warm environment in which the mother can experience, and thus develop new ways of thinking and relating in the world (Ivey, 2011). These sentiments may therefore rather draw attention to the vulnerability of the mother, and her need for support, than a notion that the mothers are incapable or child-like. In describing how the therapeutic relationship might offer a space to develop new skills, Joyce said the following:

My goal might be to help them [mothers] develop some theory of mind, some sense that we have different thoughts and feelings to others, that my feelings and their feelings are separate, and that would take place over time through the relationship.

Participants highlight that something happens in the therapeutic dyad between them and the patient in which fundamental mothering capacities described earlier are developed, and that these can then be translated to interactions between the mother and her child outside the therapy room. Just as the mother acts as the container for the baby and uses her mind to help making meaning of the baby's experience, the clinical psychologist does the same for the patient. The mother is then able to develop skills and expand her capacity for parenting through a 'good enough' therapeutic relationship (Gabbard, 2018; Ivey, 2011). Given that mothers with SMI often have their own experiences of poor parenting in their childhood as indicated by earlier sub-themes, the therapeutic relationship can modify relational patterns through a new and corrective experience. This process can be healing for individuals who have had adverse early life experiences, and who have impaired attachments (Gabbard, 2018; Lemma, 2015). Thus, the clinical psychologist is able to utilise the therapeutic relationship to meet the needs of the mother, and enhance her skills and empower her to better parent in the context of SMI.

Overall, however, the findings are evident that participants' concerns about the child often shape their interventions with the mother, as echoed in literature (Chandra et al., 2019; Krum et al., 2014). The above findings illustrate a professional and evidence-based approach to practice with mothers with SMI, underpinned by theory and ethical responsibility. Interestingly, the findings reveal that the participants are also faced with navigating their own

duality in the treatment, which may further influence their perspectives of mothering with SMI, as well as the way in which they intervene with mothers with SMI.

4.3.2 Personal and Professional Duality in Interventions

The findings suggest that MHCPs who work with mothers with SMI also have to negotiate duality in their interventions, including navigating their own identities, and beliefs regarding motherhood and mothering. These perceptions underpin the rewards and frustrations clinical psychologists may experience when working with this group of patients. The experiences of psychologists when working with mothers with SMI is largely under-researched, with studies focusing on broad groups of MHCPs, rather than the experiences of specific professionals (Eliezer et al., 2022; Krum et al., 2014; Strand & Rudolfsson, 2020). This section of the findings therefore contributes to a knowledge gap in the field, and more specifically, in the South African context. The following findings also address the dual aim of this research, which is to both understand the impact of SMI on mothers, but also the experiences of the clinical psychologists tasked with working with them.

4.3.2.1 The Psychologist as a Parent, a Child, and Professional

These findings draw attention to the fact that the perceptions of mothering with SMI of participants are not only underpinned by their theoretical orientation, but on their own experiences of being mothered themselves. This created an interesting bridge between their patients and themselves, and highlights how the professional and the personal cannot necessarily be separated (Lemma, 2015). The experience of mothering is universal, and we have all been mothered in one way or another (Baraitser, 2008). As such, it is unsurprising that the participants' own experiences influence and shape their perception of what it means to be a mother, and mothering with SMI.

The findings reveal that psychologists can cast a "*critical gaze*" (George) upon mothers with SMI, and research indicates that often MHCPs working with this population have stigmatising or unfavourable attitudes towards these patients (Dolman et al., 2013; Engqvist et al., 2011). Traditionally, clinical psychologists have been encouraged to maintain an objective, blank, and neutral stance when working with their patients (Lemma, 2015). This approach often meant that a clinical psychologist's own beliefs, feelings, and perceptions were banished from the therapy room and their own identity could not play a role in the therapy space (Aponte, 2022; Zeller-Steinbrich, 2018). The findings, however, draw attention to the intersubjective nature of

therapy, which acknowledges that both clinical psychologists and patients sit with their own beliefs, experiences, and social identities that inevitably permeate the therapeutic interaction (Aponte, 2022; Nissen-Lie et al., 2022). The participants were able to draw on these aspects when talking about their work with mothers with SMI, noting that their own experiences of being a child, and/or of being a parent themselves, could affect the way in which they think about, might work with, and might experience this patient population. In describing how being a parent might impact work with this population, participants said the following:

...more of a countertransference challenge that I have experienced is that I'm a parent myself. So when…I'm dealing with a person having parental challenges, it's always very difficult to kind of hold only the person that I'm treating in mind. I think my mind will also go into 'ooff, I wonder how these children are doing? Are they being taken care of? Are they safe?' – Lindiwe

...since becoming a parent I definitely was more sensitive to what that must be like for the mom and what that must be like for the child to have a mom who maybe can't do that because of her mood. – Trent

Lindiwe's statement above represents the way in which countertransference can influence a clinical psychologist's capacity to remain objective with a patient, and how it may affect his/her emotional response or reaction to a patient (Lemma, 2015; Nissen-Lie et al., 2022). This statement illustrates how the identity of the psychologist as a parent themselves might make them more cognisant and concerned about the wellbeing of the child. The second statement, by Trent, indicates that perhaps being a parent might make a psychologist more sensitive and understanding to the experiences of mothers, as also suggested by a study by Derry (1994).

In further demonstrating the way in which the social identity of the clinical psychologist enters the room, Matthew said the following:

I also wonder sometimes how much do they open up to me in the therapeutic process because, or I wonder what they think, I wonder how the therapy's impacted that, that I'm a male, I'm not a parent - you can clearly see - how much comes through into the therapy.

The intersection of the clinical psychologist's identity is evident in this quote, and just as the intersection of the mother's identity affects her experiences (Moultrie & Kleintjies, 2006; Nkosi & Van Der Wath, 2012), the intersection of the clinical psychologist's identity may influence his interventions with mothers with SMI. The quote also highlights how mothers with SMI may not disclose or be open with professionals about their parent status or experience because of the fear of receiving judgement and criticism (Engqvist et al., 2011). The parenting status of the clinical psychologist, as indicated by the participants, seems to either reinforce this, or make a mother feel more comfortable to discuss parenting issues. Additionally, Matthew argues that the very fact that he is not a parent and not a woman makes it harder for him to feel "*qualified to judge parenting skills*". Rather, he drew on his own experiences of being parented, and how this has influenced his emotional and psychological development, to position his perception on what it means to be a mother, and what it means to be a child. Just as the mother is required to 'Encounter the Ghosts of Parenting Received' (Barlow & Cairns, 1997) to make sense of their mothering identity, psychologists have to experience the same internal process when thinking about their patients as mothers. Additionally, it could be argued that psychologists' implicit and procedural memories of early relational interactions are also triggered (Raphael-Leff, 2018) in response to working with mothers with SMI. This is particularly relevant within a therapeutic relationship which mirrors that of a mother-child (Slochower, 1994). Participants too have to think about, and confront their own attachment, and internal representations of mothers (Barlow & Cairns, 1997; Fraiberg et al., 2018). The participants' perceptions on what structures the mothering identity are therefore not only influenced by their work with patients who are mothers, but from their views, biases, and preconceptions which are, just like the mothers, also shaped by their own childhood.

These findings demonstrate that the psychologist's own identity might have a role to play in their treatment with mothers with SMI, which is important to consider, given the interpretivist nature of this study. The individual identity and experiences of participants' seem to have shaped their responses, and inform their perceptions on the phenomenon of mothering with SMI (Pervin & Mokhtar, 2022). The findings are therefore indicative of the way in which knowledge and meaning are subjective, as indicated in the interpretivist paradigm (Kivunja & Kuvini, 2017).

The contrast between participants drawing on their personal experiences of parenting to shape and structure their internal representations of the mothering identity and their professional

perceptions based in theoretical frameworks highlights an interesting intersection between the personal and professional. These findings also reveal that SMI restructures the way in which psychologists might work with mothers, and highlight the unique experiences they might have when working with this population.

4.3.2.2 Experiences of Working with Mothers with SMI

The study's findings portray the unique difficulties and rewards that clinical psychologists might experience when working with mothers with SMI. These rewards and difficulties were noted to be related to the complex interplay of dynamics that present with both identities – that of a mother and as an individual with SMI. This finding is important in addressing a research gap, in which the experiences of clinical psychologists specifically in working with mothers with SMI have been neglected, and how a broader focus on the experiences of all MHCPs has typically been researched (Krum et al., 2014; Strand & Rudolfsson, 2020). Participants' responses indicated that working with mothers with SMI can be rewarding because the therapy can have a profound impact not only on the mother, but on her child as well, as also illustrated in earlier sub-themes. Participants also described that it is rewarding to watch mothers come to enjoy being a parent, gain more insight into their mental illness, and see their symptoms improve. In describing this, the participants said the following:

... the reward is exactly the same, that as you work with the, the parent, the mother, you also know that you're working with the child; that something about these particular interventions means that the impact moves beyond the person that you see in front of you. – George

I think it's very rewarding when you start to see the mom obviously getting better and climbing out of the depressions and starting to talk about their child and starting to connect with the child on a, on a deeper level. – Trent

That's a very rewarding part of the job when you can actually connect with the mom and connect with her parts of wanting to be better for her children, wanting to be better for herself... – Raadha

Interestingly, these participants seem to focus on the rewards related to the wellbeing of the child, reinforcing that often when mothers with SMI interact with healthcare systems, the focus is predominantly on the wellbeing of the child (Chandra et al., 2019). However, Matthew

mentions that developing an "*enjoyment of motherhood*" can also be a reward of working with this population, which begins to refocus the treatment on the mother and her own identity. This has been illustrated to be fundamental for mothers working with SMI (Heron et al., 2021; Mizock et al., 2019), and is particularly critical given the poor self-esteem and sense of inadequacy mothers might experience, as described in the previous sub-themes. In some ways, the participants illustrate the way in which they can help a mother develop confidence and a sense of mastery in their mothering role, as described by Barlow and Cairns (1997). The participants' responses provide a more holistic approach that aims to empowering the mother, focusing on her own identity and internal processes, whilst still benefitting the child.

Participants also highlight that working with this patient population also comes with unique challenges. Notably, the participants discussed how challenging it can be to work with mothers with SMI when the wellbeing of the child is in fact being compromised. Trent describes that the consequences of this is often the "*neglect of the child*", and that it can be "*heart breaking when you hear that*". Similarly, Raadha describes that it feels hard to work with the mother when "*you have a niggling feeling that something more ominous is going on and you're not being fully made aware of it*". Participants also discussed other challenges linked to working with this population of patients, particularly around issues of compliance, resistance to treatment, and poor insight. These challenges are echoed in literature, indicating that because of the severity of the symptoms associated with SMI, non-compliance to treatment and poor insight is common amongst this patient population (Barlow & Durand, 2015; Johnson, 1997). Lindiwe elucidates the reason for poor compliance amongst mothers with SMI:

> *I think when there is, you know, either severe psychosis or severe, you know, disorders of pathology there is just the sense of, 'I'm too far gone, I don't want these medications that numb me, I don't wanna do this thing, I don't wanna talk, it's not actually useful for me.'*

Lindiwe highlights two difficulties in the above quote, firstly is the non-compliance to treatment, and secondly is the resistance to therapy and treatment. The participants indicate that often mothers with SMI are resistant to a therapeutic process, making psychological interventions difficult to initiate and less likely to be effective (Mizock et al., 2019). Matthew further highlights this as he stated that a lot of mothers he has worked with "*often don't even seek treatment*". Once again the complexity of this phenomenon is brought to the fore, as research also asserts that part of the reason mothers do not seek treatment or comply with

treatment is because of the harsh responses and judgement they receive from MHCPs (Chandra et al., 2019; Eliezer et al,. 2012) which has been reflected in earlier sub-themes. Access to care is also a challenge, and the available interventions for mothers with SMI are limited, and this is particularly true in the South African context (Rampou et al., 2015). As such, mothers who seek treatment from psychology professionals, if it is available, are also constrained by contextual factors.

4.4 Theme 3: Positioning Treatment in Context

The final theme revealed in the findings is related to treatment in context, and this is particularly important given the interpretivist paradigm of this study, as well as the fact that the South African context introduces unique complexities to the issue of mothering with SMI (Moultrie & Kleintjies, 2006). Treatment for mental healthcare users situated in the South African healthcare system is already constrained, and thus more specialised and holistic treatment programmes are mostly unobtainable (Rampou et al., 2015). The participants identify the challenges related to the South African healthcare system, as well as contextual and psychosocial factors that are likely to influence care for mothers with SMI. The findings also draw attention to what mothers with SMI need in terms of treatment and mental healthcare interventions.

4.4.1 The Healthcare System in South Africa

Participants highlight several areas of significance regarding the healthcare system in South Africa and how this affects treatment for mothers with SMI. Firstly, they noted that resources make a difference, and that treatment of mothers can differ depending on whether they have access to public or private healthcare resources. The participants further indicated that there is a substantial lack of treatment options for mothers with SMI in South Africa, views which are supported by local literature (Mkhize & Kometsi, 2008). The impact that SMI has on mothering and the mothering identity is both complex and unique, and as such, mothers with SMI might require specific and specialised programmes that help them manage and negotiate this duality. The findings reveal that there are several programmes that could benefit mothers with SMI that would be ideal in the South African context. Unfortunately, many mothers with SMI in South Africa do not have enough support from families, communities, and the mental healthcare system.

4.4.1.1 Lack of Family and Community Support

The lack of family and community support is described by participants as a significant challenge in terms of treatment of mothers with SMI in the South African context, but also as factors that might exacerbate non-compliance to treatment and poor treatment-seeking behaviours. Participants describe that the lack of support for mothers with SMI is often perpetuated *and* precipitated by stigma, singe-parenting, and poor mental health literacy in communities, as corroborated by literature (Banerjee et al., 2021; Moore, 2013; Perrot, 2017). Sharon emphasises the importance of support, noting that if a mother does not have some kind of social support structure it will be "*impossible for her to be able to take on that role as being the mother and managing her own mental illness*". Similarly, Trent stated that it is very difficult to parent in the context of SMI, "*especially when a mother doesn't have support*". In describing the lack of support of mothers with SMI and the consequences of this, participants further stated the following:

So I think sometimes, especially with unsupportive families, it is difficult for them to, to be honest and to seek support and to even ask for help because of that scrutiny. So they generally will just do, they'll just suffer in silence and not actually ask for help because of the backlash that they perceive they'll receive as a result of that. – Lindiwe

I suppose that there's little support for moms with severe mental illness and their babies. And what I mean by that is little support for them often in their families of origin, in the community at large. And that sort of isolation can exacerbate their illness - so social isolation, being ostracised and even ridiculed sometimes. – Joyce

...the word 'support' is coming to mind…a mom who does have mental illness - and especially severe mental illness - one would hope that she does have a robust support system. You know sometimes that can be hard to come by in South Africa. – Raadha

Participants illustrate that it is difficult for mothers to seek support from families and communities in the first place because of the perceptions of both SMI and mothering. Lindiwe describes this as "*backlash*", which as identified by literature, is judgement, criticism, social exclusion, and in severe cases, loss of custody of the child (Heron et al., 2021; Mizock et al., 2019). As participants suggest, isolation can exacerbate the mental illness. The literature accounts for this in two ways, firstly, because the mother is unable to look after her children

and maintain compliance to a strict treatment regimen which involves clinic follow ups (Rampou et al., 2015), and secondly, because isolation may increase feelings of guilt, and shame, and thus reduce the mother's internal sense of competence and wellbeing (Hine et al., 2019). Lindiwe's statement that mothers *"suffer in silence"* illustrates how disempowering SMI can be.

Joyce also asserts that there is a lack of support for the babies as well, highlighting the impact that social exclusion also has for a child, who equally experiences the social isolation and discrimination faced by their mothers (Dolman et al., 2013). Importantly, because the lack of support is likely to compromise a mother's capacity to remain psychiatrically stable, and care for her child, perpetuating the perception that mothers with SMI are incapable of being caregivers for children (Dobener et al., 2022; Reupert et al., 2021). Raadha suggests that robust support systems for mothers with SMI are not particularly prevalent in South Africa. This sentiment is corroborated by research illustrating the psychosocial adversities and lack of social support women and mothers face in the South African context (Moultrie & Kleintjies, 2006; Nkosi & Van Der Wath, 2012). Interestingly, this sentiment is contrary to the ideologies that underpin many childrearing practices in South Africa, in which a more collectivist parenting approach is undertaken (Reupert et al., 2022; Sudarkasa, 2004). These findings illustrate the way in which SMI can fundamentally shape mothering practices, to the extent where cultural ideologies regarding parenting are affected.

Importantly, the pressure placed on clinical psychologists and other MHCPs is also illustrated here, as they might be the only source of help for mothers with SMI who have limited experiences of support in their families and communities. This may enhance the need to focus solely on psychiatric stabilisation to return mothers to their social responsibilities, or to provide the rudimentary care needed for psychiatric stability to place less burden on mothers to commit to further treatment programmes (Docrat et al., 2019; Schneider et al., 2016). This therefore limits the opportunity to offer more in-depth and comprehensive interventions to mothers with SMI. The context of poor social support is further exacerbated by a healthcare system where resources are scarce and where programmes for mothers with SMI are not available (Rampou et al., 2015).

4.4.1.2 Resources Make a Difference

In South Africa there is a stark difference in public and private healthcare, in terms of resources and treatment options (Moodley et al., 2022). This is particularly applicable in the field of mental healthcare, with the public sector, and rural areas, being especially under-funded and under-resourced (Burns, 2011; De Kock et al., 2015). Matthew went as far as saying that "*mental healthcare is a luxury*" in South Africa illustrating the way in which mental healthcare is only accessible to those with access to financial resources and medical aid (Moodley et al., 2022). Given that up to 85% of South Africa's population rely on the public healthcare sector for their needs, and there are only 1.4 psychologists per 100 000 patients (Docrat et al., 2019; Mashigo, 2017), it is unsurprising that Matthew described mental healthcare in this way.

Participants' responses draw attention to the fact that resources can make a difference in terms of care for mothers with SMI. As also echoed by Matthew's statement, Joyce indicated that mothers who are "*well-financially resourced*" often have the advantage of being able to access "*other medical practitioners and that makes a big difference*". This is vastly different for the majority of South African mothers, and especially those with SMI, who might have to decide between supporting children's practical needs or using money for personal clinic visits (Rampou et al., 2015). Joyce further suggests that "*especially in under-resourced areas*" treatment does not "*serve mothers with babies particularly well*". Literature has shown that in the state sector, and particularly in rural areas, mental healthcare treatment occurs at a primary level, with the focus of care being on psychiatric stability (Docrat et al., 2019; Schneider et al., 2016). The intricate needs of mothers identified in earlier themes are therefore neglected in the care of mothers with SMI.

Given that many South African women who are mothers and who also have SMI are disproportionately affected by poverty and unemployment (Moultrie & Kleintjies, 2006), the majority of South African women with SMI are also likely to use public healthcare systems making it less likely that they will receive good quality care. Mothers who do not have private healthcare are often subject to "*long waiting lists*" (Lindiwe), "*untrained and inexperienced*" staff or a "*finite supply of medication*" (Trent). These themes have been repeatedly illustrated in literature suggesting that mental healthcare in the public sector in South Africa is profoundly ill equipped to provide quality care for mental healthcare users (Moodley et al., 2022). Participants draw attention to the contextual issues that are likely to perpetuate SMI, and enhance difficulties in parenting with SMI. The demands for mothers in South Africa to spend

prolonged periods waiting at the clinic (Booysen et al., 2021; Schneider et al., 2016) are likely to further entrench a sense of guilt and shame, and will affect their capacity to make time for their children, as illustrated in earlier themes. Furthermore, failure to receive medication is likely to put a mother at risk for relapse, and thus, further limit her capacity in her parenting. The way in which systemic factors also affect mothers with SMI in South Africa is brought to light in these findings, illustrating that it is not only the SMI and parenting demands that have to be managed by the mother, but that this needs to occur in an under-resourced context with factors that are beyond her control.

Overall, participants spoke to the fact that the broad systemic failures in the South African healthcare system make mothers with SMI more vulnerable to adversity, and that these consequences do not only affect mothers, but their children as well (Brooke-Summer et al., 2016). Additionally, the findings also reveal that there is a significant deficit of treatment options for mothers with SMI in South Africa, and that even for mothers who do receive private care, the extent of programmes specifically focusing on the distinctive needs of mothers with SMI are largely unavailable.

4.4.1.3 Deficit of Specialised Treatment Options in South Africa

All of the participants indicated that there is a significant lack of treatment options and programmes geared specifically towards mothers with SMI and the unique challenges that they face. These sentiments are echoed in literature which highlights that there is an overwhelming lack of interventions for mothers with SMI that address all aspects related to their care, such as parenting demands, parenting experiences, and managing mental illness in the context of parenting (Mkhize & Kometsi, 2008; Rampou et al., 2015). This deficit is not only present in the South African context, but has been highlighted as an issue in international literature as well (Cremers et al., 2014). Importantly, this deficit draws attention to the gap in research identified in the rationale of the current study, and highlights the overwhelming need for specialised programmes for this patient population. In describing the deficit of treatment options, participants said:

There don't seem to be many interventions in practice or places in which mums' and babies' mental wellness is addressed, or even just their mental health in terms of coping with severe mental illness. – Joyce

I don't actually know very many support groups for moms who are going through a mental illness, for example. – Matthew

Participants describe the paucity of interventions for mothers with SMI, and indicate that there are no specific programmes to address the wellness of mothers and their children, and assisting women/mothers in managing their SMI. These interventions are unfortunately widely unavailable due to a lack of resources in the mental healthcare context (Booysen et al., 2021; Brockington et al., 2011; David et al., 2011). Lindiwe also describes that the reason for the deficit of programmes for mothers with SMI in South Africa is due to the lack of "*a place, the practitioners, and the knowledge to facilitate that sort of thing*". Given the consequences that SMI has for both mothers and their children, and the long-term effects that untreated SMI can have on the development and wellbeing of children (Brockington et al., 2011; David et al., 2011; Deutsch & Clyman, 2016; Khang et al., 2008), the need for intervention programmes geared towards this population is readily apparent.

The burden of disease appears to be deepened by the lack of intervention programmes, as mothers who are overwhelmed by their SMI and the demands of being a parent may increasingly rely on the public healthcare system which is already strained (Booysen et al., 2021; Mkhize & Kometsi, 2008). Furthermore, their children are also more likely to have mental health difficulties and also rely on this healthcare system (Van Loon et al., 2014). Additionally, if mothers are unable to care for their children as a result of unmanaged SMI, there is an increase demand on the social welfare and legal system to intervene, both of which are equally under-resourced in South Africa (Brooke-Summer at al., 2016). Sharon highlights that "*prevention is better than trying to go back*", indicating how important these treatment programmes can be. The need for these programmes is therefore underpinned by the fact that prevention, as opposed to reactive interventions, are more cost efficient, socially responsible, and effective at managing the burden of mental illness in the long-term (Booysen et al., 2021). Participants describe several programmes that would be beneficial for mothers with SMI, and their children.

4.4.1.4 What Do Mothers Need?

The participants argue that there are several areas of treatment that could assist mothers in managing and negotiating the demands of parenting and living with a SMI. These suggestions appear to be based on their knowledge of, and experience of working with, this population,

their training in the field of mental healthcare, and their unique and elaborate knowledge of issues of mothering and child development (Lemma, 2015; Linden & Hewitt, 2018; Turel et al., 2020).

Participants described several different elements of mothering with SMI that would be crucial to address by treatment programmes. Firstly, some participants spoke about parent-infant interventions or 'mat work', which focuses on helping new mothers bond with their baby (Bain, 2020; Barlow et al., 2015). Participants describing this said:

So I think one of the best preventative measures is the parent-infant psychotherapy – Sharon

I think 100% starting with the baby mat interventions… - George

So I think something that's quite nice - and I know some places run this - is like an attachment workshop. – Raadha

These participants indicate that these types of programmes would be fundamental as early interventions, and as the first point of care for mothers with SMI who have babies. These intervention programmes are geared towards new mothers, and focus on supporting them through the most crucial stage of the child's development. Parent-infant psychotherapy, or 'mat work' focuses on providing a space in which mothers can interact with their infants, learn parenting skills, and improve attachment and connection with facilitation by a psychologist (Bain, 2020; Barlow et al., 2015; Peers & Frost, 2013). This type of work is underpinned by the 'good enough' parenting skills discussed throughout the findings, and focus on enhancing mothers' capacities to use these skills. Interestingly, mat work programmes are available in South Africa for mothers (Peers & Frost, 2013), however, the use of this intervention with mothers with SMI specifically is not researched. The capacity of the mother with an SMI to engage in a more complex intervention such as mat work will be dependent on the nature of her symptoms and her current functioning (Heron et al., 2021). Importantly, mat work is considered to be an intervention "that relates directly to the needs of mothers and infants being mothered" (Peers & Frost, 2013, p. 6). This type of intervention is in keeping with studies that reveal that mothers would benefit from training on parenting practices (Brockington et al., 2011; Mizock et al., 2019). These interventions, however, once again focus primarily on the mother-infant dynamic, and the wellbeing of the baby.

Nonetheless, participants also identify the support that the mother as an individual, could benefit from, for example, group interventions:

And I think probably really incredibly important, as with many, many interventions, is group spaces as well. Group spaces to come together to think about the kinds of things that might feel incredibly lonely but are actually not. – George

There needs to be that support as well. ...I wonder sometimes also in terms of support groups. – Matthew

So I think like new moms, it's very overwhelming to have a baby and just to sort of have supportive spaces even if it's supportive group therapy spaces with other new moms who also have severe mental illnesses, just to have shared experiences, to sort of have other minds to think with you and, and to share how they've managed being a mom, you know, coping with managing their mental illness, making sure that they're sort of self-reflecting and seeing where they're at, whether they are coping. – Raadha

These quotes highlight how group spaces might be particularly beneficial to mothers, specifically in terms of peer support, a sense of community and shared experiences, and the opportunity to think together about how to cope with the demands of parenting with a SMI. The potential benefits of group work for mothers with SMI are similarly reflected in literature, in which a space to discuss and connect with other mothers with SMI can be incredibly therapeutic (David et al., 2011; Hine et al., 2019; Radley et al., 2022; Reupert et al., 2017). Given the lack of support that is often a prevalent part of the experiences of mothers with SMI, and how they might often be isolated from other mothers (Dolman et al., 2013; Hine et al., 2019), support groups have prominent potential in terms of successfully intervening with mothers with SMI. This may also have significant value in the South African context in which collective mothering is emphasised (Sudarkasa, 2006).

Participants also identify that individual spaces are equally important for mothers which both include therapeutic, supportive, and psychoeducational aspects:

But mothers with mental illness need individual spaces too – Matthew

I certainly think they need to be in therapy if they can. I also believe that moms also often have bad education around what medication they can be on that can potentially help their mood. So I certainly think they need correct psychoeducation around that information – Trent

So I think a lot of information is needed and a lot of normalising, a lot of sort of just supportive work to be that - I guess I'm just thinking now from a therapeutic perspective - if you have a mom come in with severe mental illness to sort of normalise some of the experiences of being a mom. – Raadha

The participants' sentiments regarding the individual treatment for mothers with SMI illustrate that there are aspects related to their care that are not only centred around the child. For example, as Heron et al. (2021) suggest, psychotherapy could focus on issues of self-esteem, confidence, and symptom management. These types of therapeutic goals, and the therapeutic focus identified by participants, would be especially important for mothers who are already faced with stigma, blame, and poor support (Heron et al., 2021). Lindiwe went as far as to say that ideally a mother could be supported psychologically in two different spaces; one which focuses on the parental guidance, and the other which focuses on the "*person and their symptoms*". As described earlier, these spaces are often interlinked and Lindiwe highlights that this can complicate the way in which a mother might "*relate with the treatment plan*". This supports the need for a more mother-oriented focus to interventions that prioritise the mother's own identity and experiences (Heron et al., 2021). The expansive treatment needs of mothers with SMI are also illustrated by Lindiwe's comment, highlighting how complex this phenomenon is. Interestingly, Trent's comment above appears to be orientated around a more cognitive behavioural individual intervention, which is different to the more psychoanalytically informed responses that focus on the internal world of the mother and her experiences of SMI. This is important to note given the theoretical backdrop of this study based primarily on psychoanalytic literature.

Importantly, this final section has been positioned as such in order to reorientate the reader to the focus of this study, which is on the *mother* with SMI, something which has frequently been overlooked in both research and mental healthcare interventions (Brockington et al., 2011; Eliezer et al., 2022; Mizock et al., 2019). The phenomenon of mothering with SMI is multi-layered with several interrelated internal and external factors that shape the uniqueness of the mothering experience in the context of SMI. The following section concludes this report, and

draws attention to the pertinent findings from the study, as well as the limitations of the study, and their relevance related to clinical practice and future research.

CHAPTER FIVE: SUMMARY, RECOMMENDATIONS AND CONCLUSIONS

In this section, a summary of the findings is presented which answers the research questions initially set out by this study. Thereafter, the contributions of the study are explored, followed by an exploration of the clinical implications of the findings. This is particularly crucial given the clinical nature of the topic of this study, and the way in which the findings drew attention to clinically relevant issues. The limitations of the current study are then discussed and linked to the recommendations for both practice and research.

5.1 Summary of Findings

The findings draw attention to the complex and nuanced nature of the dual identity in the phenomenon of mothering with SMI. Before considering the way in which SMI impacts the mother, the notion around what it broadly means to be a mother was interrogated. As corroborated in the literature (Barlow & Cairns, 1997; Cowling & Van Gordon, 2021; Hine et al., 2019; Jenkins, 2019; Murray et al., 2019; Slade and Sadler, 2018) the findings elucidate the way in which the mothering identity is not only constructed by the individual, but that it is moulded by theoretical notions, external expectations, and internal representations engendered by one's own experiences of being mothered. Notably, Winnicott's (1959) concept of the 'good enough' mother underpinned many of the participants' responses, and appeared to shape the participants' narratives around the mothering identity. Beyond meeting the instrumental needs of the child, the ideal mother is considered to be warm, nurturing, and intuitive, and possesses characteristics form a safe relationship in which the infant develops capacity to both be aware of their external environment, and his/her internal world (Hine et al., 2019; Jenkins, 2019; Louw & Louw, 2016; McKinney & Meinersman, 2022). Unfortunately, this description prescribes rigid and unattainable standards for mothers who have their own difficulties, such as SMI. Even outside the context of SMI, finding unwavering joy in the mothering journey, and becoming an ideal mother, is challenging. Participants drew attention to the pressure that the mothering expectations create, and how overwhelmed mothers can feel having to be 'ideal' caregivers, and continue to fulfil social and occupational responsibilities (Dolman et al., 2013).

Participants restructure the mothering identity in the context of SMI, indicating that mothering is substantially different in the face of SMI, and might deviate from theoretical, cultural or

societal mothering norms (McKinney & Meinersman, 2022). SMI introduces a new angle of complexity to the mothering identity. Entering into the mothering identity already includes a process of renegotiation, reorganising and reprioritising of one's life, and relational and occupational demands (Barlow & Cairns, 1997). SMI creates additional demands that have to be navigated, and as participants illustrate, this prevents the mother from fully suspending her own needs in sacrifice of the infant's (Hayes, 1996). Mothers have to delicately balance the needs of their child with their own needs (Barlow & Cairns, 1997; Hayes, 1996), and SMI can impose on this process, demanding more attention from the mother, and increasing the need for the mother to focus on her own wellbeing, compared to mothers without SMI. The findings thus reveal the way in which the SMI becomes a 'third' that alters the exclusive and unshared dynamic between the mother and infant (Britton, 1989; Hayes, 1996; Jacobs, 1999).

The findings further highlight that a dual focus is often not undertaken in the treatment of mothers with SMI. Either, the mothering identity is not acknowledged in a patient with the SMI, or the mothering role is prioritised over the SMI at the expense of the mother's individual needs (Banerjee et al., 2021; Brockington et al., 2011; Eliezer et al., 2019; Heron et al., 2021; Lacey et al., 2019). Nonetheless, participants acknowledge that the mothering identity and an SMI are inextricably linked, because mental illness becomes part of one's identity, as does motherhood. Notably, the findings reveal that the mothering identity was also considered something that is 'transmitted' vertically across generations, illustrating how the mothering identity is not only developed in the context of external expectations, but is also based on one's own experiences of being a child, and of being mothered. This, as Barlow and Cairns (1997) present it, is described as a process of encountering "Ghosts of Mothering Received". In drawing attention to the cyclical nature of SMI, the findings revealed that mothers with SMI have often had poor parenting experiences (which would have predisposed them to developing SMI), and that as such, it is not only the SMI that might impact their parenting practices, but their own poor emotional and psychological development (Brockington et al., 2011).

Participants consider the 'good enough' parenting requirements as incongruent with SMI, drawing attention to the widespread enmity towards mothering with SMI. The findings draw attention to the way in which SMI affects insight, emotional regulation, and orientation to reality, as also described in literature (Zumstein & Riese, 2020) and how this limits a mother's capacity for insight, emotional awareness, and perspective taking for the child. This is compounded by the fact that mothers with SMI often already present with a disturbance in

emotional and relational functioning due to their own childhoods, which is likely to further affect their capacity to develop and adaptively use 'good enough' mothering skills. Participants emphasised that especially in the active phase of symptoms of an SMI a mother's ability to take care of her child is particularly compromised. In delineating whether a mother is able to mother in the context of SMI, the findings drew attention to both the access the mother has to support (including family, community, and professional support), as well as the extent to which the mother's own attachment is impaired.

Furthermore, SMI can potentially distort and disrupt one's identity, and this is equally true for the mothering identity. The findings also illustrate the way in which SMI can affect a mother's experience of her identity, noting that having to take care of herself, as well as her child, in the face of SMI can feel like an insurmountable task. As a result, participants suggested that mothers with SMI often experience an overwhelming sense of guilt and shame associated with their parenting difficulties, and that the confidence in their parenting is significantly reduced by the presence of an SMI. Participants positioned the experiences of shame and guilt as the consequence of comparing parenting practices to what is considered the 'good enough' mother.

The findings also suggest that the need for interventions targeting the unique needs and specific dynamics that present in this population is therefore pivotal, however, the duality also creates a difficult terrain that MHCPs have to navigate when treating mothers with SMI. Participants indicate how they are faced with the dilemma of their therapeutic responsibility towards their patient, and their ethical and moral responsibility toward the wellbeing of the child. At the first point of care, treating SMI is the primary objective, however, the participants illustrate the way in which there is a significant focus on the wellbeing of the child, as well as the parenting responsibilities of the mother. As evident in participants' responses, the identity and individual experiences of the mother is often overlooked, a pattern which has also been found in other studies (Eliezer et al., 2022; Mizock et al., 2019). Interestingly, the findings reveal how, in the therapeutic relationship between a mother with SMI and a clinical psychologist, the child becomes the 'third' who enters into the patient-clinical psychologist dynamic, and which demands the attention and mind of the clinical psychologist (Britton, 1989; Jacobs, 1999).

Participants also reflect on the way in which the focus on the child not only places pressure on the clinical psychologist, but on the mother who is expected to make a recovery to return to mothering responsibilities. The findings draw attention to the fact that treating mothers with

SMI involves high stakes, in that the possible impact on a vulnerable child can be, in severe instances, life threatening. As such, many participants suggest that it is often not possible to overlook the wellbeing of the child, and that this puts pressure on them to ensure a successful intervention. A focus on the child leads clinical psychologists to centralise the need for direct parenting interventions as a key part of treatment. Participants highlight that a key part of this process includes education and training on parenting practices. This focus is identified in literature as an important need for mothers with SMI and is therefore in keeping with general consensus about what support is required for mothers with SMI (Brockington et al., 2011; David et al., 2011).

Participants draw attention to the way in which the parenting practices can be refined in a less direct manner, through the therapeutic intervention. In this way, the relationship between the clinical psychologist and the mother is characterised by the same 'good enough' skills, as the clinical psychologist is attuned, warm, present, and engages in a process of mentalising to form a meaningful connection with the patient/mother. The participants assert that the clinical psychologist-patient relationship mirrors the ideal mother-child relationship, and through the therapy the mother can internalise these patterns of interacting, as modelled by the therapy, and translate them into the relationship with her child. Participants described this as a process of *"mothering the mother"*, which is a contentious notion in literature (Slochower, 1994) but suggests that the person sitting in the therapy room is equally as vulnerable and in need of support. The therapeutic relationship also challenges the mother's own attachment style, which as suggested in the findings is also implicated in the SMI and mothering practices, and provides the mother with new and corrective relational experiences, which are both healing for her, and potentially for her child. However, as the findings reveal, an equally important process is focusing on the mother's experiences of having an SMI and the way in which her own internal world has been fragmented, drawing attention to the problem identified in this study, which is that the individual identity of the mother, and her experiences are often disregarded in lieu of what her mothering status means in terms of her child.

Interestingly, the duality, and complexity of working with this population group, was not only identified as something experienced by the mother, but also by the psychologists treating them. The findings highlight the way in which psychologists have to consider and balance their professional and personal thoughts about what it means to be a mother, which too are underpinned by their own experiences of being parented, parents themselves, and of being a

child. This created an interesting bridge between the patients and themselves, and highlights the way in which the professional and personal are often interlinked, contrary to the notion that clinical psychologists should be neutral, 'blank slates' (Lemma, 2015). The findings drew attention to the way in which the participants' own experiences of being a parent means that they inevitably drawn to thinking about the child. For participants who are not parents, the focus became on whether their parenting status would impact the way in which a mother might relate to them, or the way in which they might perceive parenting practices. This was also thought about in relation to gender, and how women might find it hard to experience psychological support from an individual who may not experience the same cultural and societal pressure that women do in relation to the mothering role (Frizelle & Kell, 2010; Hine et al., 2019).

In keeping with the dual focus, the study also draw attention to the experiences of clinical psychologists working with mothers with SMI who are tasked with particularly complex responsibilities. The findings describe that although there are several unique difficulties when working with mothers with SMI, such as the emotional burden that the intrusive awareness of the vulnerable child might bring, or the poor insight or resistance of mothers to treatment, there are also several rewards when working with this population. Relevant to the problem posed by this study, in which these narratives regarding this phenomenon typically draws attention to the child (David et al., 2011; Miklush & Connelly, 2013), is that many participants found a lot of reward in the impact that their interventions might have on a child. Some participants did, however, describe that the fact that mothers might experience more enjoyment in their role, and that the interventions might alleviate some of the mother's own internal distress, is also a reward in working with mothers.

The final theme in the findings draws attention to the context in which treatment and mothering with SMI occurs. The unique factors that influence care of mothers with SMI in South Africa was highlighted by participants. Firstly, was the lack of family and community support that mothers with SMI often experience, and how this plays a fundamental role in limiting her ability to mother effectively. Participants suggested that poor responses to mothers with SMI by others, such as isolation, social exclusion, and discrimination, contributes to the difficulties mothers with SMI might have in maintaining psychiatric stability and effectively fulfilling social and occupational responsibilities. This was corroborated by literature, highlighting the way in which societal and community responses compromise a mother with SMI and her

capacity to parent (Dolman et al., 2013). The lack of social support was also noted to be difficult when mothers need to adhere to treatment regimens, have prolonged hospital admissions, and attend clinic visits. A child left behind becomes a prominent concern, perpetuating the urgency described early in the findings to treat mothers until they return to premorbid functioning and return them to their roles. More in-depth treatment options become limited for these mothers who, because of the extent of their responsibilities and the lack of support, are unable to commit to further treatment programmes. These findings therefore draw attention to the fact that it is not only SMI that impacts parenting abilities in mothers, but external factors that may further challenge and compromise their capacity to manage their dual roles.

The participants also draw attention to the way in which resources can prominently affect the available treatment options for mothers with SMI. For mothers without access to financial resources or private medical aid, treatment options are particularly limited, as supported by local literature in the field of mental healthcare (Mkhize & Kometsi, 2008). Participants drew attention to the challenges that mothers with SMI might face in the public healthcare setting, such as long waiting lists, medication deficits, and untrained healthcare professionals. These factors put mothers at further risk for absence and relapse, and may further entrench a sense of guilt and shame. Another prominent feature of the findings was the broad deficits of specialised treatment options in South Africa for mothers with SMI. Participants highlight the profound need for treatment options, underpinned by the sentiment that prevention is far more effective than reactive treatment for mothers and their children.

The participants identify several treatment options that would be crucial in assisting mothers, but reiterated that these programmes are not feasible in the South African context due to the lack of resources. Participants first suggested that parent-infant interventions, or ‘mat work’ focusing on early bonding between a mother and a baby are crucial. Secondly, participants draw attention to the possible benefits of group interventions which might provide a supportive space for mothers in which their own experiences and difficulties are highlighted and thought about. Finally, the findings illustrate the importance of individual spaces for mothers with SMI, which focus on their own experiences, not only of being a mother, but also a mental healthcare user. This final point reorientates the reader back to the purpose of the study, which is to draw attention to the importance of the mother in this phenomenon, an identity which is frequently overlooked (Eliezer et al., 2021).

These findings have answered the dual-focused research questions, firstly by elucidating the perceptions of psychologists regarding the impact of SMI on mothering, in terms of the capacity for women to mother, the dual demands of each identity, and the needs of mothers with SMI to fulfil their role. Secondly, these findings have drawn attention to the way in which the perceptions of clinical psychologists might influence clinical practice, drawing attention to the decisions made around therapeutic interventions and treatment plans, and the factors that inform clinical psychologists' perceptions. These findings therefore have numerous contributions that will be explored further in the following section.

5.2 Contributions of the Study

This study has several noteworthy contributions, but most importantly, it contributes to an under-researched area of mental health care, that of mothers with SMI. This study especially contributes to the significant deficit of research on this topic in the South African context. This study did not focus on the impact on the child of mothers with SMI, as typically explored in this field of research (Bee et al., 2013; Brockington et al., 2011; Mowbray et al., 2006; Murphy et al., 2017; Van Santvoort et al., 2015), but draws attention to the impact of the mother and her own identity. The findings therefore offer a new perspective on mothering with SMI, which also considers the mother's own experiences, perceptions, and difficulties, and the way in which she navigates these in turbulent and unpredictable contexts in which extraneous factors can significantly shape her experiences. Furthermore, the findings of this study challenge the notion that mothers with SMI are incapable of mothering (Awram et al., 2017), but supports the growing viewpoint that mothers with SMI, with adequate support, can in fact be effective and successful mothers (Brockington et al., 2011; David et al., 2011). Therefore, this study challenges the stigma and shame often associated with mothering with SMI, and begins to draw attention to the human and subjective experiences of mothers with SMI. The findings of the study draw attention to the importance of support for mothers with SMI, as well as the contextual factors that contribute to the difficulties that mothers face with SMI. The dual focus of the study also means that the findings have relevance for clinical psychologists working with this population of patients. This contributions of the study to clinical practice will be elaborated on in the next section.

5.3 Clinical Implications

This study has several important clinical implications that are particularly relevant for the field of mental healthcare and specifically the clinical psychologists working with this population of

patients. Firstly, the study draws attention to the unique needs of mothers with SMI, and the way in which these needs have been repetitively overlooked in mental healthcare (Eliezer et al., 2022). The parent status of the mother and the SMI require a delicate balancing, and necessitate equal consideration in treatment programmes (Brockington et al., 2011). For clinical psychologists working with this patient population, an onus to consider the dual identity of the patient for the wellbeing of both the mother and the child is evident. The findings reveal the way in which clinical psychology intervening with mothers with SMI does not always prioritise the maternal experiences and psyche, and that the focus is overwhelmingly directed towards the child. As such, clinical psychologists may neglect the more nuanced, intrapsychic, and unconscious processes related to mothering and the maternal identity (Baraitser, 2008).

The findings also highlight the potential role of clinical psychologists when working with this population, and perhaps call for a focus, in clinical contexts, of psychological interventions with mothers with SMI. Even mothers who will not necessarily manage more therapeutically inclined interventions may benefit from psychological interventions that support them in managing the complexity of mothering, and the way in which mothering processes become even more strenuous in the context of SMI. A redirection of focus of interventions could empower mothers, give them a voice, and encourage more discourse regarding parenting with SMI. This may have a prominent role to play in reducing stigma and challenging stereotypes regarding these assumptions. Clinical psychologists are therefore not only in a position to directly assist a mother and her child, but contribute to transforming broader narratives regarding mothering with SMI, merely by adapting their interventions to incorporate a more holistic account of the maternal experience. Additionally, the findings challenge clinical psychologists regarding their perceptions of mothering and mothering practices, and suggest a need for more receptiveness to the way in which mothers construct their own mothering identity, and the ways in which cultural and societal expectations may differ from the Eurocentric psychoanalytic theories. Finally, an appreciation of the already overwhelming role of mothering allows for a less punitive approach to mothers with SMI who may be struggling with parenting, attending clinic appointments, and managing their illness.

The findings also call for more introspective and reflexive practices when interacting with mothers with SMI, given the propensity for this topic to activate the internal implicit and procedural memories of early relational interactions (Raphael-Leff, 2018) of clinical

psychologists working with mothers with SMI. The dual identity of the psychologist is therefore fundamental to hold in mind, requiring psychologists to consider their own attachment and internal representation of mothers and the way in which this may overtly or inadvertently affect the way in which they treat mothers with SMI. Finally, the findings reveal the external and contextual factors that stretch the capacity of mothers with SMI. For clinical psychologists working with these populations, a systems-oriented perspective rather than an individual focus may allow for a more holistic perspective of the challenges faced by mothers with SMI. The findings therefore call for a shift in clinical thinking with regard to mothering with SMI. Given the nature of the study, however, and the focus on the individual perceptions and experiences of participants, the findings do not necessarily represent the sentiments of all clinical psychologists and therefore these clinical implications are limited in this regard. The limitations of the study therefore need to be considered in relation to the above discussion.

5.4 Limitations of the Study

The following limitations were considered in this study and will be useful in terms of recommendations for future research:

- The study focused broadly on perceptions of individuals with SMI, which accompanies a range of different diagnoses which have associated symptoms. SMI was conceptualised at the beginning of the study in order to delineate what the focus of this study would be. However, a limitation of this study is that it did not focus more narrowly on specific illnesses or symptoms (e.g. psychosis). A narrower approach may have allowed for a more defined scope and provided an alternative insight into the way that different aspects of SMI may impact on mothering. This limitation was also illustrated in the findings, in which participants showed how different symptoms could compromise mothering in the context of SMI.

- Additionally, this study also focused on the impact of SMI on mothering practices, and many of the participants drew attention to the effect on children. The study did not specify the ages of the children, also meaning that the findings depicted a broad representation of the impact that SMI can have on mothering. This is opposed to a narrower focus on the effect that SMI can have on a mother who has children at different stages of development (e.g., a child who is several months of age is far more dependent on her than a child who is fifteen years old) which may have yielded different findings. Additionally, the study did

not interrogate the potential impact that the number of children a mother has would shape her mothering in the context of SMI. However, given the focus of this study on the mothering identity and experience, these elements were not considered necessary to delineate at the outset of the research process.

- This study has also not focused on psychologists' perceptions of the identity of the woman before she becomes a mother, which perhaps draws attention away from the identity of the individual, not necessarily linked to her mothering role. Importantly, SMI may result in unplanned motherhood, and it may be important to consider what occurs for the mother prior to falling pregnant, and her transition into the mothering role in the context of SMI.

- Another limitation of this study is that the research was conducted from the viewpoint of professionals working with mothers with SMI, and therefore may be viewed as a more 'top down' generation of knowledge, rather than the empowerment of mothers with SMI to have their own voices heard (Borcsa et al., 2021).

- This study also, unintentionally, had participants who work predominantly from a psychoanalytic framework, which as the findings show have inextricably informed their perceptions. This is important as psychologists who are trained, and work from other theoretical orientations might have different perspectives.

- In addition to the above limitations, due to the unique experiences of individual perspectives, and the small sample size, the study will be difficult to replicate, and the findings are inherently not generalisable to the population. This means that there are several factors that influence the impact that SMI has on mothering, as suggested by participants, that may not be universal. The participants illustrated the way in which they think about each mother and their individual circumstances, drawing attention to the importance of context in this study. Despite that this study has not aimed to generalise the findings (Bryman, 2012), it is important to acknowledge that these findings are not representative of the perspectives of all clinical psychologists working with all mothers with SMI.

This topic is relatively under-researched in the South African context, and the limitations of this specific study draw attention to both the complexity of the phenomenon of mothering with

SMI, as well as the need for research into the phenomenon of mothering with SMI in South Africa specifically. These limitations also underpin the recommendations of this study.

5.5 Recommendations

Based on the above findings, several recommendations can be made, in terms of mental healthcare contexts, clinical interventions, future research, as well as policy and resource allocation.

Recommendations for mental health care institutions

The findings reveal a significant variation in the way in which mothers with SMI are treated in mental health institutions, which can positively or negatively influence the experiences of mothers, as well as the outcome for the child. The findings illustrate how the dual identity of the individual may not be considered, resulting in a narrow and individualised focus of treatment and intervention, or a neglect of the parenting status. These findings stress the imperative for MHCPs to acknowledge both of the identities in their treatment with mothers with SMI, not only in terms of the superficial implications of the intersection of these identities, but also the intricate and complex context introduced by these dual identities. The need for mental healthcare professionals to consider the unique demands that mothers experience, as opposed to patients without children, is vital. It is evident in the findings that the perceptions of MHCPs directly influence treatment practices, and thus, more cognisance around the unique experiences of mothers with SMI is vital for improved care that addresses all aspects related to their needs. For example, the literature suggests that mothers with SMI desire more child-friendly experiences for their clinic appointments (Rampou et al., 2015). This could be a cost-effective and feasible adaption for mental healthcare contexts, which might be able to prioritise appointment times for mothers, be more open to children accompanying them, or be more aware of the consequences of medication shortages or long queues (Rampou et al., 2015). As the findings suggest, adaptions in the care for mothers with SMI could have significance for the wellbeing of the mother and the child, and thus reduce the long-term burden of care.

Recommendations for treatment programmes

The findings of study highlight several recommendations from clinical psychologists regarding what support could be beneficial for mothers with SMI in order to prioritise the mother's wellbeing, and as such, increase the possibility of a healthy developmental trajectory for the baby. The findings suggest that mat work, or parent-infant psychotherapy interventions would

be crucial for mothers with SMI. Incorporating the infant into the interventions might also contribute to a more parent-friendly experience for mothers with SMI who attend clinic appointments. This type of intervention may, however, also require more training for clinical psychologists to specifically work with this population and thus, professional development programmes could be directed towards equipping psychologists with these skills. The available parent-infant psychotherapy programmes or mat work programmes could be adapted and developed to more specifically focus on mothers with SMI and their unique needs.

Additionally, the findings revealed that support groups and individual psychotherapy with a dynamic focus could be beneficial for mothers with SMI. Support groups in particular could be a cost-effective and resource-conserving way to support several patients, and have benefits in terms of social support networks for mothers which may improve their prognosis (Hine et al., 2019; Radley et al., 2022; Reupert et al., 2017). In a context such as South Africa, in which support for mothers with SMI is already absent (Rampou et al., 2015), and where resources are limited (Moodley et al., 2019), support groups could play a fundamental and impactful role in addressing this treatment gap efficiently. Finally, in terms of individual therapy, the findings call for a multidisciplinary team approach to treatment in which the psychologists' role in working with the internal world of the mother is preserved; and where necessary, the role of other MHCPs, such as social workers, can address the needs of the child. This may reduce the burden of on the psychologist and ensure that the therapeutic space can be held for the mother as an individual first.

Recommendations for future research

The limitations identified in this study draw attention to areas that could potentially be addressed in future research on this phenomenon. First and foremost, the imperative to conduct future research on this topic is informed by the profound lack of research on this topic in the South African context. Further research would be fundamental in drawing attention to the needs of mothers with SMI, as well as the lack of resources available to assist this group of patients. Research on this topic also elucidates the complexity of patient cases that MHCPs are faced with in these contexts, and thus further research could identify issues pertaining to training and clinical practice for MHCP's working with specialised groups of patients. Future studies could have a more narrow focus, drawing attention to specific diagnoses or symptoms of SMI, or specifics of mothering, such as the age of the children in a mother's care or the transition into mothering with an SMI. This might draw attention to more nuanced issues experienced by this

group of patients. Additionally, future studies could focus more specifically on the experiences of mothers, as narrated by the mothers with SMI. This type of research would be fundamental in giving a voice to individuals who are often excluded from social discourse (Borcsa et al., 2021) and empowering mothers with SMI to share their experiences, thus giving them an opportunity to be heard and understood. Additionally, a more comprehensive, mixed methods approach to this type of phenomenon might result in more generalisable findings that could be useful in informing policies, laws, and regulations about mental healthcare.

Recommendations regarding policy and resource allocation

The main finding that underpins the recommendations regarding policy and resource allocation is the potential long-term benefits of focusing resource, treatment efforts, and policies on mothers with SMI. The negative longitudinal effects of SMI on mothers does not only result in more reliance on the state in terms of mental healthcare, but also on more reliance on other sectors of the public system, such as social welfare. Furthermore, the outcome for the children will also have consequences in terms of burden of care, which again will result in more long-term reliance on state systems for healthcare and social welfare related interventions. Ultimately, policy and resource allocation targeting mothers with SMI are prevention methods, which in the long-term have far preferable outcomes for society. The findings of this study thus stress the imperative for policies and resources to be targeted to the holistic and comprehensive care of mothers with SMI which address their complex needs, as well as the needs of the child. The need for policy and resource allocation therefore moves beyond the individual, and highlights the systemic implications of the lack of care for this patient population. Additionally, policy and resource allocation will also contribute to social transformation, and aid in breaking the stigma of mental illness and parenting that is evidently so pervasive in society (Borcsa et al., 2021).

5.6 Conclusion

This qualitative, interpretivist study undertook to explore the perceptions of clinical psychologists regarding the impact of SMI on mothering. The study maintained a dual focus, which enabled an exploration of both the impact of SMI on mothering, and the experiences of clinical psychologists working with this population group. The findings revealed the complex and nuanced nature of this phenomenon, and the duality that is present in the identity of the mother as well as the psychologist. The impact of SMI on mothering and the mothering identity is intricately interweaved with contextual factors, as well as the internal and intrapersonal

processes that occur in the individual mother. Clinical psychologists tasked with working with this population of patients are challenged with the profoundly delicate task of balancing the unique needs of the mother, whilst ensuring the wellbeing of the child. This study has begun the conversation, which has been avoided and foreclosed in South Africa, regarding mothering with SMI, and the role of healthcare professionals in treating this patient population.

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APPENDICES

Appendix A: Participant Information Sheet

Dear Sir / Madam

My name is Emily Walton, and I am a Masters student in Clinical Psychology at the University of the Witwatersrand, Johannesburg. As part of my studies, I am required to undertake a research project, and I am investigating the impact of severe mental illness on mothering under the supervision of Dr Clare Harvey. The aim of this research project is to find out how clinical psychologists perceive the impact of severe mental illness on mothering.

As part of this project, I would like to invite you to take part in an interview. This activity will involve conversing with myself as the researcher about the topic and will take around 60 minutes. The interview can be on an online platform of your choosing or face-to-face at a time and place convenient for you. With your permission, I would also like to audio record the interview using a digital device. This recording will be stored on a password protected computer and only the researcher will have access to this recording. The audio recordings will be transcribed and all identifying details will be excluded from the transcripts. The transcripts will only be accessible to the researcher and the supervisor.

There will be no personal costs to you if you participate in this project. You will also not receive any direct benefits from participation but there are no disadvantages or penalties if you do not choose to participate or if you withdraw from the study. You may withdraw at any time or not answer any question if you do not want to, without any negative consequences. The interview will be completely confidential. I will not be asking for any identifying information, and the information you give to me will be held securely and not disclosed to anyone else. I will be using a pseudonym (false name) to represent your participation in my final research report. Any identifying details that you disclose of institutions at which you worked or currently work, as well as of any cases you discuss, will remain anonymous in the transcripts and final write up. In the unlikely event that you experience any distress or discomfort at any point in this process, we will stop the interview or resume another time.

If you have any questions during or afterwards about this research, feel free to contact me on the details listed below. This study will be written up as a research report which will be available online through the university library website. If you wish to receive a summary of this report, I will be happy to send it to you (optional). Anonymised and confidential research publications may be in the form of journal articles and / or conference presentations. With your permission the data collected from this research project may be used by other researchers in an anonymised format.

If you have any concerns or complaints regarding the ethical procedures of this study, you are welcome to contact the University of the Witwatersrand's Human Research Ethics Committee (Non-Medical), telephone +27(0) 11 717 1408, email hrecnon-medical@wits.ac.za.

Yours sincerely,

Researcher

Emily Walton; emilyjoywalton@gmail.com; 079 513 6410

Supervisor

Dr Clare Harvey, Clare.Harvey@wits.ac.za, 011 717 9999

Appendix B: Consent Form

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

SCHOOL OF HUMAN AND COMMUNITY DEVELOPMENT
PSYCHOLOGY

CONSENT FORM

The Impact of Severe Mental Illness on Mothering: Perceptions of Clinical Psychologists

I, ……., agree to participate in this research project. The research has been explained to me and I understand what my participation will involve. I agree to the following:

(Please circle the relevant options below).

I agree that my participation will remain confidential	YES	NO
I agree that the researcher may use anonymous quotes in his / her research report	YES	NO
I agree that the interview may be audio recorded	YES	NO
I agree that the information I provide may be used in an anonymised format after this project has ended, for academic purposes by other researchers, subject to their own ethics clearance being obtained.	YES	NO

…… (signature)
…… (name of participant)
…… (date)

…… (signature)
…… (name of person seeking consent)
…… (date)

Appendix C: Interview Schedule

Interview Schedule

Demographic Information

Age:

Gender:

Theoretical Orientation:

Current Work Context (Public/Private):

Questions

1. What experiences have you had working with mothers with severe mental illness? What do you understand by 'severe mental illness'?

2. From a psychological perspective, what do you think the main tasks and responsibilities are of mothering?

3. How do the symptoms of severe mental illness affect, if at all, the mother's ability to meet the physical demands of the child?

4. How do the symptoms of severe mental illness affect, if at all, the mother's ability to foster the emotional and psychological wellbeing of the child?

5. How does severe mental illness affect, if at all, the mother's ability to utilise important skills (e.g., reflective functioning, theory of mind, autonomy granting and discipline, soothing, and fostering emotional regulation)?

6. Can you describe how severe mental illness might be implicated in mothers' internal representations of mothering and how they develop their own approach to mothering?

7. Can you describe how severe mental illness might affect the mother's ability to balance her own needs and the needs of the child?

8. How do you think severe mental illness affects the mother's confidence in her ability to be a mother?

9. How do your perspectives on how severe mental illness might affect mothering influence or shape the way in which you intervene or treat this patient population as a clinical psychologist?

10. How do your interventions with mothers with severe mental illness differ from your interventions with patients who do not have children?

11. What is the biggest challenge that mothers with severe mental illness face in their families?

12. What is the biggest challenge that mothers with severe mental illness face in their communities?

13. What is the biggest challenge that mothers with severe mental illness face when interacting with the mental healthcare system?

14. What psychological support do mothers with severe mental illness need?

15. How do these challenges impact psychological service provision to mothers with severe mental illness?

16. What difficulties do you experience working with this population?

17. What rewards to you experience working with this population?

Appendix D: Data Analysis Example

TRANSCRIPT EXERT	EXAMPLE OF APPROACH TO ANALYSIS
L: It does make sense, but it's very difficult to *[laughs]* to answer it in, in that, um, so I think what, I mean, I think it's, it's difficult in it, it depends on the particular symptoms, right, that a person has. So for example, if a person or a parent is struggling with uh or part of the symptoms that they have are things like hallucinations that, you know, and you're hallucinating that a child is, you know, there's a snake, you know, sleeping next to your child, the measures that you're going to take in order to, to bring their child to "safety" - and I'm using safety in inverted commas here because your child would be safe, it's just that your perception is that there is a threat - the, the measures that the parent will take to protect that child may actually be detrimental to the child themselves. So I think it depends really on the symptoms, so things like unusual beliefs or of of, of, you know, like unusual thoughts or unusual beliefs. Like a, a parent that feels like, you know, some children will be born with a, I don't know, a birthmark, or they'll develop a rash or something. So if your, your thoughts and your beliefs are that this rash is caused by, you know, this danger that's coming or this threat that's coming, the measures that, you know, one may take to prevent that may actually be harmful to the child. Sometimes it's even like things like that are simple, like hygienic kinds of taking care of the child. But it, it really, really does depend. I think it depends mostly on the symptoms that the, the parent is presenting with that will then affect the way that they parent. So, for example, if you're looking at, you know, my bipolar patient, it would be, you know, those feelings of sadness and hopelessness may	*Symptom specific.* *Altering mothering approaches.* *Threat to child.* *Symptoms of SMI.* *Impact on instrumental needs of child.* *Impact on behaviour, emotions and cognition of mother.*

make, actually used to make them very suicidal. And, and they would think, you know, "If I commit suicide, what's gonna happen to my child? So maybe we should both not be around." So that also presents some danger to the child. So I think it's, it's different things like that or feelings of guilt or feelings of despair, all of those kinds of things actually affect the, the way that you think about your child and the way that you will then parent them or want to give them safety and soothing and comfort and all of that. I: Mmm, mmm. So I mean, I think we've spoken a little bit about kind of the, the, sort of interaction between the mom and the child and I'm wondering if you can tell me a little bit about how mental illness from your perspective might kind of be implicated in the mothers internal representations of her mothering and her identity as a mother and how it might sort of affect their development, affect their, their own sort of approach to mothering? If that makes sense? L: Mmm, so do you mean like in terms of their identity? I: Ja, I mean, I think kind of the identity as a mother comes with quite a lot of things and I was wondering if, if severe mental illness might be implicated in that identity. L: Ja, I mean it does. It, it definitely would. Like severe mental illness would affect the way that a parent relates to their child, or even the way that they understand their role as being a parent, whether it's in a sense of inadequacy, of feeling like, "I don't even know how to take care of myself."	*Possible harm to child.* *Impact on capacity to respond to emotional needs of the child.* *Effect on 'good enough' mothering skills: safety, comfort and soothing.* *Duality/interrelatedness of identity.* *Effect on actual identity of mother.* *Incapacitating nature of SMI on the person (? Even outside context of mothering).*

And this is a, you know, a narrative that I heard quite a lot of, "I don't know how to take care of myself, how am I supposed to take care of this person?" Sometimes it could be a narrative of, "I think this is a, this is a test for me or it's a punishment for all of the things that I've done and therefore now I have this child to take care of, which means that I can't be self-indulgent anymore because now I have to take care of this child." But I think even things like just, you know, confusion of, you know, what am I supposed to do? How am I supposed to do it? Because, I mean, if you think about a severe mental illness, it really affects the person's thought processes, their cognitive capacity. It affects their, the way that they relate to their world, which is part of the big thing, right. But it's not like a cognitive distortion that can be eliminated by, I don't know, just doing affirmations or chanting things. There's actually a biological, genetic and chemical reasons why this person is struggling in the way that they do. So you know, things like taking care of your medication, you know, going to therapy, using skills and groups and all of that become absolutely important. But when a person feels absolutely overwhelmed by the environment and by the task of being a parent, they neglect some of those things that are actually treatment plans that are there for them to feel better and therefore parent better. So those interactions, the way that they see themselves as parents. You know, a parent is supposed to know when they, why their child is crying. But the reality is no, not really. You can anticipate their needs, you can guess and do trial and error while the child is crying, but it's not all the time when you can actually pinpoint to why is this child crying. But when you already have those cognitive, you know,	*Dual demands that are unattainable.* *Giving up of independence, mother's own needs in lieu of the child's.* *Effect on cognition.* *Effect on relating.* *Genetic element.* *Importance of compliance to treatment regimens.* *Mothers feeling overwhelmed in their responsibilities.* *Contribution of environment.t* *Barriers to care.* *Good enough mothering skills.*

distortions and those thought processes, you're already thinking that "that means it's because I'm failing, because I'm not a good parent." So some of those things can really affect the way that the person is relating to something.	*Impact on self-esteem and self-confidence.*
But I mean, I think the other big, the other big part of it with parenting is that it triggers your own childhood. And if there was any traumatic incidences in that area, a lot of those projections kind of come into the parenting space when one parents their own child. So ja, it's a whole lot of things that could interrupt or influence or impact just that, that relationship between a mom and their child because of a severe mental illness, depending on the nature of that severe mental illness and what for them is incapacitated - whether it's the thought process, is it physical stuff, is it more emotional reasoning, is it more, you know, attachment? All of those kinds of things. Helping the child develop a secure circle of security, you know, not being overly stressed when a child is walking away, you're playing, and all of that; not creating a sense of clinginess and anxiety in a child. All of those things can be, you know, disrupted because of a severe mental illness.	*Encountering the ghosts of mothering received.* *Being parented shapes parenting as well – own childhood memories triggered and re-enacted.* *Nuanced and complex nature of SMI and mothering.* *Several interrelating factors.* *Good enough mothering skills.* *Expectations of the ideal mother.* *Mothering skills are negatively influenced by SMI.*

Appendix E: Ethics Clearance Letter

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

SCHOOL OF HUMAN AND COMMUNITY DEVELOPMENT ETHICS COMMITTEE
CONSTITUTED UNDER THE UNIVERSITY HUMAN RESEARCH ETHICS COMMITTEE (NON-MEDICAL)

CLEARANCE CERTIFICATE:	**PROTOCOL NUMBER: MCLIN/22/08**
PROJECT TITLE:	The Impact of Severe Mental Illness on Mothering: Perceptions of Clinical Psychologist.
INVESTIGATOR	Walton Emily (742178)
SCHOOL/DEPARTMENT OF INVESTIGATOR	SHCD/Psychology
DATE CONSIDERED	10 June 2022
DECISION OF THE COMMITTEE	Approved unconditionally
RISK LEVEL	Minimal Risk
EXPIRY DATE	31 December 2024

ISSUE DATE OF CERTIFICATE 11 July 2022 **CHAIRPERSON** C Harvey
(Dr Clare Harvey)

Cc: Dr Clare Harvey (Supervisor)

DECLARATION OF INVESTIGATOR

To be completed in duplicate and **ONE COPY** returned to the Chairperson of the School/Department ethics committee.

I fully understand the conditions under which I am are authorized to carry out the abovementioned research and I guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee.

Signature **Date** **12/07/2022**

PLEASE QUOTE THE PROTOCOL NUMBER ON ALL ENQUIRIES