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Adult daughters' experiences of growing up with a mother who suffered from a severe mental illness

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Adult Daughters' Experiences of Growing Up With a Mother Who Suffered From a Severe Mental Illness

A thesis submitted to the faculty of Arts of The University of The Witwatersrand, in partial fulfilment of the Masters Degree in Clinical Psychology, Johannesburg.

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SENATE PLAGIARISM POLICY

Declaration by Students

I, Tracy Plant (Student number: 1723807) am a student registered for Masters Degree in Clinical Psychology in the year 2019. I hereby declare the following:

- **I am aware that plagiarism (the use of someone else's work without their permission and/or without acknowledging the original source) is wrong.**
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Contents

1. Chapter one 1
    1.1. Introduction to the research area 1
    1.2. Research Aims 4
    1.3. Rationale for the study 4
2. Chapter two: Literature review 7
3. Chapter three: Research methodology 28
    3.1. Research Design 28
    3.2. Theoretical framework 28
    3.3. Research question 29
    3.4. Sampling strategy 29
    3.5. Data collection 31
    3.6. Data analysis 31
    3.7. Ethical Considerations 33
    3.7.1. No Harm to Subjects 33
    3.7.2. Voluntary Participation 34
    3.7.3. Informed Consent 34
    3.7.4. Protecting participants' Privacy and Anonymity 34
    3.8. Reflexivity 35
4. Chapter four: Results and discussion 37
    4.1. Introduction 37
    4.2. Putting the puzzle pieces together 38
    4.2.1. Noticing patterns/ changes in mothers' behaviour 38
    4.2.2. Moments of insight 45
    4.2.3. Feelings of relief through gaining an understanding of mental illness 49
    4.2.4. Layered understanding of human difficulties 52
    4.3. Mother daughter relationship 55
    4.3.1. The re-assignment of family roles 56
    4.3.2. Loss, Sorrow and Lack 60
    4.3.3. Emotional distance 64
    4.4. Navigating different dimensions of a woman's identity 66
    4.4.1. Perception of self 67
    4.4.2. The female body 69
    4.4.3. Being a mother 72
    4.5. Other caretaking figures 75

4.5.1. The role that fathers played....75
4.5.2. Turning to other members in the family for support....78
4.6. Coping through control....80
4.7. Behind closed doors....85
4.8. Wishes for others in similar situations and ideas for interventions....88
4.8.1. Keeping children in the loop....88
4.8.2. Being 'seen' by Professional services....90
4.8.3. Sharing with another daughter....92
5. Chapter five....95
5.1. Conclusions....95
5.2. Limitations of the research....100
5.3. Recommendations for future research....100
References....102
Appendix A: Semi-Structured Interview Schedule....118
Appendix B: Participant Information Sheet....120
Appendix C: Consent Form (Interview)....121
Appendix D: Consent Form (Recording)....122

1. Chapter one

1.1. Introduction to the research area

The mother-infant dyad is considered to be the most important relationship in the facilitation of early childhood development (Bion, 1962a, 1962b, 1970; Bowlby, 1953, 1960, 1969, 1973, 1979, 1988; Klein, 1926, 1935, 1940, 1946, 1975a, 1975b, 1975c; Winnicott, 1960a, 1960b, 1963, 1965, 1971). It is therefore important to acknowledge how the mental state of a mother can interplay with the development of a child in many ways and on many levels (Alvarez-Monjaras, Rutherford, & Mayes, 2019; Blum, 2017; Sorenson & Schuelke, 1999). Research suggests that mothering ability and behaviour can be directly affected if a mother has a mental illness (Alvarez et al., 2019; Hipwell, Goossens, Melhuish, & Kumar, 2000; Manning & Gregoire, 2006; Oyserman, Mowbray, & Meares, & Firminger, 2000; Panos et al., 2006). The transition to motherhood can be a challenging task. It requires psychological adjustments, and there are biological changes and neural changes both during and after pregnancy (Alvarez-Monjaras et al., 2019). According to Evagorou, Arvaniti and Samakouri (2016), during the postpartum period up to 85% of women may experience some type of emotional difficulties but this does not necessarily mean that they will qualify for a mental illness diagnosis. Research shows that a small but significant proportion of mothers experience a serious mental illness either before or after childbirth (Cuipers, Weitz, Karyotaki, Garber & Andersson, 2015; Drury, Scaramelaa & Zeneah, 2016; Oyserman et al., 2000). Post-natal depression has been reported to be the most common psychological disorder in women after childbirth (Gelaye, Rondon, Araya & Williams, 2016; Lyons-Ruth, Wolfe, Lyubchik, & Steingard; McLennan, Kotelchuck, & Cho, 2002; Sawyer, Ayers & Smith, 2010).

Mothers who have mental illness are divided into two different groups in the literature: mothers who have been diagnosed with a mental disorder prior to having children and those who develop a mental illness following the transition to parenthood. Irrespective of the heterogeneity of this group, children of women with a mental illness are an at-risk group (Craig, Judd & Hodgins, 2005; Cuipers et al., 2015; Evagorou et al., 2016; Goodman & Garber, 2017; Glover, 2014; Gelaye et al., 2016; Handley, Michl-Petzing, Rogosch, Cicchetti & Toth, 2017; Hails, Reuben, Shaw, Dishion, Wilson, 2017; Sawyer et al., 2010). The impact of maternal psychopathology may even start during the perinatal phase of pregnancy (Austin, 2003; Drury et al., 2016; Glover, 2014). A child's development begins when a child is conceived, and therefore unborn infants could be impacted by their mother's mental illness in a number of

ways (Drury et al., 2016; Evagorou et al., 2016; Grantham-McGregor et al., 2007; Goodman & Garber, 2017). The perinatal period has been described as a period of risk for the mother and the infant around parturition and the first post-partum month (Austin, 2003). For example, the increase of in-utero cortisol, which might be released when a mother is in a heightened emotional affective state, has the potential to negatively impact the neurodevelopment of an infant (Glover, 2014). Furthermore, women diagnosed with depression during the prenatal period have been reported as being less conscious and less aware of the impact that their own nutritional diet might have on their infant, which might lead to low infant birth weight and might increase the risk that an infant is born prematurely (Raposa, Hammen, Brennan & Najman, 2014). There is an increased recognition in literature that the prevalence of depression arising antenatally is similar to that of post-natal depression (Austin, 2003).

Mothers remain at risk of developing a mental illness several years after they have given birth (Glover, 2014; Oyserman et al., 2000). The context of parental and maternal mental health are linked as being a mother of young children is acknowledged to increase the risk of psychiatric symptoms such as anxiety and depression (Oyserman et al., 2000). Maternal psychopathology has well documented negative effects on children from infancy through the entire developmental phase and even beyond this (Brockington et al., 2011; Engur, 2017; Fraser & Pakenham, 2009; Hipwell et al., 2000, Letourneau, Tramonte, & Willms, 2013; Manning & Gregoire, 2006; Oyserman et al., 2000; Trondsen, 2012). Research indicates that parental mental illness can impact the emotional stability and developmental outcomes of children in a variety of ways (Brockington et al., 2011; Engur, 2017; Fraser & Pakenham, 2009; Garley, Gallop, Johnston, & Pipitone, 1997; Gladstone, Boydell & McKeever, 2006; Manning & Gregoire, 2006; Oyserman et al., 2000; Polkki, Ervast & Huupponen, 2005; Trondsen, 2012). There are very few qualitative studies that explore the potentially lingering impact of these experiences, as reported by adult offspring (Dunn, 1993; O'Connell., 2008; Kadish, 2015; Knutsson-Medin, Edlund, & Ramklint, 2007; Petrowiski & Stein, 2016; Williams, 1998). In this study, the term *adult offspring* refers to individuals over the age of 18, whose mothers suffered from severe mental illness during these individuals' childhood. This research project uses the term *severe mental illness* to encompass severe psychiatric disorders that have been diagnosed by a healthcare professional which include severe depression, bipolar mood disorder, schizophrenia and other psychotic illnesses.

Research suggests that the impact of maternal mental illness on the child is not so much about the illness variables or categorical diagnoses (Brockington et al., 2011; Engur, 2017; Hipwell et al., 2000; Oyserman et al., 2000; Tarullo, DeMulder, Martinez & Radke-Yarrow, 1994). Rather, the impact seems to depend on the nature and duration of the parent's illness, timing and severity of the episodes, and the multiple interactions between the child's gender, age and developmental needs (Brockington et al., 2011; Oyserman et al., 2000; Tarullo et al., 1994). Research also indicates the importance of the child's familial and social support structures in relation to the impact of the mother's mental illness (Hipwell et al., 2000). Furthermore, other significant factors include the specific kind of maternal psychopathology, whether it is acute, severe and frequent, or milder and less frequent, and the child's temperament (Brockington et al., 2011; Engur, 2017; Knutsson-Medin et al., 2007; Oyserman et al., 2000; Panos et al., 2006). The relative importance of these associated factors are not well understood (Duncan & Browning, 2009; Engur, 2017; Hipwell et al., 2000; Oyserman et al., 2000; Panos et al., 2006) as there are discrepant findings in the research relating to small sample sizes, different social circumstances of the families and different ages of the children studied (Cogan et al., 2005; Hipwell et al., 2000).

There is a large body of research that has investigated the nature of mental illness, the impact of mental illness on maternal functioning, and the risk that is placed on the child growing up with a mother with a mental illness (Craig,et al., 2005; Cuipers et al., 2015; Evagorou et al., 2016; Goodman & Garber, 2017; Glover, 2014; Gelaye et al., 2016; Handley, Michl-Petzing, Rogosch, Cicchetti & Toth, 2017; Hails et al., 2017; Letourneau et al., 2013; Sawyer et al., 2010). Some research has found an interplay between the child's gender and the way that the child experiences growing up with a mentally ill mother (Benson et al., 2010; Brockington et al., 2011; Oyserman et al., 2000; Radke-Yarrow et al., 1994; Tarullo et al., 1994).

While there are effects on both sons and daughters, this research project has focused on adult daughters' experiences because there is research that suggests that daughters are even more negatively impacted by maternal mental illness than sons (Benson, Harris, Rogers, 2010; Radke-Yarrow et al., 1993; Tarullo et al., 1994). Some literature suggests that the mother-daughter relationship is developmentally important because daughters often look to their mothers as role models (Bojczyk, Lehan, McWey, Melson, & Kaufman, 2011; Lewis, Katsikitis, & Mulgrew, 2015; Radke-Yarrow et al., 1993; Tarullo et al., 1994). Another reason why daughters may be even more negatively affected than sons is that a mother-daughter relationship has also been perceived as a cornerstone to female identity development (Benson,

Harris, Rogers, 2010; Maor, 2012; Maor & Cwiker, 2016; Ogle & Damhorst, 2003). Mothers can also play an important role in communicating to their daughters a wealth of information about self-image and body image (Ogle & Damhorst, 2003). This communication between mother and daughter may be negatively impaired in mentally ill mothers which can have a longstanding impact on adult daughters (Maor & Cwiker, 2016). However, little is known about adult daughters' experiences of growing up with a mother who suffered from severe mental illness. The following research studies have focused specifically on reflections of adult daughters' experiences of growing up with mentally ill mothers: Dunn, (1993), Kadish, (2015), Knutsson-Medin et al., (2007), O'Connell. (2008), Petrowiski & Stein, (2016) and Williams, (1998). Therefore, the aim of this research is to further explore the unique adult daughters' experiences of growing up with a mother who suffered from severe mental illness.

1.2.Research Aims

The overall aim of this research was to explore adult daughters' experiences of growing up with a severely mentally ill mother. This research aimed to explore adult daughters' experiences by asking participants about their experiences retrospectively (when they were children and adolescents) and exploring their current experiences (as adults). Further, this research aimed to explore whether and how, the experience of growing up with a mentally ill mother may have impacted the participants on an emotional, social or interpersonal level. Research suggests that the gender of a child growing up with a mentally ill mother might influence the way that a child experiences growing up with a mentally ill mother (Brockington et al., 2011; Oyserman et al., 2000; Tarullo et al., 1994). Some research suggests that daughters are even more negatively affected than sons of mentally ill mothers (Bojczyk, et al., 2011; Lewis et al., 2015; Radke-Yarrow et al., 1993; Tarullo et al., 1994). Therefore, this research aimed to explore the unique experiences of daughters who grew up with a severely mentally ill mother in the hope of further understanding any potential gender specific experiences. There are also very few clinical interventions for adult children of mentally ill mothers and this research aimed to gather more information about this cohort in the hope of potentially informing future intervention strategies.

1.3.Rationale for the study

Research suggests that children of mentally ill mothers are at risk for psychiatric illness, developmental delays, and/or psychological difficulties (Brockington et al., 2011; Engur, 2017; Garley et al., 1997; Gladstone et al., 2006; Fraser & Pakenham, 2009; Manning & Gregoire, 2006; Oyserman et al., 2000; Polkki et al., 2005; Steadman et al., 2007; Trondsen, 2012). On

the other hand, the research that has focused on risk among children of a mentally ill mother has been criticized for being one dimensional, or of taking a problem orientated perspective (Cogan, Riddell, & Mayes, 2005; Duncan & Browning, 2009; Gladstone et al., 2006; Trondsen, 2012). A number of studies have demonstrated that some children display substantial resilience despite the challenging circumstances of growing up with a mentally ill mother (Beardslee, Versage, & Gladstone, 1998; Fraser & Pakenham, 2009; Kadish, 2015; Knutsson-Medin et al., 2007; O'Connell, 2008; Petrowiski & Stein, 2016).

Against this background and the many questions that are still unanswered, the current research project focused specifically on adult daughters' experiences of growing up with a mother who has been diagnosed with severe mental illness. This was the chosen focus in order to allow a qualitative exploration into exploring adult daughters' experiences of growing up with a mentally ill mother. As has been mentioned, there are effects on both sons and daughters who grow up with a mentally ill mother. This research decided to focus specifically on daughters' experiences because some research suggests that daughters may be even more impacted by maternal mental illness than sons (Benson et al., 2010; Radke-Yarrow et al., 1993; Tarullo et al., 1994). This has been attributed to various reasons relating to mother-daughter identification, daughters looking to mothers as role models, and propositions that the mother-daughter relationship is a cornerstone to feminine identity development (Benson et al., 2010; Maor, 2012; Maor & Cwiker, 2016; Ogle & Damhorst, 2003). However, the effects of the mother-daughter relationship - in situations of maternal mental illness - needs to be explored further.

The impact of maternal mental illness on a child is dependent on the interaction of episodes of mental illness, the onset of mental illness and on a child's specific developmental phase (Oyserman et al., 2000). It is also affected by the frequency and severity of the mental illness episodes (Oyserman et al., 2000). For adult children, as their mothers increase with age, so too do the number of years that they are exposed to the mental illness (Nathiel, 2007; Oyserman et al., 2000). Hence, the effects of maternal psychopathology would be cumulative. Adult daughters would also be going through different sorts of experiences in comparison to younger daughters, and in turn babies and toddlers have their own particular needs (Bojczyk et al., 2011; Downs, 2003). Each specific developmental phase will be affected differently, with the youngest being most at risk to the effects of maternal psychopathology (Brockington et al., 2011; O'Connell, 2008). However, little attention has been paid to experiences of adult daughters growing up with a mentally ill mother across different developmental phases in a

qualitative manner (Shrier, Tompsett, & Shreier, 2004). It is important to explore this further to understand if particular developmental phases impact different experiences or not. Therefore, qualitative research in this area is needed, so that the perceived effects of adult daughters' experiences can be better understood (Duncan & Browning, 2009; Oyserman et al., 2000).

This research will allow for adult daughters' experiences to be foregrounded, which is an important perspective for this cohort, seeing that adult children are often considered to be a neglected sample (Dunn, 1993; O'Connell, 2008; Knutsson-Medin et al., 2007; Petrowiski & Stein, 2016; Williams, 1998). Furthermore, this research will focus on the experiences of living with a parent with a mental illness which is different from the discourse of risk and resilience. Gladstone and colleagues (2006) explain that children of severely mentally ill mothers are primarily viewed as being either at risk on many levels or those who are resilient. In this way, the experiences of the children get lost in the risk-resilience discourse (Trondsen, 2012). Actively consulting adult daughters could also provide insights into interventions, support and improve early intervention strategies, especially in South Africa (Kadish, 2015; Gladstone et al., 2006; Oyserman et al., 2000).

2. Chapter two: Literature review

This literature review will present a collection of knowledge and theoretical contributions around the research question and will be presented in the following sequence. The first part of the literature review will introduce some of the literature on maternal mental illness. It can be diagnosed in mothers before pregnancy, during pregnancy and after childbirth. This will be followed by research that discusses the way in which maternal mental illness can impact children both biologically and environmentally (Cogan et al., 2005; Cowling et al., 2004; Duncan & Browning, 2009; Dunn, 1993; Engur, 2017; Garley et al., 1997; Knutsson-Medin et al., 2007) and environmentally (Bearsdlee & Wheelock, 1994; Craig et al., 2005; Downey & Coyne, 1990; Duncan & Browning, 2009; Gearing, Alonzo, & Marinelli, 2012; Knutsson-Medin et al., 2007; O'Connell, 2008;Perera et al., 2014; Williams, 1998). The third part of the literature review will include relevant qualitative literature in the research area that relate to experiences of growing up with a severely mentally ill mother. While some of these experiences have been reported by offspring of both sexes, there are some gender specific experiences that are reported in some of the literature which will be discussed (Benson et al., 2010;; Radke-Yarrow, Zahn-Waxler, Richardson, Susman, & Martinez, 1994; Tarullo et al., 1994). After this, some of the literature on the resilience and coping strategies of children growing up with mental illness is also discussed. The final section of the literature review discusses attachment theory, particularly the work of John Bowlby (1953; 1960; 1969; 1973; 1979; 1988). The review also includes a brief discussion of the work of psychoanalytic object relations theorists: Melanie Klein (1926; 1935; 1940; 1946); Donald Winnicott (1960a, 1960b, 1963, 1971), and Wilfred Ruprecht Bion (1962a, 1962b, 1970). The work of a number of leading psychoanalytic theorists has been included in this literature review. This theory provides an underpinning for the research project, potentially offering insight into the developmental and emotional effects that maternal mental illness might have on offspring.

It would be a mistaken assumption to presume that people with severe mental illnesses do not have children or if they do, they do not bring their children up themselves (Gladstone et al., 2006). In fact, people with serious mental illness are as likely as the general population to have children (Abraham & Stein, 2013; Kahn, Osyerman, Bybee, & Mowbray, 2008; Gladstone et al., 2006). Women particularly, are at risk for an episode of mental illness after the birth of their child/ren and are at risk of developing a serious mental illness even a number of years after childbirth (Austin, 2003; Oyserman et al., 2000). During their most difficult periods, parents with mental illness have a significantly decreased capacity to take care of their children

(Abraham & Stein, 2013; Duncan & Browning, 2009; Dunn, 1993; Engur, 2017; Fraser & Pakenham, 2009; Kadish, 2015; Knutsson-Medin et al., 2007; O'Connell., 2008; Petrowiski & Stein, 2016; Polkki et al., 2005; Trondsen, 2012; Williams, 1998). Advances in many spheres have allowed severely mentally ill mothers to raise their children in their own homes (Gladstone et al., 2006; Polkki et al., 2005; Trondsen, 2012). Thus, maternal mental illness has been a point of increased and sustained interest for researchers given the fact that children who grow up with mentally ill mothers are at risk of 'doubly negative' circumstances (Fraser & Pakenham, 2009; O'Connell, 2008).

The first part of this 'double negative' is that there is an increased genetic risk for mental illness in children of mentally ill mothers (Abraham & Stein, 2013; Cogan et al., 2005; Cowling et al., 2004; Duncan & Browning, 2009; Dunn, 1993; Engur, 2017; Garley et al., 1997; Knutsson-Medin et al., 2007; Mowbray, Bybee, Oyserman, MacFarlane, & Bowersox, 2006; O'Connell, 2008; Polkki et al., 2005; Tarullo et al., 1994). Oyserman and colleagues (2000) also note that 32-56% of children of mothers with serious mental illnesses may develop some type of diagnosable mental illness. 13 % of children who grow up with a parent diagnosed with schizophrenia will develop schizophrenia themselves, in comparison to the prevalence in the general population which is estimated to be around 0.5-1% (DelBello & Geller, 2001; Duncan & Browning, 2009; Dunn, 1993). Similarly, the genetic risk is also higher for children of parents who have bipolar disorder (7.8%) in comparison to the general population (Knutsson-Medin et al., 2007; Manning & Gregoire, 2006). Depression is the most frequently diagnosed mental illness of children who grow up with mentally ill mothers (Garley et al., 1997; Hammen, Burge, Burney & Adrian 1990; Klein, Lewinsohn, Rohde, Seeley, & Olino, 2005; LeClear O'Connell; 2008; Tarullo et al., 1994). For example, Garley and colleagues (1997) estimated that more than 50% of children of depressed parents will experience a major depressive episode by the age of 20 years. O'Connell (2008) documented slight gender differences in presentation of mental illnesses amongst children of mentally ill parents which will be discussed later in this literature review.

When calculating the relative risk of a child developing a mental illness, it seems important to also consider the psychosocial, cultural and environmental factors that contribute to the second part of the 'double negative' (Bearsdlee & Wheelock, 1994; Craig et al., 2005; Downey & Coyne, 1990; Duncan & Browning, 2009; Gearing et al., 2012; Knutsson-Medin et al., 2007; O'Connell, 2008;Perera et al., 2014; Williams, 1998). One of the most detrimental factors for

a child growing up with a mother who has a mental illness is the impact that severe mental illness has on parenting ability and on the family system more generally (Brockington et al., 2011; Dunn, 1993; Halsa, 2018; Hipwell et al., 2000; Knutsson-Medin et al., 2007; O'Connell, 2008; Panos et al., 2006; Trondsen, 2012). Oyserman and colleagues (2000) also note that maternal mental illness is only a small part of the total risk that children are exposed to as the subsidiary impact of maternal mental illness on the family system is substantial. Family conflict is commonly reported in families with parents who have mental illness as there are often family disruptions, higher rates of divorce and separation and higher levels of discord among family members (Allen-Meares, Blazevski, Bybee, Oyserman, 2010; Dunn, 1993; Engur, 2017; Gladstone et al., 2006; Mowbray et al., 2006; Oyserman et al., 2000).

Along with this increased level of family conflict (Allen-Meares et al., 2010; Beardslee et al., 1998; Craig et al., 2005; Dunn, 1993; Downey & Coyne, 1990; Duncan & Browning, 2009; Engur, 2017; Gladstone et al., 2006; Knutsson-Medin et al., 2007; O'Connell, 2008; Oyserman et al., 2000; Williams, 1998), literature suggests that families with parents who are mentally ill are also exposed to more socio-economic difficulties which becomes a point of conflict in itself (Mowbray et al., 2006). Research also suggests that the low socio-economic status of mothers is a stronger predictor of developmental challenges and psychiatric disorders in children than the mental illness diagnosis of the mother alone (Costello et al., 1996; Kessler, Foster, Saunders, Stang, 1995; Johnson, Cohen, Dohrenwend, Link, & Brook, 1999). Craig and colleagues (2005) also state that the combination of poverty and other social disadvantages from the effects of maternal mental illness (such as stigma and social isolation) should not be overlooked. Thus, maternal mental illness can have a direct impact on the broader familial system and in turn, significant impact on the home environment which may be conflictual, tense, chaotic and potentially financially strained (Cogan et al., 2005). The entire family system, according to Petrowiski and Stein (2016) is impacted by maternal mental illness including relationally and financially.

Moreover, literature suggests that maternal mental illness also impacts the family system on a broader social level (Fudge & Mason, 2004; Gladstone, 2010; Knutsson-Medin et al., 2007, Rutter et al., 1997, Smith, 2004). A theme that recurs in literature about growing up with mentally ill parents includes family lives characterized by poor social relations (Dunn, 1993; Engur, 2017; Hall, 2004; Garley et al., 199). There is often decreased social connectedness amongst families with maternal mental illness as many family members reported little enduring

interpersonal closeness with the social world (Dunn, 1993). Rather, they experience social alienation and lack social support (Dunn, 1993). This social isolation has also been attributed to the stigma surrounding mental illness (Corrigan & Miller, 2004; Dunn, 1993; Engur, 2017; Fjone, Ytterhaus & Almyik, 2009). In some ways this isolation is self-imposed as they would not talk about what went on in the family owing to sense of shame or humiliation around their situation (Dunn, 1993; Kadish, 2015; Pitman & Matthey, 2004; Polkki et al., 2005). These difficult social circumstances are often concomitant and exacerbate familial challenges and stressors on the family system (Engur, 2017). This is aligned with Sameroff and MacKenzie (2003) who postulate that childhood development is influenced by an amalgamation of different individual factors (such as age, temperament and gender) and the bi-directional interactions that occur between the child and their environment.

Maternal mental illness can also impact the way that mothers interact with their children (Craig et al., 2005; Duncan & Browning, 2005; Trondsen, 2012). The parenting style of a mother who has severe mental illness has been described as erratic (Brockington et al., 2011), inconsistent (Kadish, 2015), unstable (Oyserman et al., 2000) and unpredictable (Trondsen, 2012). The degree of impairment in the mother-daughter relationship appear to be related to the nature of the mother's mental illness (Hipwell et al., 2000). For example, in psychosis, a mother's delusions could prevent her from being able to respond appropriately to her child owing to her clouded reality (Brockington et al., 2011; Duncan & Browning, 2005; Engur, 2017). Children could be incorporated into their mother's delusional thinking and this could result in potential risks including abuse, neglect and infanticide (Engur, 2017; Gearing et al., 2012; Hipwell et al., 2000; Snellen, Mack, & Trauer, 1999). Furthermore, in psychosis, children might be exposed to their mother's hallucinations and delusions, witnessing bizarre and unpredictable emotional and physical behaviour (Brockington et al., 2011; Craig et al., 2005; Duncan & Browning, 2005; Engur, 2017; Gearing et al., 2012; Hipwell et al., 2000). The massive blurring of ego boundaries which occurs in psychosis may distort a mother's ability to distinguish herself from her infant which might result in a delusional failure to recognize the existence of their child (Perera et al., 2014; Snellen et al., 1999). According to Gearing and colleagues (2012), distorted expressions of reality and strange behaviour exhibited by actively psychotic mothers is likely to cause significant anxiety in children as they may be confused and distressed by their mother's behavior. This is likely to be psychologically disorientating for them.

Mothers with psychosis might sometimes be experienced as detached, out of touch and emotionally unavailable which is another way that maternal psychosis or depression can have

a negative effect on offspring (Dunn, 1993; Garley et al., 1997; Gearing et al., 2012; Kadish, 2015; Perera et al., 2014; Radke-Yarrow et al., 1993; Trondsen, 2012; Williams, 1998). Along with this emotional withdrawal, literature suggests that psychotic mothers often have reduced eye contact, may find it difficult to pick up on verbal and non-verbal cues from their children, and may be less able to be create a positive emotional climate (Dunn, 1993; Gearing et al., 2012; Hipwell et al., 2000; Oyserman et al., 2000). The negative symptoms experienced in psychosis could expose a child to an impoverished maternal and social environment (Snellen et al., 1999). According to Hipwell and colleagues (2000), mothers diagnosed with severe psychosis are perceived as being the most impaired in their care of their infants. This level of impairment was then followed by a bipolar mood disorder and then major depressive disorder (Hipwell et al., 2000).

In comparison to maternal depression, there is less research about maternal bipolar mood disorders (Hipwell et al., 2000; Oyserman et al., 2000; Tarullo et al., 1994; Venkataraman, 2011; Venkataraman & Ackerson, 2008). Bipolar mood disorder is a severe mental illness characterized by primarily a disruption in mood (American Psychological Association [APA], 2013; Venkataraman & Ackerson, 2008). While bipolar mood disorder is a mood disorder, it may also include symptoms of psychosis (APA, 2013). Mothers diagnosed with bipolar mood disorder may experience rapid mood swings with periods of depression and then periods of mania which may be characterized by accelerated speech, increase in energy, flight of ideas, irritability, euphoria and grandiosity (APA, 2013). In Venkataraman and Ackerson's (2008) research study, mothers suffering from bipolar mood disorder reflected on how their depressive episodes and manic episodes affected their parenting in distinct and different ways. For instance, mothers expressed how when they experienced a major depressive episode, they were less involved in their children's lives because they had a lack of energy and they found it difficult to get out of bed during the day (Venkataraman & Ackerson, 2008). The participants in Venkataraman and Ackerson's (2008) also reflected on how their manic episodes brought about challenges which included that they found it difficult to be attuned to the needs of their children owing to their flight of ideas about business ventures, for example. This indicates how mothers who suffer from bipolar mood disorder have shifts in mood and subsequently their behaviour is chaotic and unpredictable for the child and for the family environment (Oyserman et al., 2000; Venkataraman, 2011; Venkataraman & Ackerson, 2008). Mothers diagnosed with bipolar mood disorder have been reported to be tense and disorganized with their children as their behaviour can be erratic from one moment to the next (Tarullo et al., 1994). The

oscillation between severe depression and periods of mania can be discombobulating for children (Tarullo et al., 1994).

Another mood disorder, severe major depressive disorder, is in fact the most common mental illness within the body of research that relates to mothers with mental illness (Austin, 2003; Cuipers et al., 2015; Dahlen, 2016; Gelaye et al., 2016; Nylen, Moran, Franklin, & O'Hara, 2006). Maternal depression is widespread, with some research suggesting that an average of one in ten children are exposed to maternal depression every year (Goodman & Garber, 2017; Oyserman et al., 2000). Research also suggests that severe antepartum and postpartum maternal depression might be an associated with health related difficulties and developmental delays in children (Austin, 2003; Cuipers, Weitz, Karyotaki, Garber, & Andersson, 2015; Dahlen, 2016; Gelaye, Rondon, Araya, & Williams, 2016; Nylen et al., 2006). Mothers diagnosed with severe depression may show lack of emotional warmth (Manning & Gregoire, 2006; Steadman et al., 2007). Severe depression might interfere with a mothers ability to be nurturing and attentive towards her child(ren) as she may be emotionally saturated with her own difficulties (Manning & Gregoire, 2006; Oyserman et al., 2000; Polkki et al., 2005; Radke-Yarrow et al., 1994; Steadman et al., 2007). Dyadic attunement with an emotionally available and sensitive primary caregiver is important for the development of an infant's affect regulation and cognitive skills (Hipwell et al., 2000). However, the impact of severe maternal depression on such dyadic attunement is well documented in literature as mothers with depression are less affectively synchronized with their children (Allen-Meares et al., 2010; Dahlen, 2016; Gelaye et al., 2016; Hipwell et al., 2000; Nylen et al., 2006).

Along with a lack of emotional warmth, mothers diagnosed with severe depression may show also anhedonia (Manning & Gregoire, 2006; Radke-Yarrow et al., 1994). This may infiltrate into the amount of time and interest spent in nurturing the relationship with their children (Hipwell et al., 2000). For example, some research suggests that depressed mothers may spend less time on enrichment activities with their children such as singing, telling stories, and playing games (Paulson, Dauber, & Leiferman, 2006). All of these mother-child interactions are important for cognitive and emotional development (Oyserman et al., 2000; Polkki et al., 2005). Severe depression impacts both the interaction and the communication between mother and child (Allen-Meares et al., 2010; Manning & Gregoire, 2006; Tarullo et al., 1994).

We now move into the discussion about some specific gender differences that have been reported in literature amongst children who have grown up with mentally ill mothers.

Daughters of mentally ill mothers have been reported to be more vulnerable than sons to develop psychiatric disorders (Andrews, Brown, & Creasey, 1990; Jensen, Bloedau, Degroot, Ussery & Davis, 1990). Adolescent daughters who identify with their mothers and maintain emotional involvement may be more likely than sons to be impacted by their mothers' mental health (Gilligan, 1982; Steinberg, 1987). Literature suggests that males present with more behavioural disorders such as attention deficit disorder whereas females present with more emotional challenges (O'Connell, 2008). Williams (1998) indicated that adult daughters of mentally ill mothers may struggle with eating disorders, as well as other emotional difficulties. In Mowbray and colleagues (2006) analysis of adult children from the perspective of the mentally ill mothers, it was documented that 54% of the 157 daughters had psychological problems. Daughters of mentally ill mothers have higher levels of issues concerning gender role identity in comparison to sons (Chodorow, 1997; Tarullo et al., 1994; Waterhouse, 1997). Some research suggests that daughters of mentally ill mothers seem to be more negatively impacted than sons which could be owing to the fact that the mother-daughter relationship has a direct impact on the formation of feminine identity (Chodorow, 1997; Kadish, 2015; Ogle & Damhorst, 2003; Radke-Yarrow et al., 1993; Spitzack, 1990; Tarullo et al., 1994). Daughters look to their mothers for self-esteem, how they should feel about themselves and about their bodies (Ogle & Damhorst, 2003). However, there seems to be less research on gender differences in specific relation to experiences of growing up with a mentally ill mother.

As indicated above, maternal mental illness can have damaging and longstanding effects on the lives of children. The interplay between maternal mental illness and other environmental factors can also negatively impact children growing up. However, some authors, such as Burman (2007), have noted the tendency of 'mother blaming', whether blatant or inferential, that is present in some psychoanalytical theory and practice. Many developmental theories discuss the motherly role as a universal and consistent structure regardless of cultural factors (Burman, 2007). It is important to acknowledge that the model of caregiving can often include distributed maternal care or collective care for children performed by grandmothers, creche teachers or extended family (Burman, 2007). While this research project focused on mothers only, the role of the father figure and other women in the family have not been ignored. For example, it is important to acknowledge that a resilience-enhancing factor would be one healthy parent or caregiver available during childhood (Beardslee et al., 1998; Kadish, 2015). A supportive father or someone else in the family such as a helper has the potential to override some of the effects of deficits in maternal functioning and symptoms relating to severe mental

illness (Kadish, 2015; Oyserman et al., 2000, Perera et al., 2014). However, given marital discord, divorce and absent fathers in children of mentally ill mothers; these children often do not have an experience of paternal involvement which will negatively impact the developmental outcome for children (Oyserman et al., 2000).

This literature review will now discuss the impact of hospital admissions on the mother-child relationship. Literature reports that some children often experienced their maternal care to be intermittent and/or disrupted maternal care due to hospital admissions (Dunn, 1993; Brockington et al., 2011; Garley et al., 1997; O'Connell, 2008). This impact of mother-child separation is particularly difficult for young children (Case, 2005). The process of hospitalization has been described in research as a complex experience for some children of mentally ill mothers as they felt a sense of ambivalence (Garley et al., 1997; Cogan et al., 2005; Dunn, 1993). A part of them were relieved that they could be looked after by someone other than their mother and a part of them was also distressed about the hospitalization (Garley et al., 1997; Kadish, 2015). Some children expressed that they were afraid of the hospital setting as seeing their mother heavily sedated was anxiety provoking (Brockington et al., 2011; Cogan et al., 2005; Dunn, 1993; O'Connell, 2008; Perera, Short & Fernbacher, 2014). In Kadish's (2015) study, the participants discussed their difficulties adjusting to when their mothers returned from hospital when their were in childhood, rather than in adulthood.

Research suggests that children feel a range of emotions towards their mentally ill mothers, including a sense of general confusion about their mothers and the mother-child relationship, which continues into adulthood (Dunn, 1993; Gladstone et al., 2006; Petrowiski & Stein, 2016; Trondsen, 2012). One aspect of the confusion seems to arise from feelings of loss and sorrow in response to parental mental illness, even though their parents were still alive (Trondsen, 2012). This sense of sorrow was further perpetuated when these children were exposed to familial and social networks which were so different from their own; a stark reminder of the healthier family relationships these children did not have (Trondsen, 2012). Dunn (1993) in her study, indicated that adult children expressed oscillating between guilt from the belief that they had somehow contributed to their mother's psychosis, and loyalty which often meant that they could not allow themselves to be cared for by a substitute caregiver. Pickering and colleagues (2015) also reported that daughters often feel obliged to be there for their mothers and take on caregiving roles despite having some reluctance to do so. Given these different, and sometimes contradictory emotions that children feel towards their mentally ill mothers, it is not surprising

that a common finding in literature was that many children wanted to understand and make sense of their parent's mental illness (Cogan et al., 2005; Garley et al., 1997; Trondsen, 2012).

Despite the desire to gain more understanding about their mother's mental illness, it seems that for many children this desire was not met because neither family nor social support systems facilitated open communication about their mother's mental illness (Dunn, 1993; Cogan et al., 2005; Knutsson-Medin et al., 2007; Perera et al., 2014; Polkki et al., 2005; Trondsen, 2012). Families with parental mental illness are often socially deprived and this is perpetuated owing to the stigmatization of mental illness (Brockington et al., 2011; Cogan et al., 2005; Gladstone et al., 2006; Manning & Gregoire, 2006; Trondsen, 2012). As a result of this stigmatization, teasing and bullying, or just the fear of this, many children keep their home life secret and separate from their life in social settings (Cogan et al., 2005). Daughters of mentally ill mothers' in Dunn's (1993) study reported feeling 'different' from other 'normal people as they felt as if they had two lives each with its own reality owing to their family secrets. In Cogan and colleagues' (2005) research, children reportedly avoided asking friends over to visit after school out of fear that their friends might not understand their parents erratic behaviour that related to a mental illness. This situation was described as being painful and shameful for these children (Brockington et al., 2011; Cogan et al., 2005; Oyserman et al., 2000; Trondsen, 2012). The fact that many children felt as if they could not share their experiences with their social networks resulted in barriers to help-seeking behaviour on both a formal and informal level (Cogan et al., 2005; Dunn, 1993; Trondsen, 2012; Williams, 1998). The feeling of shame was an ongoing difficulty, which resulted in adult children feeling isolated and unable to discuss their family difficulties with support systems due to the stigmatization (Dunn, 1993; Kadish, 2015; Williams, 1998).

Another experience of growing up with a mentally ill parent that is very prevalent in literature is the concept of role reversals (Dunn, 1993; Fraser & Pakenham, 2009; Garley et al., 1997; Gladstone et al., 2006; Knutsson-Medin et al., 2007; Mowbray et al., 2006; O'Connell., 2008; Petrowiski & Stein, 2016; Polkki et al., 2005; Trondsen, 2012). Role-reversal implies that children may not be properly taken care of, but they rather take on adult roles that are inappropriate for them (Gladstone et al., 2006). By becoming involved in providing care for the parent, these children are at risk of poorer outcomes than non-caregiving children (Fraser & Pakenham, 2009; Garley et al., 1997; Gladstone et al., 2006; Mowbray et al., 2006; Polkki et al., 2005). There can thus be a sense of a lost childhood which impacts numerous factors including children's health, emotions and lifestyle (Gladstone et al., 2006; Polkki et al., 2005;

Trondsen, 2012). According to some research studies, adolescents with mentally ill parents are less likely to establish their own educational or vocational goals because caring for their mentally ill parent has a direct negative impact on their academic outcomes (Dahlen, 2016; Garley et al., 1997; Manning & Gregoire, 2006; Mowbray et al., 2006; Polkki et al., 2005; Trondsen, 2012). Gladstone and colleagues (2006) highlighted that role reversals could sometimes provide children with a sense of mastery and might make them feel as if they are contributing to their family in a time of anxiety and stress. Despite being burdensome, this sense of competency fostered by role reversal was also reported on in Polkki and colleagues' (2005) research and in Trondsen's (2012) research study. However, this is a precocious sort of competency as it might be a way to manage inner conflict through an overemphasis on self-sufficiency (Kadish, 2015). Role reversals place particular risk for mental illness in adulthood because these children take on adult roles before they are emotionally or developmentally ready (Fraser & Pakenham, 2009; Garley et al., 1997; Gladstone et al., 2006; Mowbray et al., 2006; Polkki et al., 2005; Trondsen, 2012).

Despite all of the literature that suggests that children who grow up with mentally ill parents are at risk on many levels, some literature suggests that some of these children may also show resilience despite difficult childhood experiences (Beardslee, Versage, & Gladstone, 1998; Kadish, 2015; Knutsson-Medin et al., 2007; Petrowiski & Stein, 2016). Resilience refers to the ability of children of mentally ill parents to respond adaptively in the face of adverse circumstances (Fraser & Pakenham, 2009). Resilience can also be conceptualized as the process whereby difficult circumstances are mediated by the influence of certain protective factors (Fraser & Pakenham, 2009). For example, Beardslee and colleagues (1998) explained how a resilient child who grows up with a mentally ill parent has certain characteristics that have been documented to help them cope with their mentally ill parent. These included: understanding their parents' mental illness, being able to speak openly about their experiences and being able to separate themselves from the emotional experiences of the parent (Beardslee et al., 1998). This resilience shown does not shield these children from invulnerability and it does not imply emotional wellbeing (Rutter et al., 1997, Williams & Corrigan, 1992). Sometimes the active coping style and resilient behavioural patterns may generate a sense of mastery in children amidst a chaotic home environment, which is often deeply desired by these children (Kadish, 2015; O'Connell, 2008).

There are several coping strategies of children of mentally ill mothers that are described in literature. Mental health literacy has been documented as an important factor in helping

children cope with their mother's mental illness (Fraser & Pakenham, 2009). Garley and colleagues (1997, p. 100) explained how children of mentally ill parents are sometimes "*hung[ry] for information*" about their mother's mental illness. Children of mentally ill mothers found it helpful to understand and be aware of certain triggers (Garley et al., 1997). Noticing the signs and symptoms of their mother's mental illness was also reassuring at times (Fraser & Pakenham, 2009; Garley et al., 1997; Trondsen, 2012). Once children became more aware of these symptoms, some children developed a vigilant attitude to be able to detect these symptoms in their mother (Kadish, 2015). Trondsen (2012) also refers to children experiencing a constant anticipated anxiety, which he describes as being in 'emergency alert mode'. This helps the child become acutely aware of the symptoms and triggers of their mother's mental illness. This serves as both a coping mechanism and a protective mechanism for these children. It is therefore understandable that unanswered questions about maternal mental illness is a source of concern, fear and frustration for children (Trondsen, 2012). In Fraser and Pakenham's (2009) study, resilience was enhanced if the child had mental health literacy, social connectedness and good coping strategies. Fraser and Pakenham (2009) also noted that many young children hold misconceptions about mental illness which may perpetuate and reinforce worries and distress. Thus, Fraser and Pakenham's (2009) study noted the importance of providing information to children of mentally ill parents to increase their understanding of the illness and to decrease their fears that they are to blame for their parent's mental illness.

This literature review will now turn to consider the work of a number of leading psychoanalytic theorists whose thinking offers a way to understand the developmental and emotional effects of maternal mental illness on offspring. The discussion begins with attachment theory, which is a helpful framework to understand mother-infant interaction (Craig et al., 2005; Duncan & Browning, 2009). As has been mentioned, the mother-infant bond can be impacted if a mother has a severe mental illness. John Bowlby (1953, 1960, 1969, 1973, 1979, 1988), a pioneer of attachment theory, proposed that all individuals are born with an innate need to form a safe and secure emotional bond with their primary caregiver. Bowlby (1953, 1960, 1969, 1973, 1979, 1988) emphasized the importance of the establishment of a sense of security within the infant's earliest relationships, which should be characterized by safety, sensitivity and predictability. Literature indicates that mental illness can interrupt this sense of security, i.e. the development of a secure attachment between mother and child (Brockington et al., 2011; Duncan & Browning, 2009; Hipwell et al., 2000). As indicated by the previous paragraphs in this literature review, severe mental illnesses can impact the mother-infant bond in different ways depending

on the nature of the mental illness. All mental illnesses have the potential to negatively impact the ability to respond appropriately to the needs of the infant. This is likely to leave the infant feeling distressed and anxious which possibly impacts attachment patterns (Bowlby, 1952; 1969; Burman, 2007). Difficulty in attachment patterns from childhood can result in longstanding difficulties, as Bowlby (1952, 1969) emphasized that attachment is the cornerstone of adult mental health.

There are four types of attachment styles as postulated by Bowlby (1953, 1960, 1969, 1973, 1979, 1988). A child develops a secure attachment when they experience their parents to be emotionally and physically available to them (Bowlby, 1960). Securely attached children believe that their parents can attend to their needs of proximity, emotional support and protection (Bowlby, 1953, 1960, 1969, 1973, 1979, 1988). Securely attached children have the ability to explore and play freely in the company of their caregiver. They are open to engaging with strangers, they show distress at the departure of their caregiver and are visibly happy on their return (Bowlby, 1953, 1960, 1969, 1973, 1979, 1988). It is through attentive and dutiful mothering that children experience a secure environment which allows them to learn to control and regulate their emotions (Burman, 20007). Attachment patterns in childhood infiltrate into adult attachment patterns and research suggests that securely attached adults will have positive views of themselves, their parents and their relationships (Bowlby, 1953, 1960, 1969, 1973, 1979, 1988; Crowell, Treboux, Gao, Fyffe, Pan, & Waters, 2002; Schore & Schore, 2008; Slade, 2008). Securely attached adults feel comfortable with intimacy and independence, whilst being able to balance the two (Feenay, 2004; Feenay & Collins, 2001; Feenay & Thrush, 2010; Schore & Schore, 2008; Slade, 2008; Waters & Cummings, 2000).

It appears that children of mentally ill mothers are less likely to develop secure attachment patterns (Brockington et al., 2011; Duncan & Browning, 2009; Feenay & Thrush, 2010; Hipwell et al., 2000; Lo, Chan & Ip, 2017; Main, 1983; Shaver & Miklincer, 2002). An example of an insecure attachment is the anxious-ambivalent attachment pattern (Bowlby, 1953, 1960, 1969, 1973, 1979, 1988). Anxious-ambivalent attachment is often characterized by separation anxiety in children as they show distress when their caregivers leave but do not feel reassured upon their arrival (Bowlby, 1953, 1960, 1969, 1973, 1979, 1988). This results in a skeptical and wary pattern of interaction as infants may feel uncertain about where they stand with their caregiver, hence the ambivalence. Anxious ambivalent adults seek high levels of approval, be overly dependent, show high levels of emotion, and can be impulsive in their relationships (Lo et al., 2017; Main, 1983; Schore & Schore, 2008; Slade, 2008). Another form

of insecure attachment is the anxious-avoidant attachment style, which is developed when an infant's needs are frequently unmet (Bowlby, 1953; 1960; 1969; 1973; 1979; 1988). These children come to believe that their emotional needs have no influence on their caregiver and the child therefore avoids and shows little emotion towards their caregiver. Infiltrating into adulthood, anxious-avoidant adults desire independence, self-sufficiency and appear invulnerable to attachment feelings (Shaver & Miklincer, 2002). Their pattern of communication and conflict is characterized by suppression of feelings and distancing themselves from the conflictual situation (Milyavskaya & Lydon, 2012). Avoidant and ambivalent attachment patterns represent strategies to regulate a suboptimal attachment with their primary caregiver by minimizing or hyperactivating attachment behaviour (Davidsen et al., 2015).

Acknowledging the impact of maternal psychopathology on children's attachment patterns is likely to be relevant for this study because the pattern of attachment in childhood could have a direct impact on behavioural and emotional outcomes in adulthood (Austin, 2003; Bowlby, 1953, 1960, 1969, 1973, 1979, 1988; Brockington et al., 2011; Craig et al., 2005; Davidsen et al., 2015; Duncan & Browning, 2009; Hipwell et al., 2000; Lo et al., 2017; Main, 1983; Milyavskaya & Lydon, 2012; Oyserman et al., 2000; Shaver & Miklincer, 2002). Duncan and Browning (2009) documented that children of mothers who have schizophrenia are more likely to have an anxious attachment style. In Hipwell and colleagues' (2000) study, the majority of children who had psychotic mothers also developed an insecure attachment style. The lack of secure attachment can impact future relationships, social competences and a basic sense of self-confidence (Bowlby, 1960; Brockington et al., 2011; Oyserman et al., 2000). Craig and colleagues (2005) report that there is a relationship between insecure attachment in infancy and psychiatric illnesses in adulthood. This lasting impact of childhood attachment issues was also noted in Duncan and Browning's (2009) study. Adult daughters of mothers with mental illness experienced ongoing difficulties in trust and felt vulnerable in adult intimate relationships (Duncan & Browning, 2009). This concurs with Kadish's (2015) research that also highlights that none of the participants, daughters who grew up with mothers who had psychosis, felt as if they were securely loved by their mothers.

Children who have not had the experience of having emotionally attuned mothers and those who do not feel safe with their caregivers, are likely to develop a disorganized attachment style (Davidsen et al., 2015). In a disorganized attachment style, there is an overall lack of attachment behavioural patterns as they have no consistent way of managing their relationships

and interactions with their caregivers (Bowlby, 1953, 1960, 1969, 1973, 1979, 1988). They display mixed behavioural patterns, have different feelings relating to their caregivers that range from indifference, mistrust and are insecure about whether or not they should seek proximity. Such mixed feelings influence adult attachment patterns (Bowlby, 1988). Individuals with a disorganized attachment style often find developing and maintaining relationships extremely difficult, are mistrustful of others and consider themselves as unworthy (Bowlby, 1988). An individual with a disorganized attachment style has an increased risk of psychopathology in childhood (Davidsen et al., 2015). Disorganized attachment might also the strongest single predictor of later psychopathology (Sroufe, Egeland, Carlson, & Collins, 2005).

Pyschoanalytic object relations theory is also an important part of this literature review and will now be discussed in relation to the research focus. Paediatrician and psychoanalyst Donald Winnicott (1960a, 1960b, 1963, 1965, 1971) emphasized the environment in the formation of the self, proposing that the environment (when 'good enough') facilitates the maturational process of the infant's development. Winnicott (1963) uses the term 'good enough' to describe the parental function of providing sufficiently for what the infant needs at a specific developmental period in the relationship. However, maternal mental illness may impact a mother's ability to be 'good enough' for their infant and her illness may impact several important maternal functions that Winnicott proposes. Winnicott (1963) places importance on 'primary maternal preoccupation' which is when the mother is preoccupied with the needs of her infant which at times feels part of herself and the mother is able to adapt herself to the infants changing needs. When a mother is 'good enough' infants might be able to develop and grow at their own pace owing to less impingements on their development.

However, when a mother is mentally ill, it might be very challenging for her to be able to be 'good enough' and primarily attuned to the needs of her infant (Abraham & Stein, 2013; Duncan & Browning, 2009; Dunn, 1993; Engur, 2017; Fraser & Pakenham, 2009; Kadish, 2015; Knutsson-Medin et al., 2007; O'Connell., 2008; Petrowiski & Stein, 2016; Polkki et al., 2005; Trondsen, 2012; Williams, 1998). Maternal mental illness might prevent mothers from being fully in tune with the needs of their infant and thus they might struggle to protect their infant from complications and impingements from the world that the infant cannot understand (Winnicott, 1960). The infant might experience their environment as unsafe and might respond with compliance which leads to the isolation of the infant from its own spontaneity going forward in life, resulting in a false self and a set of false relationships (Winnicott, 1960, 1971).

Through these experiences, an infant might not be able to access its mother developmentally, and not really be able to use its mother for optimal psychological growth. Rather, such an infant might begin its developmental growth by 'reacting' to its environment rather than beginning its life by existing (Winnicott, 1960, 1971). This might make it difficult for an infant to express how it feels and infants in this type of environment might find it difficult to be spontaneous but rather may need to overly adapt to maternal needs. This may lead to the formation of a false self-structure (Winnicott, 1960, 1971). Infants who experience their mother as not 'good enough' might be extremely compliant at the expense of their own vitality (Winnicott, 1960, 1971). These experiences of early childhood development and the development of a false self and a set of false relationships can influence the way that an adult interacts in the world which is important to hold in mind in relation to this research project.

Other factors that contribute to the development of a false self is a failure in mirroring and holding (Winnicott, 1960). According to Winnicott (1960), it is very important that the mother is able to mirror their infant's feelings so that the infant can recognize its own feelings and be able to act as a separate being. However, severe mental illness could interfere with prevent the mirroring ability of the mother. Negative symptoms could result in mothers expressing inappropriate affect or a psychotic mother could be out of touch with reality which would likely hinder her ability to be attuned to the needs of her infant. It is also important that a mother creates a 'holding environment' to insulate the infant from stress and carefully allowing moments for frustration slowly rather than overwhelming their infants emotionally (Winnicott, 1960). This allows for the infant to feel emotionally held by their mother and they experience a feeling of integration and understanding which facilitates a trusting relationship with the mother (Winnicott, 1971). Severe mental illness might also impact this process as the holding environment could be characterized by chaotic, various affect states or behaviour. Severe mental illness could impact a mother's ability to be aware, empathetic, and reliable, which are important factors that promote an infant's healthy emotional development (Winnicott, 1960, 1963, 1971).

Melanie Klein (1926, 1935, 1940, 1946, 1975a, 1975b, 1975c), a British Psychoanalyst, was the pioneer of Kleinian theory which in turn is part of psychoanalytic object relations theory. This theory places emphasis on the interaction between actual (external) objects in a person's life and phantasies (internal objects) (May, 2017). Central to Klein's (1926, 1935, 1940, 1946, 1975a, 1975b, 1975c) thinking about an infant's psychic world are biological drives and instincts. Klein (1926, 1935, 1940, 1975b, 1975c) places a lot of emphasis on the role of drives

and how they are expressed in mental phantasies. According to Klein (1926), the earliest bodily impulses, bodily urges and bodily experiences are given meaning in the infant's phantasies. Although these mental processes take place at the level of phantasy, they are extremely vivid for the infant because after birth an infant is not able to distinguish between what is reality and what is phantasy (Klein, 1926). The drives of an infant are often directed towards an object. For instance, when an infant is hungry the infant might desire a breast to give them milk as they do not merely take pleasure in the process of being fed. Resultantly, an infant's urges and instincts become infused and tied up with an object (Innovative). With this in mind, Klein (1962) proposes that drives are relational.

In the early stages of an infant's life, an infant relates through part objects as the infant's perceptual skills are immature and are not developed yet (Klein, 1926, 1935, 1940, 1946, 1975a, 1975b, 1975c). This means that it is difficult for an infant to pay attention to more than one thing at a time, or it is difficult for an infant to believe that it may only be experiencing one part of a person (Blass, 2014). The first part object that an infant is able to relate to is the breast of its mother (Klein, 1952, 1975a, 1975b). For instance, if an infant is hungry, this experience is more than just feeling an unpleasant bodily sensation. Rather, in an infant's phantasy, the infant experiences the mother's breast as being absent and in phantasy may experience deprivation, and then the breast becomes a bad part-object in the mind of the infant. Whereas if the infant experiences the mother's breast as being available and present, the breast provides gratification and becomes a good part-object in the mind of the infant. This is an example of how beneath bodily sensations are unconscious meanings which form phantasies, and which populate the mind of an individual (Klein, 1926, 1952, 1975a, 1975b).

Klein (1946) proposes that the infant makes use of various psychical mechanisms (which are in phantasy) to cope with their intense needs, drives, terrors and fears that are experienced in infancy. An infant may use the psychical mechanism of splitting which involves separating what it feels to be good and bad experiences. These are kept completely separate from one another. Initially the infant experiences parts of the mother's body as separate, called part objects (Klein, 1926, 1975a, 1975b). These can be experienced as all good or all bad. For instance, the infant might experience the relationship with the mother's breast as being either all gratifying or all frustrating. Initially the infant cannot comprehend that the mother has both good and bad parts which comprise the whole object (person) (Klein, 1926, 1975a, 1975b). Another psychic mechanism that Klein (1926, 1935, 1946) refers to is called projection. Projection is a phantasy process when an infant projects its own feelings or impulses onto

another object (Klein, 1926, 1935, 1946). This enables the infant, in phantasy, to disavow any overwhelming internal affective states into the external world (Klein, 1946). The infant may experience pleasure when they are well-fed, and they project this pleasure (which is experienced as a good feeling) onto the breast and therefore believe that the breast is good. The good breast then becomes a frame of reference and prototype for all things good whereas the bad breast represents all things destructive, bad and evil (Klein, 1926, 1935, 1946, 1975b). In this way, the infants project their own terrifying and painful affects onto an external object outside of themselves. This makes them feel that they have rid themselves of any bad sensations and they now believe that they hold all of the goodness inside of themselves (Klein, 1926, 1935, 1946, 1975b). Introjection, which is another psychic mechanism, is when an infant in phantasy takes in something from the outside world into their internal world (Klein, 1926, 1935, 1946, 1975b). For instance, objects that are experienced as intensely anxiety provoking for the infant may be introjected into the internal world of the infant and become internal persecutors for the infant (Klein, 1946). An adult daughter who experienced their mother as being punitive might expect similar behaviour from someone else who reminds them of their past. In this example, one could say that this daughter has introjected a punitive internal object, which she may use as a frame of reference for other interpersonal relationships.

According to Klein (1926, 1935, 1946, 1975a, 1975b), infants are active contributors to the development and creation of their inner world that is populated by internal objects. Internal objects are thus an "*amalgam of the self and external objects*" (Clair, 1995, p. 39). Klein (1926, 1935, 1946, 1975a, 1975b) proposes that an individual can have two different ways of experiencing and relating to internal and external objects. For the first few months the infant is only able to relate to part objects whereas after four or five months, the infant may begin to relate to whole objects (Klein, 1946, 1975a). This shift from perceiving part objects to whole objects represents the shift between the paranoid schizoid position and the depressive position. Klein (1946) posits that an individual can shift momentarily between these different states. As the name suggests, the paranoid schizoid position is when the infant primarily experiences paranoia about whether or it will be destroyed or persecuted. Seeing as though an infant in this developmental position relates to part objects, they experience everything in extremes of either being all good or all bad (Klein, 1935). In phantasy, the infant thus wants to keep all of the goodness inside of itself and expel all of their badness onto external objects through projection. By locating all of the badness outside of themselves, infants often experience persecutory anxiety in this position as they experience the other to be rejecting, bad, scary and humiliating

and they fear retaliation (Klein, 1935). Therefore, the infant may have violent phantasies of destroying their mother's breast.

Infants develop the capacity for the depressive position four or five months after birth (Klein, 1935, 1946). There is a change in the way that infants relate and perceive objects in the depressive position as the infants begin to acknowledge that an object is made up of different parts which come together to create a whole (Klein, 1956). Resultantly, new anxieties emerge (Klein, 1935). Infants begin to realise that the same part object that they tried to attack was actually part of a whole object. Infants may be left with a phantasy in their mind that they tried to destroy their good loved object which leaves them with feelings of guilt, anxiety and badness (Klein, 1956). Infant are left with phantasies that they must fix this damage and repair what they have attempted to destroy (Klein, 1956). If infants do not have this experience of reparation in their phantasy, they may feel as if they lost their loved object which can bring about depressive anxiety. They may continuously feel as if they deserve to be punished, they are left with feelings of guilt and they might perceive themselves as being inherently bad (Klein, 1930). Without the experience of reparation with their loved object, infants may find it very difficult to access any goodness inside of themselves (Klein, 1946). The process of reparation could be impaired in mothers with severe mental illness because mentally ill mothers may be experienced as distant and inaccessible. Thus, an adult daughter growing up with a severely mentally ill mother could have the phantasy that she destroyed her loved object and is responsible for losing her loved object. She may be left with the phantasy that she 'murdered' her mother and may be paralyzed with feelings of guilt about this.

Another British Psychoanalyst who is important to acknowledge in relation to this research project is Wilfred Ruprecht Bion (1962a, 1962b, 1970). Bion is well known for his model of meaning making which is his theory of thinking (Bion, 1962a, 1962b, 1970). It is beyond the scope of this literature review to discuss all of his theoretical contributions. Thus, for the purpose of this literature review, only his container-contained model will be elaborated on. In order to understand the different relationships between the container and contained, it is necessary to understand and define each of these terms. Bion (1962a) describes the container as not a 'thing' but rather a function of an individual's mind. The container refers to the way in which an individual is able to think about and make sense of their lived experiences, so as to develop insight into their internal world (Bion, 1962a). The contained, is described as living, fluid, ever-expanding and continuously changing (Bion, 1962a). The contained is made up of an individual's unconscious and their raw sensory experiences which make up beta elements

(Bion, 1962a). These beta elements are so raw and primitive that that they have not developed meaning as they are just coming into existence (Bion, 1970). In order to make sense of these beta elements, they need to be transformed by an Alpha function (the container) so that the individual can make links between these nascent thoughts and sensory experiences to their lived experienced (Bion, 1962a).

According to Bion (1962a) an infant's mind begins to develop at the breast of their mother. The experience of breast feeding is more than simply an experience of being fed. Rather, Bion (1962) posits that a mother is able to take in an infant's non-verbal communications (the contained) and think about them and further respond to them. Thereafter, the infant is then able to experience their mother's state of mind at an unconscious and conscious level which might relate to her feelings about the child and about herself (Bion, 1962a). The infant also experiences their mothers thinking process and her ability to think about her infant (Bion, 1962a). This process is the beginning of an infant having the capacity to believe that their feelings can be attended to, thought about and responded to (Bion, 1962a). However, when a mother is severely mentally ill, an infant might introject an object that has a poor capacity to contain him/her, attend to him/her, think about and respond to his/her emotional and physical needs. In this case, rather than feeling contained, infants may experience their mothers as being leaky containers and are left with unbearable emotional states that they are unable to metabolise on their own (Bion, 1962a).

Bion (1962b) created the term reverie to describe the frame of mind and process whereby a mother can receive both good and bad projections from the infant, tolerate the infants distress or happiness, take in the infants feelings, digest them and give them back to the infant in a more tolerable form. This process of reverie is called alpha function. The capacity to provide alpha function is directly influenced by a mother's own internal world (Bion, 1962a). If a mother is severely mentally ill, it may be difficult for her to be able to digest (provide this alpha function) for her infant, some or all of the time. Her infant may then be left with his/her unbearable feelings and experiences, called beta elements, because of the mother's incapacity as a result of her own emotional difficulties. Bion (1962a) described three relationships between the container-contained: the symbiotic, the commensal and the parasitic. In the mother-infant model, a symbiotic configuration is when the infant is able to project their unbearable experiences into their mother, who can then transform them into a more manageable and digestible form, and this is then returned back to the infant (Bion, 1962a). This makes the infant feel contained and less overwhelmed. The commensal relationship is when the container and

contained can work together to mutually benefit each other, there is space for thinking and knowing which is helpful for the infant (Bion, 1970).

However, mothers who are mentally ill may be incapable of providing the containing function to their children which could result in a parasitic container-contained configuration (Bion, 1970). This experience of feeling uncontained by their mother can be internalized by the infants, as they have in fact experienced a shut down and reversal of thinking (Bion, 1970; Joffe, 2008). Such infants are thus left with their overwhelming beta elements cannot be made sense of or thought about. The parasitic container-contained relationship can be destructive, damaging and explosive (Bion, 1970; Joffe, 2008). This could also lead to a minus container-contained configuration where the container (mother) does not want to know the contained (infant's beta elements) (Bion, 1970; Joffe, 2008). When infants do not have the experience of being able to communicate/transfer beta elements into the maternal container, they are left with unbearable anxieties that can neither be thought about nor soothed. Infants are then left with a so-called *nameless dread* which can be petrifying (Bion, 1962a, 1962b). Through this experience, infants are left with anxiety that they cannot process. This is utterly overwhelming and effects psychological development (Bion, 1962a, 1962b). In these severe cases infants may lose hope of finding a container and may stop trying to access this from external objects (Bion, 1970). This could result in them feeling as if they are on the outside in their relationships and they may often feel that other people are not interested in their difficult experiences (Bion, 1970). Their experience of the parasitic container-contained configuration might have exposed them to a mind that attacks links, rather than creates links, which is anti-developmental. This might have longer lasting emotional and relational difficulties in adulthood (Joffe, 2008).

This literature review has discussed some research that has been conducted pertaining to children's experiences of growing up with a mentally ill mother. Different threads of relevant literature and knowledge were consulted, to try to contextualize the current research topic against a broader body of literature in this field. The literature review began by acknowledging the prevalence of mental illness in mothers prenatally and antenatally. The impact of maternal mental illness was described in a 'double negative way' in relation to increased genetic risk and the impact on the broader system in which the child lives and is raised. Despite the challenges documented throughout literature about children growing up with mentally ill mothers, resilience and coping skills are also acknowledged in this literature review. This reiterates how growing up with a mentally ill mother can lead to a range of experiences, some pathological and some adaptive. Attachment theory and psychoanalytic object relations theory

were also discussed in the final section of the literature review and pertinent tenants of these theories were discussed with the research focus in mind.

3. Chapter three: Research methodology

3.1.Research Design

The aim of this research was to explore the participants' experiences of being raised by a mother who suffers from a severe mental illness. This research aimed to explore and describe adult daughters' experiences in a qualitative nuanced way, rather than using quantitative and statistical procedures to capture participants experiences (Denzin & Lincoln, 2007; Langdridge & Hagger-Johnson, 2009; Levitt, Motulsky, Wertz, Morrow, & Ponterotto, 2016). A qualitative approach allowed for the exploration of personal life experiences and insight in relation to the research topic (Babbie & Mouton, 2007; De Vos, Strydom, Fouche, & Delport, 2011; Willig, 2013). A qualitative research design allowed for participants' voices to be heard and their subjective experiences to be captured in a way that was described by them and made sense to them (Babbie & Mouton, 2007). This research employed an inductive approach which put the participants at the forefront and allowed for the participant-generated meanings to take precedence throughout the research process (De Vos et al., 2011; Langdridge & Hagger-Johnson, 2009; Parker, 2005; Willig, 2013). It was therefore important that the research design was open-ended and flexible enough to accommodate new, and unexpected experiences when they emerged (Babbie & Mouton, 2007; Willig, 2013).

3.2.Theoretical framework

This research adopted an interpretivist, inductive approach. An intepretivist approach is based on the premise that people continuously interpret, create and make meaning of their experiences (Babbie & Mouton, 2007). An interpretivist approach is concerned with trying to explain the subjective reasons and meanings that people attribute to certain experiences (De Vos et al., 2011; Willig, 2013). Therefore, this approach allowed the researcher to try and gain access into an individual's life world by exploring their subjective understandings of their experiences and to further explore how participants attribute meaning to and/or sense of their experiences (Esterberg, 2002). This approach recognises that experiences are made up of different thoughts, feelings and perceptions which were acknowledged throughout this research to capture the overall texture and different threads of the participants' experiences (Willig, 2013). This is particularly important for this research as experiences of growing up with a severely mentally ill mother is multi-dimensional and are likely to bring about different thoughts, feelings and perceptions.

This research was also inductive in nature as it attempted to use the participants' experiences as the foundation of the research, rather than using a pre-existing framework to guide the

research process (Babbie & Mouton, 2007; Parker, 2005; Willig, 2013). Employing an inductive approach seems to be apt for this particular sample who have been described as invisible and overlooked in literature (Dunn, 1993; O'Connell, 2008; Knutsson-Medin et al., 2007; Petrowiski & Stein, 2016). However, it is very difficult to get an insider's perspective completely, as research is a dynamic, two-way process owing to the researcher's own subjectivities (Smith et al., 1999; Willig, 2013; Williams, 1998). This was held in mind when adopting the interpretivist, inductive approach that was used in this research.

The particular theory that was used for interpretation in this research study was object relations theory[1]. Particularly, the work of the following psychoanalytic object relations theorists provided bearing to this research: Melanie Klein (1926; 1935; 1940; 1946); Donald Winnicott (1960a, 1960b, 1963, 1971), and Wilfred Ruprecht Bion (1962a, 1962b, 1970). Object relations theory was originally developed out of clinical work and is often used in clinical application with patients in psychotherapy as it is underpinned by a specific understanding of the unconscious and its evolution (Bollas, 1992). In this research, object relations theory was used to gain in-depth insight and a nuanced understanding of the participants' experiences of growing up with a severely mentally ill mother. When object relations theory is used in an applied way, which what was done in this research study, it is important that researchers are circumscribed about using this theory in research, the theory should never be used to over interpret what the participants say, and the theory should always be used tentatively throughout the data analysis.

3.3.Research question

1. What are adult daughters' recollections and reflections growing up with a mentally ill mother?

3.4.Sampling strategy

Participants were selected in accordance with the aims and objectives of this research. Purposive, non-probability sampling was used to gain access to the sample (De Vos et al.,

[1] Object relations theory proposes that an individual's psychic development and intrapsychic processes are largely influenced by an individual's internalized representations of their primary caregivers, which are called internal objects (Bollas, 1992; Bollas, 2009; Scharff, 2005). These internal objects are representations of an infant's internalized early childhood experiences (Scharff, 2005). These internal objects could be a source of comfort, but they could also be a source of pain, anxiety and fear which could influence an individual's psychic process (Bollas, 1992; Bollas, 2009). The way that the internal objects interact in an individual's unconscious world, and how the internal objects interact with external objects in an individual's reality, shapes the way that an individual interacts in the world and influences how they navigate their own interpersonal relationships (Scharff, 2005).

2011; Denzin & Lincoln, 2007; Terre Blanche, Durrheim, & Painter, 2004). As indicated in the literature review, research suggests that daughters growing up with a mentally ill mother can be even more negatively impacted than sons, thus the decision to focus specifically on adult daughters in this research (Kadish, 2015; Nathiel, 2007; Radke-Yarrow et al., 1993; Tarullo et al., 1994). Adult daughters who were raised by severely mentally ill mothers are a difficult sample to gain access to, as in literature they have been described as invisible, unnoticed and not a priority of the mental health care systems (Dunn, 1993; O'Connell, 2008; Knutsson-Medin et al., 2007; Petrowiski & Stein, 2016; Williams, 1998). They are also sometimes reluctant to share their experiences because of stigma and shame (O'Connell, 2008; Williams, 1998). The complexity and continuation of stigma towards mental health in society and the need for concealment might also affect adult daughters' decisions to participate in this sort of research (Cogan et al., 2005).

Purposive sampling allowed the researcher to select appropriate participants using certain predetermined criteria (Denzin & Lincoln, 2007; Terre Blanche et al., 2004; Willig, 2013). The predetermined criteria were that the participants should be female, older than the age of 18 and able to speak about their experiences in English. In addition, their mother must have been diagnosed with a severe mental illness by a mental health professional, and the daughter must have been brought up by their mother during childhood and adolescence. As a protective requirement, participants should not have been hospitalized for psychiatric illness within the previous two years.

Access to participants was gained by posting an advertisement on various neighborhood groups and research groups on Facebook. The researcher messaged the administrator of the social media group to ask for permission to gain access, and thereafter, a post was put up with the researcher's email address so that potential participants could contact the researcher if they were interested in participating in this study. The original post on the Facebook group gained traction as other members of the group shared the invitation. The participants contacted the researcher directly on social media or via email. After the participants had contacted the researcher, suitable times were arranged for the interview. It transpired that the eligible participants of the study had mothers with the following mental illness diagnoses: four participants had mothers who had been diagnosed with severe depression, one participant's mother had been diagnosed with bipolar mood disorder, one other participant's mother had been diagnosed with psychosis.

It is important to further situate the sample of the participants in this research, and reflect on the homogeneity of the sample that was accessed in this research. All of the participants are white females. The youngest participant was 26 years old, one participant was 29 years old, two participants were 33 years old, one participant was 45 years old and the eldest participant was 56 years old. Four of the participants are married and two participants are single. Of the six participants, three of the participants are mothers. It might be possible that this particular group of adult daughters volunteered because of their access to social media platforms, as many individuals are not on social media. Further, I might not have gained access to a more diverse sample perhaps due to cultural sigma.

3.5.Data collection

Data for this research was gathered by means of semi-structured interviews (De Vos et al., 2011). The interview questions were based on available literature and were devised by the researcher and her supervisor. The questions in the semi-structured interview schedule (Please see Appendix A) acted as stimuli and were designed in an open-ended way (Di Cicco-Bloom & Crabtree, 2006). This allowed for a balance between ensuring that the research questions were answered while also allowing participants to share any additional information that they wanted to share (Di Cicco-Bloom & Crabtree, 2006; Langdridge & Hagger-Johnson, 2009; Parker, 2005; Willig, 2013). The fact that the interview questions guided rather than dictated the interview is a characteristic benefit of a semi-structured interview. The researcher was freer to probe interesting areas that arose, and the interview could follow the participants experiences or interests raised (Smith, 2004). This also allowed for the participants to be the 'expert' in their own story, rather than the interview being rigid and inflexible (Terre Blanche et al., 2004). This can be less daunting for the participants and rapport is more likely facilitated as a result (Smith, 2004). To further enhance the rapport, the researcher tried to create an interview environment in which the participants felt relaxed, heard, and accepted. Once consent for audio recording had been obtained, all interviews were recorded and transcribed verbatim. The interviews took place at a location convenient to the participants and this included participants' homes or at another mutually convenient venue.

3.6.Data analysis

Thematic content analysis is widely used as a qualitative analytic method (Braun & Clarke, 2006; Parker, 2005; Riessman, 2008). Braun & Clarke's (2006) step-by-step framework for thematic content analysis was used for the data analysis in this study. This data analysis tool was most conducive to this research study for several reasons. Given the nature of the research

question, it was important to use a flexible analytic technique that could generate a rich, nuanced and detailed understanding of the data which is something that thematic analysis is known for (Smith et al., 1999). Thematic content analysis also facilitated a meaning making process, whereby links could be created across the data to further understand patterns, similarities and difference across the data sets (Smith et al., 1999; Willig, 2013). This allowed for each participants story to be heard, rather than using a pre-existing coding framework. The thematic analysis was done in an inductive manner, ensuring that the themes were linked to the data (Braun & Clarke, 2006). However, Braun and Clarke (2006) acknowledge that the researcher is actively involved in the identification, analysis and reporting of the themes and one can never fully free him/herself from theoretical and epistemological commitments. Hence it is important that the researcher take steps to maintain an ongoing reflexive awareness of his/her internal processes, for example, by keeping a research diary (Please refer to Section 3.8).

The following steps were followed in accordance with Braun and Clarke's (2006) framework for thematic content analysis:

1. *Immersion in the data.* The researcher emerged herself in the data to understand the breadth and width of the data. This required the researcher to scan the transcribed interviews several times.
2. *Generating initial codes.* In this phase, the raw data was assessed by generating initial codes from the data. This coding process was data driven rather than using a pre-existing coding framework.
3. *Searching for themes.* The researcher thought about the relationships between the codes. These collated codes were then organized into overarching themes and potential sub-themes.
4. *Reviewing and refining themes.* The candidate themes were refined to ensure that the themes adequately captured the contours of the data. Sub-themes were created when certain themes needed to be further refined. It was important that the themes formed a coherent pattern and accurately reflected the participants' stories.
5. *Defining and naming themes.* Once the thematic map of the data was created, the essence of each of the themes were identified to name and define the aspect of the data that the theme captures. It was important that the definition and naming of the themes was an internally consistent account with the accompanying narrative.

6. *Producing the report.* The themes generated from the data provided a framework that was the basis of the data analysis of the report. The themes were carefully summarized to represent central aspects of the data. The themes have relevant quotations to indicate the validity of the analysis and to provide a nuanced and in-depth depiction of the data set.

3.7.Ethical Considerations

The researcher applied for, and was granted, ethics clearance from The University of The Witwatersrand. The participants were given information forms and informed consent forms to sign. The research process was explained to them and they were given an opportunity to ask any questions before the interview commenced. All of this will be discussed in more detail below.

3.7.1. No Harm to Subjects

In all aspects of the research project, it was very important that no harm on any level including physical, emotional or psychological was brought to the participants who were involved in the research process (Parker, 2005; Willig, 2013). Although adult daughters of mentally ill mothers are not an 'at risk' group, they are a sensitive population due to their experiences and the content of the interviews may have lead to emotional distress. This was the reason why participants were selected only if they had not been hospitalized for psychiatric illness in the last two years. In addition to this measure, those who participated were debriefed after the interview ended, which allowed the researcher to discern any anxiety that may have been elicited during the interview. One participant became tearful during her interview, so the researcher checked in with her to ascertain whether she felt she could continue with the process. She replied that she felt alright and was prepared to continue with the interview. The participants were also provided with specific contact details of free face-to-face counselling services, including the Emthonjeni Clinic at Wits, where participants were given a specific contact person (the clinic supervisor) to call if they wished to arrange counselling. They were also given the option of telephonic counselling services such as Life Line or SADAG, that they could access if they experienced any distress after the interview had ended. As previously mentioned, the interviews were conducted at a place that was most convenient for the participants.

3.7.2. Voluntary Participation

Participants should never be forced to participate in any research study and participation should be voluntary at all times (Babbie & Mouton, 2007; Terre Blanche et al., 2004). The researcher respected individuals wishes if they declined to participate in the research. Some potential research participants contacted the researcher after they saw the research invitation but did not follow through with their initial impulse. They were not contacted again if the researcher did not hear back from them. Furthermore, participants were told at the start of the interview that if they were uncomfortable at any point, they would be allowed to stop the interview.

3.7.3. Informed Consent

Before beginning the interview, all of the participants were given a participant informant sheet (Appendix B). This sheet had information about the aim of the study, potential risks of the study and what is required of them throughout the research. The participants were also given a consent form (Appendix C) which clearly stated potential risks of the study and what is required of them throughout the research. The participants were also informed that this research falls under ongoing research that is being conducted by Dr Yael Kadish. The consent form was clear and concise to ensure that there was a sense of clarity of what was expected of the participants. The participants had an opportunity to discuss the consent form and ask any questions about the research process prior to signing. This was to ensure that the consent form was completely understood. The participants were asked for two signatures. The first signature was for consent to participate in the research (Appendix C) and the second signature provided consent for the audio-recording of the interview (Appendix D).

The use of a psychoanalytic approach to interpret research data has some implications in relation to informed consent. For instance, using this theoretical framework has the potential to be experienced by the participants, upon reading this research, as being intrusive. Having said this, the results and discussion were thoughtfully, carefully and respectfully presented. Furthermore, I was tentative in the use of object relations theory. These aforementioned aspects were measures that were used to guard against any distress to participants why may read this research.

3.7.4. Protecting participants' Privacy and Anonymity

In order to uphold anonymity and personal privacy in this research, no identifying information was included in the report and the participants have been given a pseudonym to protect their

identity. The consent forms have been kept separately from the interview transcripts so that the real names of the participants cannot be traced back to the transcripts.

The audio recordings have been saved in a password protected file available only to the researcher and her supervisor. The anonymous transcripts have been kept on the researcher's and her supervisors password-protected computers. Only the researcher and her supervisor have access to the data.

3.8.Reflexivity

The goal of qualitative research is to try and get as close to the participants' experiential world as possible, however, it is impossible to do this entirely as the researcher's own subjectivity will always be involved (De Vos et al., 2011; Di Cicco-Bloom & Crabtree, 2006; Willig, 2013). This subjectivity can be involved in all stages of the research process and therefore reflexivity is an essential component in qualitative research (Willig, 2013).

It is important that the researcher is aware of her own personal biases and maintains internal reflexivity in regard to her own values, experiences, beliefs and interests. These could infiltrate the research process in various ways. In this particular case, I am an adult daughter – not of a mother who is mentally ill – but I have been exposed to the impact that mental illness can have on a family system. I am aware that this had an effect on my life. It has influenced my own personal worldview and the way in which I perceive the world. I needed at all times to be conscious of the questions that I could possibly be inadvertently avoiding due to my personal experiences. I needed to be aware of my own blind spots that might have led to a distortion of the research process, as a result of my own (although different) experiences (Berger, 2016). For this reason, I kept a journal of all my personal experiences during the research process. I was also regularly in contact with my supervisor to ensure that my personal experiences and feelings were not intruding on the research process.

Reflexivity also involves an awareness of the positionality of the researcher in terms of social roles, power dynamics, race and age for example (Willig, 2013). I am a white, female, middle-class clinical psychology student which may have influenced the way in which participants interacted with me. Perhaps as a result of the participants' internalized perceptions of what psychologists do, there might have been a part of them that was fearful of sharing their difficult emotional experiences out of fear that they might be perceived as a potential 'patient' or as someone who could be 'diagnosed' with a mental illness like their mothers were. They may have been more forthcoming with parts of themselves that they believed would be less likely

to be ‘psychoanalysed’ by me. My personal characteristics could have also impacted on access to the sample, as other adult daughters might be more willing to share with someone who is also female. It was important that I maintained ongoing internal dialogue, in order to be continually aware of my own positionality in this research process (Berger, 2016).

4. Chapter four: Results and discussion

4.1.Introduction

This chapter will present the themes that arose from the research interviews; these themes will be discussed in relation to the existing literature.

Through the process of thematic analysis, six themes were identified in the data. The order of the themes in this chapter will be presented to facilitate an easier understanding of the data set as a whole. Illustrative quotations were used to provide evidence for the themes in the data. The first theme is 'putting the puzzle pieces together'. Within this theme, the following subthemes emerged: 'noticing patterns in their mothers' behaviour', 'moments of insight', 'feelings of relief' and 'layered understanding of human behaviour'.

The second theme identified is 'the mother daughter relationship'. Within this theme the following sub-themes emerged: 'role reversal', 'loss, sorrow and lack', and 'emotional distance'.

The third theme, 'navigating different facets of a female identity' includes subthemes of 'perception of the self, 'the female body', and 'being a mother'.

The fourth theme that will be discussed is called 'other caretaking figures'. Within this theme, two subthemes will be elaborated on. Firstly, 'the role that fathers played' will be discussed and 'turning to others in the family for support' will be discussed thereafter.

The fifth theme that will be discussed is 'coping through control'.

The sixth theme that is covered is 'behind closed doors'.

The final theme is called: 'wishes for others in similar situations and ideas for interventions'. The sub themes which follow from this include 'keeping children in the loop', 'being 'seen' by professional services' and 'what to say to another daughter'.

Lastly, for easier negotiation of this chapter, a description of the participants' mothers specific mental illness diagnoses has been provided. Pseudonyms have been used in all cases.

Josie's mother was diagnosed with major depressive disorder. Ashley and Michelle's mothers were also diagnosed with major depressive disorder. Angela's mother was diagnosed with bipolar mood disorder. Mandy's mother had a comorbid diagnosis of major depressive disorder and anxiety. Fiona's mother was diagnosed with psychosis. However, the type of psychosis was not known by Fiona.

4.2.Putting the puzzle pieces together

This first theme brings together various reflections in regard to how the participants made sense of their mother's behaviour in relation to maternal mental illness struggles. Children being able to understand maternal mental illness, has been documented as a protective factor for them (Beardslee et al., 1998; Cogan et al., 2005; Fraser & Pakenham, 2009; Garley et al., 1997; Gladstone et al., 2006 & Trondsen, 2012). However, the actual process of 'putting the puzzle pieces together', in other words, how they acquire this information, is less well documented in the literature. For the participants of the current research project, an important part of 'putting the puzzle pieces together' began with their own observations of significant changes in their mothers' behaviour. Indeed, it seemed that their own observations were the predominant method through which they came to understand what was happening, when their mothers were mentally ill. It is striking to note that none of the participants in their childhoods, seem to have had another adult to explain and contain what was happening to their mothers. Thus, it seems they were left alone to put the pieces together. This is an extraordinarily difficult thing for a child to do and this lack of adult mediation of their experiences would be experienced as a second significant failure of their environments.

Participants also reflected on other moments of insight that precipitated a realisation that their mothers were mentally ill. All of the participants expressed feelings of relief when they were able to gain more of an understanding about their mother's mental illness. Their experiences highlighted how they had to 'put the puzzle pieces' together by themselves as they were not given a clear, comprehensive and ongoing picture of what was happening with their mothers. The participants also stated that through their experiences of growing up with a mentally ill mother, they gained a layered understanding of human difficulties. This made them realise that behaviour was often formed by several 'puzzle pieces', which helped them gain empathy towards others.

4.2.1. Noticing patterns/ changes in mothers' behaviour

All of the participants reflected on how they observed a noticeable change in their mothers' patterns of behaviour, something they recognised from past episodes, which signalled something significant for them. Whilst all of the participants made reference to noticing changes in their mother's behaviour, the changes in the patterns observed differed depending on their mother's particular illness. It was this shift in behaviour that signalled for the participants that there was something worrying or disturbing happening with their mothers. Participants tried to piece together the events leading up to these certain changes. Josie's and

Angela's mothers suffered from major depressive disorder. These participants reflected on a distinct decline in their mother's involvement and experienced their mothers as withdrawn, detached and distant. Josie stated:

> *She would do everything and as a mother, she was very hands on. She would play with us, teach us how to make things, we would make sandcastles, we would walk everywhere, do everything together and then suddenly she would just be exhausted and for a whole weekend at a time she wouldn't get out of bed at all.*

Josie's narrative is that she experienced her mother as actively involved and playful at times. On the other hand, Josie also experienced her mother to be distant and far away, isolating herself in her bedroom when she was feeling depressed. The oscillation between these two different types of behaviours was quite a shift between two very different experiences of her mother, for Josie. In a similar vein, Ashley's mother was also diagnosed with major depressive disorder and she reported noticing that her mother would become paralysed by her depression, so much so that she could not get out of bed. The quote below reflects how Ashley experienced her mother as being shut off from the world, therefore being shut off from her daughter in times of depression:

> *I remember coming home as a child many days and she would be sleeping the whole afternoon, curtains closed and in the bed. And maybe that was before she was really diagnosed and medicated for it, but she would just shut herself off to the world.*

It is widely reported in literature that maternal depression might interfere with a mother's ability to be physically and emotionally available for her children (Austin, 2003; Cuipers et al., 2015; Dahlen, 2016; Gelaye et al., 2016; Nylen et al., 2006) which was experienced by both Josie and Ashley. They reflect on their experiences of being little girls and seeing their mothers go through sudden changes and shifts in moods. This must have been scary and confusing for them to see. One moment their mothers were actively involved and present whereas when their mothers had a depressive episode, there was a large gap in their lives. This was very difficult for them to make sense of at that age as they had to navigate two extreme experiences. On the one hand, they had a wonderful mom. On the other hand, they also had a mother who was distant and uninvolved. They were left, as children to try to work out (put the puzzle pieces together) what was happening to their mothers. This experience is also documented in literature as children of mentally ill mothers often felt as if they were not given enough information about their mothers mental illness and they were left to try and work out what was going on with their

mothers on their own (Dunn, 1993; Cogan et al., 2005; Knutsson-Medin et al., 2007; Perera, Short & Fernbacher, 2014; Polkki et al., 2005; Trondsen, 2012).

Some of the participant's mothers don't seem to have been able to remain attuned to their needs. Rather, Josie and Ashley experienced their mothers as sometimes unavailable to them and sometimes shut off in their own world, behind drawn curtains and closed doors. The perception of maternal depression through the lens of adult children is not widely commented on in literature. Rather, research about maternal depression often relates to the mothering style, rather than the way in which children make sense of their mother' mothering style in relation to the mental illness. For example, a large body of literature acknowledges that when mothers are depressed, it is very difficult for them to be attuned to the needs of their children as they may be emotionally saturated with their own difficulties (Manning & Gregoire, 2006; Oyserman et al., 2000; Polkki et al., 2005; Steadman et al., 2007).

A similar experience was reported by Angela whose mother was diagnosed with bipolar mood disorder. She stated how she also felt shut off by her mother at times. This is reflected in her statement:

> *Like we could go, come home from school like "hi mom I want to tell you about my day!" in an innocent child kind of thing. But she would have like to locked the door and leave a note on the door saying "my psychologist says that I need to look after myself and you guys must look after yourselves now for the rest of the day. That was it.*

Angela's and Ashley's quotations reflect a desire to have shared something (be taken care of and be held in mind by their mothers) with their mothers, such as their daily activities, but often were unable to do so owing to their mothers isolating themselves from their family, and the world at large. Ashley and Josie reflect on how their mothers would be involved in their lives when well, but when ill, they would shut off. Angela further reflected on how she would either see her mother, when ill as shut off, manic or extremely aggressive. This quote also relates to her experience of noticing inconsistent and erratic patterns of behaviour, oscillating between three different experiences of her mother's behaviour. Winnicott (1960) states that rather than developing themselves as human beings, when things go wrong, children may become too concerned about adjusting their behaviour to their emotional needs of their mothers. In fact, it seems that deciphering what 'state' their mothers were in, was a central concern for these participants, as they began existing by reacting to things rather than just being able to focus on

their own lives as children. Angela reflects her experience when her mother was aggressive in the following extract:

> *She started to put the childrens' lives in danger she always used to attack my dad. I am one of five so there is a lot of us. She would always attack my dad and then she started to endanger us. She started to completely misbehave, it was so dangerous for everyone around. Like she pushed me out of a car once.*

It is likely that different children will have a variety of different thoughts and feelings about a mother who shuts herself off from the world, versus a mother who is behaving in an aggressive manner (Beardslee et al., 1998;Brockington et al., 2011; Hipwell et al., 2000). For example, infants and children might experience a depressed mother as inaccessible and distant (Evagorou et al., 2016; Manning & Gregoire, 2006; Oyserman et al., 2000; Polkki et al., 2005; Radke-Yarrow et al., 1994; Steadman et al., 2007) Whereas an aggressive mother is likely to be perceived as dangerous, terrifying and destructive (Oyserman et al., 2000; Venkataraman, 2011; Venkataraman & Ackerson, 2008). Both of these different experiences are likely to be internalised by infants and children, and represented in their phantasies (Klein, 1946). The consequences of having these terrifying unconscious phantasies might be that individuals experience themselves as unlovable by the unavailable, rejecting or explosive other which has a direct impact on their emotional state and their interpersonal relationships. In Angela's case, she found it extremely disorientating that she had to navigate three different behavioural states of her mother.

As a response to the lack of consistent maternal behaviour of mothers who are severely mentally ill, children may live with anticipated anxiety of not always being able to know what to expect from their mothers (Fraser & Pakenham, 2009; Garley et al., 1997; Trondsen, 2012). Angela expressed feeling unsure about what type of mother she would return home to when she was younger. Angela also reflected on how after not seeing her mother for some time, she would still feel extremely anxious about what might happen when she was in the presence of her mother. Both of these experiences left her with feelings of anticipated anxiety. In the below quotation, Angela reflects on the severity of her anxiety when she would sometimes visit her mother when she was older, and no longer living with her mother:

> *It was really tough, I would often have quite serious panic attacks when I was with her and I never, I think it was because of the memories that would come back…Because my mom, when we were a family unit she was highly volatile, so it could explode at any*

moment, at any time… So I think when I started to see her again it, like I would have serious panic attacks because I think that the anxiety would come back, not that the anxiety ever left, that was a pretty hectic thing .

Along with this pattern of unpredictability of her mother's mood, Mandy shared that her mother could be extremely impulsive. Her mother was diagnosed by a professional with both major depressive disorder and anxiety. However, Mandy also believes that her mother has borderline personality disorder[2]. This was not diagnosed by a professional but rather speculated on by Mandy herself after learning more about this personality disorder in her undergraduate degree in Psychology. This impulsivity was often seen in her mother threatening suicide and she would "*climb into her car and drive away and leave [her] and [her] siblings* alone". Mandy stated:

It was terrifying, absolutely terrifying. My mum would leave us and say that because we as three siblings were fighting that she's now going to commit suicide and leave. Obviously it was a mental manipulation game and at that point we didn't realise that. We were so terrified that she is going to kill herself .

Mandy highlighted how her mother would often act impulsively and threaten to kill herself. This seems to have been terrifying for Mandy and she felt that her life was so unpredictable and she felt as if her mother could kill herself at any moment. Her quotation above reflects an experience of a daughter being left behind, seeing her mother drive away and feeling unsure about whether or not her mother would return again. This ignited an extreme sense of fear, dread and confusion in Mandy. There is less research about the specific impact of impulsive, erratic maternal behaviour on children, but there is a lot of research that speaks to the impact of threatening suicide towards children. Trondsen's (2012, p. 180) research highlights how participants who experienced suicidal parents had frightening memories. One participant in Trondsen's (2012) research reported how she would become very anxious when she did not know where her mother was out of fear that she may find her mother dead if she is "*only five minutes late*". Mandy, as an adult participant reflected on how she was able to, in hindsight, acknowledge that her mother's suicidal threats were manipulative moves. But Mandy said that

[2] Borderline personality disorder is a pervasive personality pattern that is characterised by patterns of instability in in interpersonal relationships, self-image, affect and markedly impulsive behaviour. This pattern of personality is present in a variety of contexts and is indicated by at least five of the following criteria: frantic efforts to avoid real or imagined abandonment, a pattern of intense and unstable interpersonal relationships, identity disturbance, impulsivity, recurrent suicidal behaviour, affect instability, chronic feelings of emptiness, inappropriate or intense anger and dissociative symptoms (APA, 2013).

when she was a child, she was unable to develop this kind of distinction and make sense of what was actually happening. Mandy also experienced her mother's behaviour as confusing, as she stated: *Yeah it's confusing because it's not all bad, there is a lot of good*.

Fiona also reflected on feeling confused when she encountered her mother in two disparate ways of being. Fiona said how at one moment her mother was "*bursting into tears and hysterically shouting*" but she also stated *"[my mother] also has got very good aspects as well like we all hav*e". She found the confusion difficult because she did not know what "*type of mother [she] would come home to*". The feeling of confusion reported by Mandy and Fiona seems to be a common experience reported by children with mentally ill mothers (Dunn, 1993; Gladstone et al., 2006; Petrowiski & Stein, 2016; Trondsen, 2012). Dunn's (1993) study noted that the confusion seemed to arise from feelings of loss and sorrow, despite the participants' mothers being alive and physically present.

I am now going to move into a psychoanalytic theoretical analysis/interpretation of what might be going on for these participants in this research. The participants' confusion seemed to arise from the contradicting emotions about their mothers. The participants may not have just experience a binary of an all good and an all bad mother, as explained by Klein (1926, 1975a, 1975b), but they would likely have also experienced an unpredictable and erratic mother as a third or overarching experience. It appears these adult participants were able to make sense of their experiences of growing up with a mentally ill mothers by acknowledging that their experiences were as being made up of both good and bad experiences. The participants were able to think about how their mothers mental illness was a part of their mother, but did not necessarily define their mother. This, according to Klein (1926; 1935; 1940; 1946; 1975a; 1975b; 1975c) is reflective of someone who might be functioning mostly from the depressive position. However, this was not likely to have been the case when they were children. They were likely to have experienced jarring inconsistencies in their mothers, not only in internal phantasy but in their perceptions of external reality. This would have been traumatic and although with maturity they can reflect on their mothers realistically, these childhood traumas will have left a mark intra-psychically and therapy would be a way to process these childhood traumas that they carry as adults (Shaw & Magnuson, 2004)

Fiona said that it was sometimes difficult to notice when her mother's behaviour was changing. She reported finding it difficult to decipher if her mother was having a psychotic episode as it was hard to differentiate some of her psychotic symptoms from her religious beliefs, which

Fiona described as a "*cult*". Despite this difficulty to recognise her mother's behaviour was very confusing. She reflected on how she would witness frightening and strange behaviours from her mother when she was psychotic:

> *She would hallucinate and see things and evil coming and it was terrifying to be a little child you know and she, not just my mother, I'm talking about other cult members as well, they used to burn our toys in front of us. They would get a notion that this is demonized and they would take it outside and set fire to it and then like maybe if I wasn't there while the deed was being done, when I got home I was told that it was set fire to, and that the demons were screaming as they were being released.*

Fiona found it really difficult, at times, to speak about her experiences as a child growing up with her mother who suffered from psychosis. In the above quotation, Fiona used the world little which could almost be a synonym depicting the level of vulnerability and fear that she experienced when she was exposed to her mother's psychotic behaviour. Fiona reflects on her terror of seeing her mother hallucinating, and also her terror observing her mother's behaviour that would accompany these hallucinations. It was terrifying for Fiona to be exposed to this when she was a young child. Fiona's experience is commonly reported in literature as children exposed to their mothers' delusions and hallucinations find this bizarre and terrifying (Brockington et al., 2011; Craig et al., 2005; Duncan & Browning, 2005; Engur, 2017; Gearing et al., 2012; Hipwell et al., 2000).

Fiona also reflected on how her mother threw away her favourite teddy bear, Bella, because her mother thought that it was possessed with demons. This was a traumatic experience for Fiona as Bella represented both safety and protection. She experienced terror, without her source of comfort, and was left wondering why her mom would want to take away something that was so precious to her. This special safety net was termed a transitional object by Winnicott (1971). Children become specifically attached to these objects (toys, a special blanket etc.) which they perceive to be special and precious to them, helping them tolerate difficult feelings (Winnicott, 1971). This attachment to a transitional object is very important to promote healthy childhood development (Winnicott, 1971). Children who have less maternal contact often use a transitional object to feel closer to their mothers in her absence (Green, Groves & Tegano, 2004).

In summary, all of the participants described how they started to notice patterns of behaviour from their mothers which helped them recognise and distinguish that something different was happening with their mothers. This is aligned with research conducted by Garley and colleagues (1997), Fraser & Pakenham (2009), Kadish (2015) and Trondsen (2012) as participants in all of these research studies also developed a hypervigilance towards any signs and symptoms of their mothers' impending illness. Angela reflected on how this hypervigilance often brought about debilitating anticipatory anxiety. Research suggests that mental health literacy in relation to knowing their mother's signs and symptoms of their mental illness was experienced to be reassuring at times (Fraser & Pakenham, 2009 & Garley et al., 1997). All of the participants did not experience their mothers behaviour as consistent and predictable, with some reported experiences being more extreme and erratic than others. For all of the participants these changes were often confusing. Sometimes their mothers were experienced as involved, whereas this could quickly shift into their mothers becoming unavailable, detached and at times, aggressive. While this left them with some feelings of confusion, they were also able to see how their mother was made up of different parts and how the mental illness did not define the entirety of their mothers. The participants described how they had to change their behaviours depending on their mother's state which according to Winnicott (1960) would have impacted their going on being as children. This echoes Trondsen (2012) who explains that children may live in 'emergency alert mode' and be hypervigilant to the environment conditions around them rather than being able to just be in the world.

4.2.2. Moments of insight

All the participants reflected on how they experienced periods of dawning insight which began to contribute to an understanding of their mothers' mental illness. However, the journey to get to these moments of insight was a gradual one and developed with maturity, the passing of time, and accumulation of experiences for the participants. The journey to reaching such insight was experienced in different ways. One participant reflected on how she made sense of her mother's behaviour as a child by first equating her mother's behaviour with physical illness and then realising that there was "*something more going on*". Josie stated:

> *She would just be exhausted and for a whole weekend at a time she wouldn't get out of bed at all. And that's the kind of thing where when you are six and you don't know what it is and she doesn't know what it is you can put that down to oh maybe she has the cold, or maybe she has the flu…If you get sick you probably would just go to bed and stay there for a while. But um that would get worse and worse over time and then with*

> *that it would just be an inability to engage with the types of things that she would normally enjoy doing… that started to indicate that there was something more going on.*

This indicates how Josie would initially interpret her mother's change of behaviour as being due to physical illness. Josie was able to identify that her mother was ill, with a cold or the flu. Perhaps when Josie was a child she found it more manageable to medicalise her mother's mental illness because she was not originally able to understand the concept and she might not have been able to bear her fears that her mother was again becoming emotionally unwell. This is aligned with Cogan and colleagues (2005) study where participants medicalised their understanding of their mother's mental illness. However, Josie acknowledged that there was a gradual shift in her understanding of her mother's behaviour when she deduced that that perhaps there was something more serious and very different going on.

Michelle also originally thought that her mother's behaviour was not related to mental illness. Rather, she explained how she wanted to think of her mother's behaviour as "*normal grief*" in response to a death in the family. However, there was another layer to this where she felt as if she too perhaps chose to see her mother's behaviour in a way that was less scary, rather than acknowledging the reality of the situation. She reflects on this in the below quotation:

> *I don't think at the time I actually realised that it was a mental illness, if I can put it that way. I think there was a lot of ignorance…I think I personally had a lot of ignorance in the sense that I protected it as the norm kind of thing. This is just the norm when someone dies you know they struggle to work through it.*

The quotation above indicates that, in a way, Michelle was in denial about her mother's mental illness. Perhaps this was a way to protect her mother but also to protect herself from acknowledging that her mother was severely ill. It might have been easier for Michelle to make sense of her mother's mental illness through something that she understood better such as a reaction to a bereavement rather than having to face her fears of something much more disturbing.

Mandy felt for a long time that her home environment was normal because she did not know or experience anything different. However, it could also be, that Mandy preferred to 'not see' what was truly happening at home. She stated:

> *Growing up with a mother with a problem you just think that that's normal and that's how life is. But I mean I would say I was in primary school, end of primary school that I would really say that I was recognised you know that something was not right. But then also perhaps that's not the case because that's just how life is so it's very difficult if that's just your normal but then you realise it's not normal.*

For Mandy, seeing her mother's behaviour as normal, seems to have been a way to protect herself from what was truly going on. This was similar to Fiona's experience, as she stated that she was "*born into it*" but she said that "*you know deep down that this isn't right*". Both Mandy and Michelle might have experienced moments when they were in denial about the reality of their experiences of growing up with a mentally ill mother as both of them did not initially acknowledge what was really happening with their mothers. In this way they tried not to face the reality of their mothers' mental illness.

On the one hand Fiona grew up believing that her experiences as a child was the norm as she had no other frame of reference. On the other hand, she always had a gut feeling that something dangerous was happening at home, even though it was not directly spoken about with Fiona.

Much like Ashley, Josie and Michelle, Angela also reflected that she was a similar age (around pre/early adolescence) when she realised that her mother had a mental illness. The lens through which she viewed her mother's mental illness was also clouded by the fact that she felt that she should not judge her mother. This is reflected below:

> *When you're a child you don't really think that there is anything wrong with your parents. They're your parents, they are that role model figure. So I just thought she was my mom you know. And then when I was about 11 years old, 11, 12 her and my dad used to fight a crazy amount… She started to put the children's life in danger she always used to attack my dad.*

In a way, Angela may not have wanted to believe that there was something wrong with her mother which echoes Mandy and Michelle's use of denial as a way of defending against reality. Angela might have wanted to protect the 'good mother', and deny the 'ill mother' as in that way she did not have to acknowledge that her mother was ill. This is a very normal childhood response, as on the one hand it is about protecting the good mother but it's also about wanting to create a sense of safety and security in the world because it is terrifying to face that things feel like they are falling apart (Bowlby, 1953; 1960; 1969; 1973; 1979; 1988; Craig et al., 2005;

Duncan & Browning, 2009). According to Bowlby (1953; 1960; 1969; 1973; 1979; 1988), childrens' feelings of safety depend on their parents ability to protect them. For a child, having a mentally ill mother could mean that the world may no longer be experienced as safe (Brockington et al., 2011; Duncan & Browning, 2009; Hipwell et al., 2000).

Angela also spoke of her difficulty to understand her mother's mental illness before the age of 12 because she was dependent on her parents and did not yet have a grasp on who she was in the world without her parents. Perhaps this was also informed by her feeling of loyalty towards her mother. Dunn (1993) reports on feelings of loyalty that children sometimes experience towards their parents, no matter the circumstances.

She elaborated:

> *And then at that point I started being told that my mom was sick, kind of thing, and it was like a thing now I had an ill mom and I was told that she was on medication.*

This indicates Angela's shift in understanding of her mother's behaviour. Originally, she wanted to protect her mother in a way by not wanting to seem to judge her, or just thinking that she is different to other mothers. Then, when she was told that her mom was on medication, something shifted inside of her. However, in a similar way to Josie, this was also a medicalisation of her mother's mental illness. For Angela, being told that her mother was on medication helped her to further understand the severity of her mother's mental illness. In a similar vein, Ashley also reflected on how she always knew that her mother was unwell but it took her time to truly understand what her mother was struggling with because it became their normal:

> *Yeah, it's, It's definitely I was already a child from what I can recall two break downs when I was in Senior School um where she was hospitalized. And yeah, that's definitely when I first realised it I was in the early teens, mid-teens…She has actually just recently just had a breakdown. She's 66. So crazy and I am 45 just for your record. So we have lived with it, yes, all our lives.*

Three participants reflected on how prior to early adolescence, they found it very difficult to make sense of their mothers' behaviours. On the one hand, they protected themselves from acknowledging the reality of the situation by employing certain defense mechanisms to defend against their anxiety. On the other hand, their experiences also highlighted how they went through a developmental meaning making process, whereby the participants found other ways

of making sense of their mother's behaviour that they knew, such as physical illness or attributing it to eccentricity or mourning. There was a slow shift in understanding, after cumulating experiences – ranging from physical illness, flu, grief, normality, to a realisation that their mothers were mentally ill for the participants. Garley and colleagues' (1997) research also found that participants had numerous responses to the question of causality of their mothers behaviour. However, it appears that there is little research in the meaning making process in specific reference to developmental changes and how adult daughters made sense of their mother's mental illness over time.

4.2.3. Feelings of relief through gaining an understanding of mental illness

All of the participants felt that they felt a great sense of relief once they understood something about mental illness and the fact that their mothers suffered from it. The participants reflected on the different ways that they gained information and understanding about their mother's behaviours which included when their mothers were hospitalised, when they were told that their mothers had a mental illness and/or when they were informed that their mothers needed to be on medication. The relief was experienced in different ways and was formed by different reasons. For example, once Josie realised that her mother did not have the flu but rather a mental illness, she found relief in knowing that she knew the root cause of her mother's behaviour but also felt relief that her mother's mental illness was treatable. She reflected on this:

> *I think that when you are a child, even at 14 or 13, if someone has gone to hospital they are then actually ill. And if they are medicated then they will get better or it is manageable. And I think that's the turning point.*

For Josie, knowing what was wrong with her mother brought about feelings of relief because there was a specific cause for her mother's behaviour. She felt that by virtue of her mother's mental illness being diagnosed, it could be treated effectively and she experienced feelings of reassurance. This seems to indicate a positive, productive interaction with health services, in that there was an acknowledgement of the seriousness of the issue as well as relief that her mother was receiving medical intervention. Garley and colleagues (1997) research study also spoke to feelings of relief in relation to medical intervention, however this was informed by the fact that children were relieved that they could be looked after by someone other than their mothers. Kadish (2015) and LeClear O'Connell (2008) studies also highlighted the fact that many participants experienced relief when their mothers were hospitalised. Another layer of

relief for Josie was that by virtue of her mother being mentally ill, it was not a choice for her mother to withdraw which decreased her feelings of resentment towards her mother. Josie elaborated on this:

> *But if there is no actual, there is something wrong, and it could be choice, you could become very resentful. But at the moment when you know that it isn't somebody's choice you can then start to forgive certain shortcomings.*

It seems to have been important for Josie to realise that her mother was not hurting her intentionally. Understanding her mother's behaviour in the context of mental illness was helpful for Josie. Mandy also shared in this experience:

> *Yeah, and also from the point of view of forgiveness it is easier to forgive somebody for being sick, if I can put it that way, you know. Because repeated terrible behaviour and terrible acting and speaking to your children you know in an awful way, you know, you have to deal with it and live with it over and over and over and over again. And it's still continuing but it's much easier to forgive somebody because they are sick, something is wrong it's out of their control, than this person is just being a horrible person.*

Josie and Mandy both reflect on some implicit anger and grievances towards their mothers for behaving in ways that the participants experienced as harmful and frightening. It is also likely that the participants may have experienced self-blame and guilt when they believed that their mothers could have chosen to behave differently. This is likely to have impacted them on an emotional level, as they may have had the phantasy that they *made* their mothers mentally ill, before they gained insight into the cause of their mothers behaviour. It was therefore a relief for both Josie and Mandy to find out that it was not necessarily a choice for their mothers to behave in a certain manner but rather that their mother's behaviours might have been formed by their mental illness. This relief was from their angry feelings, guilty feelings as well as their feelings of confusion. Sometimes these feelings of relief changed to feelings of frustration for Ashley and Josie. As these participants grew older, they became aware that their mother could take more responsibility for her mental illness and this made them challenge and question certain aspects of their mothers' behaviour. Perhaps this firmer stance with their mothers was formed by the relief that they experienced together with a further understanding how their mother's mental illness could be managed, rather than remaining passive.

Three participants reflected on how being made aware of their mother's diagnosis brought about feelings of relief because internally they had thought that their own wrong doings were to blame for their mother's illness. This relates to Garley and colleagues (1997) research which noted that participants found it reassuring to know what the causation of the mother's mental illness was. Mandy reflected on how an increased awareness of knowing that her mother was mentally ill resulted decreased feelings of internal guilt. Mandy stated:

> *Yes because [the diagnosis] helped me to distinguish between, and actually for the first time, really realise that it wasn't my fault. All the blame that I felt for the first time I could distinguish that you know this actually has nothing to do with me you know it is nothing that I did… it also helped me to deal better with her because I wouldn't take things as personally you know I would rather realise that this is an illness or this is a problem that is manifesting rather than, you know, something that I did that helped you know that helped a lot with that.*

Implicit in this quotation is that Mandy may have had an internal sense of guilt and shame that she was to blame for her mother's behaviour. She was relieved that there was an explanation and causation to her mother's behaviour. This is aligned with Dunn's (1993) study who also noted that children expressed feeling guilty which was formed by their fear that they had somehow contributed to their mother's mental illness. Similarly, Cogan and colleagues (2005) reported on how the majority of the participants in the research study expressed a belief that they had caused their mothers mental illnesses. Inappropriate feelings of being responsible for the distress of their mother's behaviour was also alluded to in the article by Radke-Yarrow and colleagues (1994).

While it brought about some relief for Mandy being told the diagnosis, Angela also experienced this relief was felt with fear. She recalled having a lot of questions when she found out that her mother was mentally ill. Angela said that she felt quite destabilised after finding out the severity of her mother's mental illness. She reflects on this process:

> *Ya fear…like you know, who am I? what is my role? what is my purpose? what do I do? what is right? what is wrong? It was a lot of that. There was not any grounding and I would say that was the biggest emotion.*

When Angela stated "*what is my role*", implicit in this could be her wondering about what role she had to play in making her mother ill. Another aspect is that she may have wondered what

role and responsibility she needed to take on to help her mother going forward. She experienced becoming aware that her mother was severely mentally ill as destabilising. She experienced her mother as being fragile and needed to be treated as such. Nonetheless, she also recalled how it was a relief for her that there was an explanation for her mother's behaviour. But, she also felt scared about what role(s) she had to play in the overall situation: whether it was a contributing role or whether it could be a protective role. This means she experienced a pressure to look after her mother at a level that is not appropriate for a child. This too adds emotional distress that the child has to find a way to manage.

In summary, it was a relief for the participants to reach the understanding that their mothers were mentally ill. The participants experienced some relief from the anger that they felt towards their mothers once they realised that their mothers did not have a choice about certain behaviours as a result of the influence of mental illness. They also may have experienced relief from their feelings of self-blame and guilt as they no longer had to carry their concerns or beliefs that maybe they had made their mothers ill. While the overall feeling was relief for many participants, Angela acknowledged that this relief was felt in conjunction with fear. Josie and Ashley expressed how this relief sometimes changed into frustration as they grew older.

4.2.4. Layered understanding of human difficulties

All the participants reflected on how their experiences with their mentally ill mothers shaped the way in which they understood human difficulties. Specifically, participants reflected on how they gained a layered understanding, acknowledging that not everything is what is seems and perhaps there is something deeper and more complicated beneath the surface that is causing a person to act in a certain way. Two of the participants entered into helping professions which is aligned with Petrowiski & Stein (2016) who noted that many participants in their research study who had grown up with mentally ill mothers had the desire to enter into the helping profession. Angela explicitly stated that her own experience propelled her towards helping others:

> *I am able to teach and help other people through my own suffering. I think that's why I am a teacher. I teach all things like ballet, English, pilates like I love teaching um and I think it's through that experience that I can understand the pain, suffering*.

Fiona also wanted to be a teacher, but she reflected on how she could not attend university because she suffers from agoraphobia. Agoraphobia is an intense fear that is triggered by the real or anticipated exposure to at least two of the following five situations: using public

transportation, being in open spaces, being in enclosed spaces, standing in line or being in a crowd and being outside of the home alone (APA, 2013). Agoraphobia is a multidetermined psychological disorder and there are many different pathways that could contribute to the development of this psychopathology (Compton, 1992). There is a lot of research that proposes that people who suffer from agoraphobia may have felt that they were under protected from catastrophic childhood experiences (APA, 2013; Compton, 1992; Diamond, 1985; Gassner, 2004; Last, Barlow, & Brein, 1984). A contributing factor to Fiona's agoraphobia might be her frightening experiences as a child and her consistent fear and terror when she was growing up with a mother who suffered from psychosis. It is likely that Fiona did not always feel protected and safe when she was growing up, and she might have believed that her very physical survival was in question from a young age. Her conscious and unconscious experiences could be that the world is dangerous and there is nobody on whom she can depend on for safety (Diamond, 1985). She might protect herself from this overwhelming anxiety by actively avoiding areas where there could be a chance that she might feel helpless or feel completely out of control of her physical safety.

Michelle also entered into the helping profession but she did not explicitly state that it was as a result of her experience of growing up with a mentally ill mother. However, this career choice might have been formed by her denied wish to be helped herself as a child (Petrowiski & Stein, 2016). Nevertheless, Michelle did reflect on how her experience made her aware that certain behaviour could be formed by several aspects rather than jumping to conclusions:

> [Her experience with her mother] *made me look at people in general differently because it does kind of give you that wake up call to make you realise that what do you need is here. Let's see, and what is beneath the surface is not necessarily the same thing. And because of that you know I was definitely more conscious of not just saying oh that person is an idiot because he or she behaves in a certain way. I kind of always took more time to process it and I think for me that is an advantage in hindsight.*

When Michelle refers to "*beneath the surface*" she is acknowledging the there is an internal , world of emotions, buried experiences, conflictual feelings, fears and fantasies, which can all influence behaviour. Michelle reflects on how she is able to read between the lines, and think about the unspoken aspects of someone's behaviour and consider the feelings behind certain words which helps her gain an intuitive understanding of another person's internal world. This is aligned with Radke-Yarrow and colleagues (1994) research where participants stated that

their experience of growing up with mentally ill mothers helped them gain capacity to imagine and understand another individual's internal state. Perhaps through Michelle's experiences of growing up with a severely mental ill mother, she became more acutely aware of this inner world which can form human behaviour - something which she might not have been aware of otherwise.

All of the participants reflected on how they believe that they gained increased empathy through their experiences with their mentally ill mother. This is aligned with Radke-Yarrow and colleagues (1994) research noted that empathy can be fostered when you grow up in an environment where you are constantly aware of the distress felt in another person. All of the participants were often exposed to intense affect and had to be on the receiving end of some intense emotions from their mothers as reported in their experiences which is also documented by Hoffman (2000). In this way, it could be that they felt that they needed to develop a sense of empathy as a way of keeping safe in the world which is aligned with Batson (2009). Batson (2009) and Hart and Ingle (2019) suggest that empathy is helpful in children of mentally ill parents because it helps them have a radar to recognise a threat or to know how to accommodate the needs of the other to try and keep themselves safe in the world. Fiona also reflects on how she feels as if she developed empathy through her experiences with her mentally ill mother:

> *I think that I am a very understanding person. So even in amongst the chaos and everything I would always like look to understand what could be happening that's made it like this try to make sense of it and stuff and understanding things.*

Fiona also reflects on how she tries to understand others in an in depth and nuanced way by thinking about what might cause a person to act in a certain manner. Her quotation above highlights how she thinks about someone's behaviour through a dynamic and interactive matrix to try and gain an understanding. This, according to Hart (2014) might help Fiona to make sense of and make meaning of people's behaviour in an insightful way. It might be that her ability to think about others internal worlds might influence her ability to self-reflect about her own internal world. Fiona acknowledges the deeper intrapsychic factors within the human experience. Fiona's own experiences helped her gain insight into others behaviours and may have increased her self-reflection skills to think about how certain behaviours are formed by both an internal and external dimension.

Participants also reflected on how this increased their empathy towards others had a positive effect in both their life and in their family life. This increase in empathy as a result of their lived experiences is documented in the literature (Batson, 2009: Gordon, 2012; Hoffman, 2000). Mandy reflects on this sentiment:

> *I am a very empathetic person, like definitely, that I am aware of the pain that people feel… and it has had a positive effect on me in my little family life, with my husband and my son.*

She further explained:

> *I try to be very sensitive towards their emotional needs. I don't always succeed at it but I try to be very aware of what they need and I tried to never say damaging things because I know you can't take it back. So I tried to be uplifting and building into people's lives. So yeah, knowing what I wanted and what I needed and what I didn't get, I'm trying to give to other people. So yeah I don't think I would have been as sensitive if it wasn't for my mom's things.*

The quotations above indicates how Mandy believes that she has an intuitive understanding into the pain that other people might feel which enhances her empathy. She is sensitive to the experiences of other people and tries very hard to be attuned and aware of how her son is feeling. This, according to Meneses and Laekin, (2017) is also helpful to gain an intuitive understanding into the world of another person which Mandy believes has positively impacted her relationship with her husband and her son.

All of the participants reflected on how through their experience of growing up with a mentally ill mother, they have gained deeper insight into peoples' lives and difficulties and they gained empathy. In a way, this influenced the choice of profession for three of the participants. Children of mentally ill mothers have been reported to be more aware of mental illness in others and have greater empathy for others (Petrowiski & Stein, 2016, Radke-Yarrow et al., 1994). The participants thinking about causation in relation to their mothers' behaviour at different levels, made some of them curious about mental health more generally.

4.3.Mother daughter relationship

This theme relates to participants' reflections on various aspects of their complex relationships with their mothers. The first sub theme that will be explored in relation to this theme is the participants' experiences of having to re-assign their family roles as both a daughter and a

sibling. The participants experienced their family roles as being in flux. Secondly, the experiences of loss, sorrow and lack in relation to their relationship with their mothers will be discussed. The final subtheme that will be discussed relates to the emotional distance that participants reported experiencing in the mother-daughter relationship.

4.3.1. The re-assignment of family roles

This subtheme highlights participants' experiences of having certain roles in their family re-assigned and by implication, reversed. The participants reflected on how they had to take on various responsibilities in the home including cleaning the house and taking care of their mothers, and in some cases, their siblings. These precocious role expectations are well documented in literature (Dahlen, 2016; Dunn, 1993; Engur, 2017; Fraser & Pakenham, 2009; Garley et al., 1997; Gladstone et al., 2006; Knutsson-Medin et al., 2007; Manning & Gregoire, 2006; Mowbray et al., 2006; Petrowiski & Stein, 2016; Polkki et al., 2005; Trondsen, 2012). Another aspect of role reversal was that the participants looked after their younger siblings. Michelle explained how looking after her mother and the home was something that she had become accustomed to as it was automatic for her:

> *I was literally looking after her I was cooking, I was cleaning, I was making sure that she ate, that she bathed, that she went to work, so that was more autopilot than anything else.*

She stated that she felt as if she also went into survival mode:

> *I went into survival mode kind of thing where I knew I had to wake up get ready for school wake my mum up make sure that she gets ready for work… So I think it was kind of an automatic thing where, you know, you kind of pilot mode kind of thing it kicks in…I think it was for me and more automated thing and a survival mode thing and not worrying about how I'm feeling at that moment. If it makes sense? So I had to try and contain the situation and manage the situation.*

Michelle may have felt propelled to take an active role in the house in order to survive in the world. She seems to have felt she had to take on those roles otherwise her family and her world would have fallen apart. It seems that this was not a wild distortion of reality. She speaks of how she had to shift her emotions aside, and move into survival mode to try and "*contain the situation*". It is interesting that Michelle used the word *contain,* in light of Bion's (1962a,b) container-contained theory, as outlined in the literature review.

In the above quotation, Michelle said that she did not always have enough time to think about how she was feeling in relation to the role reversal. It seems likely that in those times Michelle had no sense of feeling emotionally contained. By implication, it could be that a) she did not feel as if her feelings were valued enough to be expressed and b) she did not have an experience of being contained herself and rather was the container to her mother (Bion, 1962a). Her basic needs were not being met, but in addition, she was compelled prematurely to take over the adult caregiving responsibilities. It seems that the relationship between mother and daughter was reversed and by implication the relationship between container (which is usually the mother) and contained (infants beta elements) may also have been reversed.

At those times of maternal mental illness, Michelle would likely not have had the experience of being able to develop at her own pace, but rather she might have begun existing by reacting to the external demands around her (Winnicott, 1960). It appears that when she was mentally ill, Michelle's mother was unable to be a 'good enough mother'. Michelle seems not to have experienced her mother as being devoted to her needs at those times. Rather, Michelle was devoted to the needs of her mother. Michelle, in a sense, was trying to be the 'good enough daughter'. Winnicott (1971) also states that sometimes the childhood situation enables a child to behave in a certain way in the hope of finding an environment in which development could start up again. Thus, Michelle may have felt propelled to engage into "*survival mode*" because she was searching for a way to make her environment feel more manageable.

Josie reported a very similar experience. She highlighted how the role reversal became the norm in her life, from a very young age. Her quotation below reiterates how she became the caregiver for her mother and the caretaker of the house.

> *So I from very young took on a very parental role. And very soon the roles of mother and child were reversed so like practical things I would go and make dinner, I would make sure that my sister was dressed for school I would make sure that the house was tidy.*

The quotation above highlights how Josie sometimes felt as if her life at home was filled with many duties and responsibilities that she took on from an early age. Josie reflects on the absence of the experience of her mother mothering her. However, Josie elaborated that she hoped that her effort would mean something to her mother. While no other participants explicitly stated this, it may be that the reported urges of the participants to help and contain the environment may have been formed by their desire to be seen and loved by their mothers. Josie stated:

> *But also, then I would try and look after my mother and I would go and try to say you know are you hungry? No I'm not. Can I bake? I would then come up with random things and then I would just go and cook something because hopefully the effort of me doing it would mean something.*

This quotation indicates that Josie was trying really hard to sustain her mother's vitality and attention. Josie's desire to bake, or to help her mother in any way that she could might indicate how desperate she was to get her mother's love, regardless of how she had to sacrifice her own developmental needs. Winnicott (1971) posits that a child should be able to use their mother for its own growth. However, if a mother is depressed and unable to adapt and respond to her child, this process is reversed (Winnicott, 1971). For Josie she may have felt as if her mother's mental state was more important than her own needs and therefore she tried so very hard to try and make her mother feel better or access her mother by baking (for example) because she did not fully understand what was happening with her mother as a child. Josie's desire to bake might have also been born from a desire to seek approval from her mother, which is something that Williams (1998) alludes to. Josie also reflected on how she cared for her younger sister. While participants in Trondsen's (2012) study highlighted that they felt pleased to be useful to their mothers, they also noted that the role reversal brought about a lot of responsibility. In relation to responsibility, Josie reflected on how she felt as if she needed to "*shield*" her sister from "*what [was] going on*". This may have derived from her own fear and lack of sense of security, and thus she wanted to protect her sister from this experience. She stated:

> *I think that I did my very best to shield her from what is going on and I think that I largely achieved that. Um so I genuinely think that she was not aware a lot of the time what was going on because I would just say "oh mom made us breakfast here is your breakfast" or "why don't we read in here for a few hours" and she was very reclusive and quiet and would read a lot.*

This statement reflects how Josie tried to cover up for her mother by telling her sister that her mother did certain things when Josie actually did them herself. She wanted to "*shield*" her sister from being exposed to what she was being exposed to and aware of. She was filling in the role of mother for her sister. This might also reflect how she did things for her sister that she wished that her mother could have done for her. Josie reflects on how she was literally taking over her sister's emotional containment. It appears that she wanted to provide her sister with a caregiving figure so that her sister's development would not be disrupted. It seems as if

Mandy also took on a similar role with her brother like Josie did with her sister. Mandy reflects on this below:

> *I remember packing all three of us lunches and actually being extremely protective of my brother. He's 6 years younger than me and he kind of grew up with me being just another kind of mum because I was so extremely overprotective of him and my sister at that point.*

The quotation above reiterates how Mandy might have felt such a need to be a protective barrier for her siblings in the world. She looked after her siblings, tried to shelter them and take on the role of a mother for them. But one wonders who was protecting her when she invested so much into being over protective of her siblings. For Mandy and Josie, it may be that their care for their siblings elicited a pseudo mother role for them which might have been formed by a deep desire to seek bonding from another person in their family. This was also reported on by Petrowiski and Stein (2016).

Both Josie and Mandy reported that they tried to compensate for their mothers' absences by being extremely protective and active in their siblings' lives. These participants experienced a double role reversal as they became a mother to their mothers and a mother to their siblings. This highlights that the vertical relationship between mother and daughter can be impacted but so too can the horizontal relationship between siblings be impacted by maternal mental illness. The normal family roles had to be re-assigned for these participants. Dunn (1993), Williams (1998) and Kadish (2015) also found that their participants reported being caregivers to both their mother and siblings.

In terms of role reversal, Josie and Ashley reflected on how this shifted throughout age. Josie reflected on how she thought to herself when she was a child "*I am a child, I must fix*". However, Josie became resentful about this role in adolescence, but she explained that an internal battle emerged inside of her of wanting to help her mother but also rejecting this responsibility:

> *By the time I was fourteen I knew that I didn't want to fix it. I knew I didn't want to be responsible, but I would be. So it would be this huge tension of everything must be okay and I must fix it, but I reject that. And I don't want to be that.*

There was a dramatic shift in her perception of responsibility towards her mother as she became more in touch with this heavy burden of this role reversal. She further stated that while she still

looked after her mother to a certain extent as an adult, she also spoke about how tried to take on a less active role with her mother in the following extract:

> *Why am I then having to take responsibility? Why do I need to talk to your contractors? Why do I need to deal with your tax? Why do I need to remind you to sort your car licence? That's not my job. You are an adult and I am an adult.*

Similarly, Ashley also reflects on a change of heart when she was in adulthood in relation to how she saw her role:

> *You can't fix it for them and I used to take it I suppose more sensitively and more personally, but I think you can't. You just wouldn't cope. I have got my own life, my own children, husband a home. And there is a frustration for me because I am often very busy but she will never ask how it's going and yet I have to listen to all the drama you know that's going on her side.*

As children, Josie and Ashley both had a desperate desire to try to help their mothers. Yet, as a teenager Josie said that she rebelled against this responsibility. And as adults, Josie and Ashley became angry and refused to fulfil their re-assigned family roles. They both wanted to try and regain the equilibrium of the mother daughter relationship between two adults. When Josie and Ashley were adults, they needed to individuate from their mothers whilst remaining connected to them which Petrowiski and Stein (2016) note is particularly salient for young adult daughters. This shift speaks to a way of trying to manage the challenges of their mother's illness psychologically and emotionally over time. There was a clear difference in Josie's and Ashley's experiences of role re-assignment between when they were younger, when they were adolescents and when they were adults.

4.3.2. Loss, Sorrow and Lack

All the participants spoke about ways that they experienced loss, sorrow, and lack in their mother-daughter relationship. They discussed feelings of loss and sorrow which were often generated by their perception that they did not live 'normal' lives. This was also reflected by Trondsen (2012). Angela stated:

> *When I was at varsity, I would sometimes, the sadness was almost like a sort of a minor depression for a few days. I would be exhausted, had to stay in bed, crying, and sad just at the sorrow of the situation. Maybe it was sorrow for myself that I couldn't have a normal mom.*

Angela's sorrow was formed by a deep feeling of distress caused by loss, grief, and disappointment in not having a 'normal' mother. Angela's sorrow arose from experiencing her mother as absent owing to ill health, rather than the physical death of her mother. She explained this in the following extract:

> *Ya I mean of course, as a 12-year-old girl, life itself at that time is awful and to do it without a mom was really, really, really tough. Not without a mom she was there, it's not like my mom died, but to have her illness was present you know, and it was really, really tough.*

Angela reflected with a deep sense of sadness at the unavailability of her mother at an important time in her life. She desperately needed her mother yet despite being present her mother was unavailable and inaccessible to her needs. She felt as if she had to mourn her mother like a death despite her mother being alive. Angela felt as if she had to navigate her life with an important part of her compass missing. She stated:

> A *mother-daughter relationship is so paramount, it is so important and to have that not there is like not having a trunk of a tree.*

This is a similar finding to Trondsen's (2012) research study who stated that although children growing up with a mentally ill mother still have their mother, some children express a longing for a capable parent even though they are still alive. Ashley expressed a similar experience of her mother being there physically, but she was experienced as emotionally absent. This sadness was further re-evoked for Ashley by thinking about how her own daughters would not have a similar experience that she had with her grandmother which she deeply cherished. Ashley explained:

> *And there is sadness, in that she is not involved emotionally and mentally she is physically around but she is definitely not connected to my children on that emotional level … its quite sad I wonder if they will ever realise what they missed out on in a grandparents aspect. And my gran was my dad's side who I was so close to not my mom's side. And I had that special relationship and I don't think they going to have it. Which is quite sad actually, have someone to call or have other conversations with.*

Ashley reflected on how not having a present, active and involved mother brought about a sense of deep sadness. Ashley also reflected on the inter-generational impact of this sadness as she felt sad that her children will not have the experience of a maternal grandmother. This

echoes Kadish (2015, p. 488) research who also found that many participants' feelings in relation to their mothers "*were re-awakened, even exacerbated*" by their mothers' behaviours as grandmothers.

Another form of loss reported by four participants was the loss of normal childhood experiences, particularly childhood social experiences which perpetuated feelings of isolation. Bonnie (1993) noted that while separation from mothers can bring about relief, it also brings about feelings of guilt which might make children feel inclined to spend as much time with their mothers. This was an experience documented by three of the participants in this research. Michelle reflects on this below:

> *I do think that it impacted on how often I would actually go out with my friends if that makes sense. So I was kind of very selective on when I would go out how often I would go out.*

Michelle might have felt as if she needed try to limit the amount of time that she would go out and leave the house. While she does not specify her reasons for this, it may be due to her feeling as if she needed to be at home to take care of her mother rather than allowing herself to spend time with her friends. Josie reflects on a similar experience below:

> *I now think that I was withholding myself from engaging with groups of friends because I didn't want to then have to say I'm not going away, I'm not doing this, I'm not doing that. I would never go on any optional school trips because then I wanted to be home just to check that things were okay.*

Josie reflects on how she would also be very selective when she was deciding how she would spend her time away from home. She expressed how she often an obligation to be at home to make sure that things were under control. It might have been too anxiety provoking or guilt provoking for Josie to leave home as she was afraid that things at home might fall apart. In a way, her lost social opportunities may have come about from her felt obligation to be there for her mother and for her sister. Fiona also reflects, with sadness, on her missed social opportunities when she was younger:

> *As soon as I came home, everything was just handed to me…while other kids were out playing I would be inside getting my sister's bath ready and I'm getting her clothes ready. It was snowing once and my friends were walking to school when they came in*

and called for me to ask to walk to school with them in the snow. Awesome! You know? But I wasn't allowed to because I had to get my sister ready before I could go to school and then my friends had gone.

The participants' experiences of feeling as if their mothers mental illness may have impacted their social interactions is widely reported in literature (Brockington et al., 2011; Cogan et al., 2005; Dunn, 1993; Fudge & Mason, 2004; Gladstone, 2010; Knutsson-Medin et al., 2007, Rutter et al., 1997; Smith, 2004). Furthermore, it appears that in a way, these participants felt as if they lost their inner child which relates to the playful, creative, spontaneous and energetic part of themselves. Childhood is usually idealised as a time of little responsibility and being carefree, but children of mothers who suffer from mental illness are considered robbed of or have lost their childhood (Gladstone et al., 2006).

While some participants reported feeling they missed out on normal childhood experiences owing to their responsibilities at home, Fiona also reflected on her loss of opportunities more generally. She felt as if she did not have a 'normal' upbringing which brought about a sense of sadness and feelings of loss for her. She reflected on this:

I wonder what I would be like if it hadn't been for that. If I had like a normal upbringing. I often wonder what I would be like because I wanted to be a teacher that's all I wanted to do…I just feel that I've never reached any potential that I could have had… I am not saying that I would be anything, but I was never given the opportunity so I will never know.

Fiona also reflected on how seeing the researcher reminded her of a void that she experienced in her life. She compared herself to the researcher and stated:

Even seeing someone like you, and my niece, and nephew. They are at university and accomplished and they can do things and I look at them and think wow you don't know how lucky you are to have skipped a generation. It could have so easily been you and I could have so easily been you but look at you, you are flying.

This sense of loss and sadness appears to be perpetuated for Fiona when she compares her experiences and opportunities to other peoples' experiences and opportunities. This comparison was also reflected on by Ashley:

I kind of see friends whose moms are very involved and my mom is not. She's there but she is not actively involved with my girls or my life. It has kind of always been about her life and what is happening to her all the time and she would often phone and be talking about whatever happened in her week, but she will never ask me how I am.

This experience is also described by Ashley above when she reflected on how her mother seldom asked her how she is doing. She experienced her mother as being turned inward to her own life, rather than being actively involved in Ashley's life. A similar sense of loss and sadness was shared by Josie where she felt as if she could not share her difficulties and feel supported by her mother. Rather, Josie described being acutely aware of what was happening with her mother which resulted in a loss of several experiences which are reflected on below:

So I'm not looked after, and phoning home doesn't help because I'm trying to read through every conversation. So where all of my friends would phone home and say that this was awful, or I think that I was doing badly in maths, or whatever and their parents would be able to build them up. That can't really happen when you are trying to read through the sub text of that. Um so I just found it a very unrooting experience where I had nothing to grasp onto.

Josie reflected on how she does not feel looked after in her life. This is a loss for her in comparison to how she views her friends' relationships with their mothers. For Josie she said that she experienced this as "*unrooting*", similar to how Angela felt as if there was a "*missing trunk to a tree*". This speaks to how these participants felt rudderless and uncared for, at times, which was a monumental loss for them in their lives.

4.3.3. Emotional distance

Four participants reflected on how they experienced their relationship with their mother as emotionally distant. This emotional distance was often a conscious decision made in adulthood when the participants felt as if they had their own lives to live. Ashley reflected on how she took a step back from her mother (in many ways) when she became older which is explained below:

You distance yourself emotionally, you can't fix it for them, and I used to take it I suppose more sensitively and more personally, but I think you can't. You just wouldn't cope. I have got my own life, my own children, husband a home…I just switch off. I think I do switch off and I keep a distance. I am there physically and verbally but emotionally I think that I disconnect.

As was mentioned earlier, the above quotation highlights how Ashley became less emotionally invested in trying to fix her mother which came about through age, her experiences and her own developmental position which required her own navigation of milestones. Ashley explains how she was navigating a different developmental life task as an adult woman and thus she needed to establish an appropriate balance between autonomy as an independent person while maintaining certain connections within her family (Arnett, 2000; Stein et al., 1998, Mortimer, 2012). However, this was difficult for Josie to do as she reflects on this below:

> *It's quite interesting realising. Becoming aware of patterns of co-dependence and realising that and trying to create boundaries but still have the same relationship because you can't really just say, well I mean actually you could, say this is not healthy I'm out, I want to live my life. And I don't want to do that because we do enjoy each other's company and we do have a lot of fun doing things together and we add to each other's life.*

Josie reflects on her increasing awareness of what feels to her to be an internal predicament. Josie feels that she wants to set an emotional boundary with her mother, but another part of her fears that the relationship will not be the same. It seems that Josie may fear hurting her mother if she creates interpersonal boundaries in relation to her. Thus, she seems trapped by these ambivalent feelings.

Angela seemed to feel less ambivalent. She discussed her need to create emotional distance with her mom, as a way of protecting herself. Angela uses a simile as a way to describe this:

> *How I like to explain it to people is that like I made a capital investment with my mom, I put in this much of my heart if you want to call it that and whether she is, you know, telling me that I am the best thing that has ever happened to her. Or, as she has done before, calling down God to destroy me. It can go either way, my investment is the same. That's the only way I can sort of manage the relationship.*

Angela's quotation highlights how she has made an active decision to invest a certain amount of her heart into her relationship with her mother. This investment is independent from the mood and behaviours her mother. The use of an economic simile seems to indicate an emotional barrier between Angela and her mother. Implicit in her simile is a transaction that is logical, numbered, and calculated rather than being emotional, fluid and intimate. Angela's investment

of time and effort with her mother formed an emotional barrier which protected her from further disappointment.

Mandy and Michelle both reflected on their lack of emotional intimacy in their relationships with their mothers. Much like Angela, Mandy reported being very selective about what information she shares with her mother and what parts of herself she shows to her mother. Mandy reflects on how she could not share her thoughts spontaneously and in an unfiltered manner with her mother in the quotation below:

> *So the relationship is very "oppervlakkig"* [Afrikaans word for superficial] *what's the word it's not deep. It's not a deep relationship. I don't share with her my hurts and my pains. I share only with her my triumphs the only good things in my life great things. Only good things about my husband. So I keep everything light there is not that depth element, you know. Some people have a relationship with their mother where they share their dreams visions deepest darkest parts. I don't do that at all, you know. I tell her about my dogs because she loves animals and I'll tell her about my son and my studies and good things. I won't burden her with anything that I think she can't handle.*

Mandy only shares the parts of herself that she thinks that her mother wants to see which included her triumphs and good things relating to her relationships. She does not feel that she can share the deepest, darkest parts of herself which creates a psychological boundary and therefore impacts the emotional depth of the mother-daughter relationship. Mandy's implementation of this psychological boundary seems not only to be a means of protecting herself from further hurt and disappointment. Mandy appears to also want to protect her mother from being overwhelmed by emotions. In Trondsen's (2012) research, the participants expressed a desire to physically move away from their mothers – whether this be move out of the house, or move to a different location. In this research, participants had a desire to move away from their mothers psychologically by creating psychological barriers which formed emotional distance. This could have been their way to protect themselves against further emotional pain and feelings of disappointment but also as a way to protect their mothers from being stirred up emotionally.

4.4. Navigating different dimensions of a woman's identity

All of the participants described different ways that their experiences of growing up with a severely mentally ill mother has impacted the way that they navigate the different dimensions of their identity as women. The different facets relating to the participants identity as women,

that are elaborated on in this theme include: the perception of self, the female body and being a mother. All of the participants also described the importance of having other women in their families to turn to who compensated to some extent, for a lack of maternal experience. This will be the final subtheme.

4.4.1. Perception of self

While Brown and Roberts (2000) refer to the impact of maternal mental illness on the developing sense of self, three participants reflected on how they felt as if their experience of growing up with a mentally ill mother informed the lens through which they perceive themselves. Angela reflected on how she was "*very aware that [she] was not worth [her] mother's time*". This made Angela feel unworthy and unvalued by her mother, which in turn impacted her own self-worth. Angela stated:

> *It is difficult for a girl to know her value. We have had a big struggle to do that and when you have a mentally disabled mom, it is even worse. Because she doesn't value herself and she doesn't in turn, well her behaviour doesn't show that I am valued to her.*

Angela reflects on the affective intercommunications between mother and child, and how this can rapidly become elaborated into self, other and self-with-other representations (Bernstein, 2004). Angela felt as if it was a challenge for her to know her value because of two different, and perhaps interlinked reasons. Firstly, she reflects on how she did experience her mother to be someone that valued herself which may not have provided her with a role model of someone who is able to think kindly about themselves. Secondly, Angela also felt as if her mother did not show her that she was an important person and she did not feel cherished by her mother. This might have made Angela feel quite worthless and unseen by her mother, which may have negatively impacted her level of self-esteem. Angela's experience of linking her relationship with her mother to the development of self-esteem is also documented in literature (Arroyo et al., 2018; Maor, 2012;Maor and Cwikel, 2016).

Angela's reflection on how her experiences with her relationship with her mother impacted the way that she perceives herself could also be understood through the psychoanalytic theory of identification. Pathological identification is when a person unconsciously repeats or re-enacts something that someone significant in their lives often did. For example, Angela is repeating a pattern of behaviour that was exhibited by her mother (Foreman, 2016). Like her mother,

Angela also finds it difficult to know her value in the world. This process of identification is often an under recognised cause of pathological behaviours (Foreman, 2016).

Mandy reflected on a similar experience of how she felt as if her mother's poor self-esteem influenced her perception of self. She stated:

> *It brought my self-esteem down a lot. My mom doesn't have good self-esteem and I don't want to say that that rubbed off but with everything else going on in her life and her behaviour it definitely did. There's something that she projected onto her children you know?*

In a sense, there was sublimation of shared reality with Angela and Mandy as they both felt as if their mother's self-esteem impacted their own self-esteem. This too could be an example of identification. Daughters growing up with mentally ill mothers have reflected low self-esteem across literature (Hammen et al., 1990; Usmiani & Daniluk 1997; Williams & Corrigan, 1992). Not only did Angela feel as if she lacked a role model on how to love yourself, but so too did Angela feel as if she "*did not have a role model of what it is to be a woman who is valued*". She stated:

> *The role model of my mom was so sort of opaque, it just wasn't one. I had no idea what it meant to be a woman or to be self-assured.*

From the above quotation, Angela states that she did not receive input, advice, or have a role model for what it meant to be a woman in the world. The word "*opaque*" used by Angela reiterates the sense of clouded confusion around what her perception is about what it means to be a woman. There were seemingly no reciprocal experiences between mother-and daughter – that could have helped Angela feel less confused about being and becoming a woman. Rather, Angela felt as if she had to find herself as a woman on her own. This relates to Chodorow (1995) who argues that a woman's identity is very tied up to what they internalise femininity to be as their mother. Chodorow (1995) states that feminine identification is based on a gradual way of learning through observing and identifying with their mother. However, Angela felt as if she did not get any feedback from her mother in relation to her feminine identity, which, according to Chodorow (1995), can impact the development of self and result in poor self-esteem.

In relation to perception of self-worth, Fiona reflects on how she does not take care of herself as a woman. She does not spoil herself, or pamper herself. She tries to make herself as small

as possible in the world, out of a fear of being a burden to her mother (and her family more broadly) financially. She also reflected on how she tried to eat as little as possible, as she was very conscious about how much she was "*costing*" her family. She feels as if she only deserved the bare minimum. Fiona stated:

> *I don't take care of myself, sorry I know you don't have makeup on at the moment but I never wear make-up. I had my hair done the other day because it's like really needed to be done but I will literally wear clothes until they fall off my back. I have never had my nails done. No, it's just, I don't even know why I'm here sort of thing.*

Fiona further stated how she felt as if she was "*always just a job*" or "*just another mouth to feed*". She views herself as easily dispensable and thus tries to make as little demands as possible on the environment. She tries to compensate for her low self-worth by literally ensuring that she does not "*cost*" the world too much. This emphasises her poor sense of self-worth and it also highlights self-deprivation. Fiona may have internalised such a sense of internal badness (Klein, 1946) to the extent of neglecting herself in an attempt to try and repair what she feels she might have caused in the past. Given Fiona's poor attachment with her mother, this might have also impacted her gender identity formation, self-esteem and self-image which is something that Usmiani & Daniluk, (1997) allude to.

4.4.2. The female body

This sub theme relates to aspects of the female body including sexual development and weight. Three participants reflected on how their mothers did not guide them when it came to sexual development as women. Ashley, with disappointment, reflects this:

> *She never played a supportive role growing up so I think I had to find myself completely as a woman […] Ya, she was definitely not there for me at all. I got a book, and that was that and I just got on with life, so I had no emotional support or anything.*

This above quotation highlights how Ashley did not feel as if her mother was attuned to her emotional needs in regard to her psychosexual development. This is reiterated by the fact that she said "*I got a book and that was that*". Ashley felt as if her mother transferred some responsibility inherent in motherhood to another source of guidance, rather than her mother spending time with her to speak about and guide in her development as a female. This experience was also shared by Angela:

It was first of all not having like a sort of any kind of guidance, I had no guidance when it came to sex, when it came to boys, when it came to love. I had zero idea about what was right…But like, I think it always comes back to lack of ability to give attention that I sort of needed.

Angela reflected on how she felt as if her mother was not there to guide her through her sexuality and romantic relationships. She said that when her mother moved out of the house, she felt even more lost in this regard because she felt as if she wanted to be seen, but the males in the house did not have the capacity to see her in the way that she desired. She felt as if she had to find her own way when it came to her sexuality and romantic relationships. Angela also reflected on how she struggled with body issues as a woman, and how her mother placed emphasis on her weight as a female rather than who she was internally. Angela believed that this experience impacted how she views her female body. She stated:

I would say in the area of me being comfortable with my body her illness really, really, really had a huge impact on that because from a young age I was concerned with my body, how I looked, how big or small I was, um and I suppose in turn what people thought about that. Like you must be sort of be good looking you know it was always about looks. I don't remember my mom ever talking to me about having inner value, how that is more important.

It is interesting how Angela experienced her mother as being emotionally absent in some areas of her developing feminine identity (such as being attuned to her sexual developmental needs) yet placed emphasis on other areas (such as her external appearance, especially in regard to bodily weight and shape). Angela felt as if her mother placed emphasis on the 'wrong' aspects of her feminine identity. This experience might have had a direct influence on the way that Angela perceives her body. This is aligned with research about the impact of the mother-daughter relationship on a daughter's body image. Ogle and Damhorst (2003) note that mothers assert a lot of influence on their daughters appearance and appearance related behaviours. Angela said that she has always been very conscious of her weight and has had some difficulties feeling comfortable in her own skin. Angela reflects on some of her difficulties with her weight in the below quotation:

I would like scrutinise myself, and you sort of hate yourself for being who you are and it's just your shape. I never been overweight or unhealthy as such, but there have been serious periods where you know you look at your body and like I hate this encasing.

It's such a dangerous place, because you can't hate your body. It's your body, It's yours, you know, it takes up space. It is your instrument and your functionality it is just who you are. And to hate that is such a hard binary to deal with. And I would definitely relate it to mother daughter relationship I think that is where it stems from.

Angela further reflected on how she can remember observing her mother engaging in some compensatory behaviours. Although, her mother was not officially diagnosed with an eating disorder. In a way, it might be that Angela's mother passed on values about her body shape and weight concerns onto Angela, which is documented in literature (All Sabbah et al., 2009; Arroyo, Southard, Cohen, & Caban, 2018; Shawler, 2007; Waterhouse, 1997). Angela reflects on a memory of seeing her mom engage in compensatory behaviours below:

Um like I have vivid memories of walking into her room and seeing her making herself sick and then she wouldn't, it was never addressed after that. She would just shout at me and be like "get out of here Angela" and I would run out, but it was never, ya it was never spoken about maybe she wanted to pretend that it never happened.

It is likely that seeing her mother engaging in activities to try and make herself thinner may have indicated to Angela that her mother did not love her body. For Angela, her mother communicated about body image concerns both directly (by being critical about her weight) and indirectly (her mothers' dieting and weight management strategies) (All Sabbah et al., 2009; Arroyo et al., 2018). Angela did not feel as if she grew up in an environment where it was encouraged to love her body which has negatively impacted the way that she feels about her body shape. This is aligned with Arroyo and colleagues (2018) and Waterhouse (1997) who note that mothers who raise children to believe that they should love and respect their bodies are more likely to be critical of the broader culture of thinness and feel happier in their encasing.

As was the case with Angela, Mandy also felt that her mother placed more value on external appearances rather than what Mandy was experiencing internally. Mandy also experienced her mother as being weight obsessed which impacted the way that Mandy felt about her own feminine body. This is aligned with the literature that suggests that a mother-daughter relationship is one of the most significant socio-cultural factors that is associated with a woman's body image (Maor & Cwiker, 2016; Shawler, 2007; Waterhouse, 1997). Mandy reflects on this experience below:

Until today there is still a lot of conditional love that I get from my mother…If you gain weight she will tell you that she's ashamed of you, you know, things like that. It's really horrible my mom was extremely weight obsessed with herself and she projected that a lot onto my sister and I. She would always comment on the physical appearance and on weight and things.

In summary, three participants felt as if their mothers were absent when it came to guidance and support in regard to their psychosexual development. In as much as there was an absence in this area, two participants reflected on how their mothers overemphasised weight and focused attention only on the external appearance of the female body. They felt their mother had not been attuned to their developmental milestones as girls and then women, or their psychological and emotional needs.

4.4.3. Being a mother

Three of the participants had children of their own. These participants believe that growing up with a mentally ill mother has affected the ways that they mother their own children. Another participant, who does not have children, shared a similar thought. According to Bernstein (2004), themes of separation and loss are experienced in the most joyful times of a women's life; for example during pregnancy. Women often compare themselves to their mothers during this stage with a sense of rivalry, but also with a sense of empathy for their mothers (Bernstein, 2004). In relation to mothering, many participants highlight how they identify with their mother even as they assert differences to further delineate themselves as their own women which is also reflected on by Alvarez-Monjaras and colleagues (2019). Some women who often revisit their own experiences and memories of being parented when they were children when they become mothers themselves (Alvarez-Monjaras et al., 2019; Blum, 2017). Boyczy and colleagues (2003) also reported that it is common for daughters to reflect on their own experiences of childhood when they become mothers. This subtheme explores the ways in which the participants' experiences of growing up with a mentally ill mother may have influenced their own experiences of being mothers.

Ashley expressed how she feels that she is "*completely opposite* [as a mother] *with* [her] *girls*" when it comes to mothering. She wants to give her daughters a different experience than what she grew up with. However, there is a part of her that fears that she may become like her own mother and she became quite distressed at the thought. In the below quotation, she repeats the

words "*completely the opposite*" which reiterates how important this is for her and how hard she tries to give her daughters a different experience to what she had when she was a daughter:

> *I think I'm completely the opposite with my girls. So I've chosen to fight it and be completely the opposite. So I think you either go the same way, or not. I am so much more involved.*

Ashley has tried very hard to prevent some of her emotional difficulties from impacting her relationship with her daughters. She wants to be involved, present, active and engaged with her daughters. This is in complete opposite to Ashley's own experience as a child of a mentally ill mother.

Another layer of being involved with their own children's lives was reflected on Mandy. She reflected on how she wanted to be more attuned to her son's emotional needs. Mandy reflects on this below:

> *I am extremely aware of his needs especially emotionally. If he wants to cuddle with me for 10 minutes in the middle of doing something, I will leave it and cuddle with him you know. He's at daycare very long hours so when we're at home we give my attention undivided to him.*

Mandy believes that being emotionally attuned is important in her relationship with her son. She desires for a sense of emotional closeness to be fostered with her son. She wants to give her son undivided attention when she can. While on the one hand she may inadvertently overcompensate with her son, one might wonder if she might then experience some issues with this. She elaborates on how her experience of being mothered impacted her as a mother:

> *I try to be as stable and as predictable as possible you know so it definitely had a great influence on me as a mother. I'm trying to not repeat, let the cycle repeat itself […] I want him to have the emotional stability I want him to experience that no matter what he does he is loved, he is accepted, because still up until today there is still a lot of conditional love that I get from my mother*.

Mandy's quote reflects that she wants her son to experience being loved unconditionally, as an attempt not to replicate her own experience. She acknowledged the intergenerational impact of having a mentally ill mother and much like Ashley, wanted to stop this cycle from repeating itself. With acknowledging the intergenerational impact of parenting, Angela's reluctance to have children might be born out of fear. She reflects on how people should engage in a thoughtful process before having a child. She reflected on different aspects of thought:

I am not sure if I should have children. I have always wanted a family, I always wanted children but I'm not willing to do it if I don't think that I am strong enough and capable enough to make that child love itself for its entire life. Because I don't want to bring a human into the world who has the thoughts that I have had in my life.

Angela is also not a mother herself. She reflected that she wants to make sure that she is in the right mental state to be able to bring up a child. She wants to be "*strong enough and capable enough*" which is probably the opposite of how she experienced her mother to be. Despite four participants emphasising that they wanted to be different from their own mothers, Fiona is acutely aware of how her agoraphobia has impacted her relationship with her children. She expressed guilt, frustration and disappointment in herself for being a mentally ill mother herself and perpetuating the cycle. She reflected with distress and sadness on her current difficulties of being a mother who is also mentally ill.

I think that the wheels have fallen off now because the Agoraphobia. I can't take them anywhere. I can't teach my daughter how to drive things that I should be doing as a mother. I can't it's not that I don't want to, but I just can't. So I have been a little bit distant I'm not as plugged in as I should be as compassionate as I should be.

Fiona's wishes to raise her children "*differently*" and she wants her children to feel that they can "*talk about anything that they want to talk about*". However, Fiona is acutely aware of how her mental illness sometimes gets in the way of being able to be the mother that she wishes that she could be for her children. It is likely to be extremely painful for Fiona to think about how her own mental illness impacts her relationship with her own children. She reflects on how limiting her agoraphobia is for her and how often prevents her from being able to engage fully with her children. Fiona also reflected, with sadness, about how being housebound has resulted in her missing out on a lot of her children's school functions and sport activities.

The material in this sub-theme echoes the findings of Brown and Roberts (2000) and Dunn (1993). Both of these research studies highlighted how participants feared that they would become like their mothers. Kadish (2015) also alluded to participants' fear of becoming mentally ill mothers. Participants in this research study reflected on how being a good mother made them realise the pain of their own childhood deficits, putting them in touch with how much they had missed out on as children which is reflected on in the literature (Boyczy et al., 2003). It is thus not surprising that out of their own anticipation and distress, participants in this research study wanted to give the opposite experience to their children in terms of

mothering. Furthermore, the participants experiences may highlight how their experiences of being a mother themselves is influenced by their integration of their past experiences.

4.5.Other caretaking figures

This theme relates to participants' experiences of interacting with other caretaking figures, such as their fathers and others in their family. The first subtheme that will be discussed will relate to the role that the father played for the participants when they were growing up with a severely mentally ill mother. Secondly, the subtheme of turning to other women in their family for support will be discussed.

4.5.1. The role that fathers played

Five of the participants reflected on the role of their fathers played within their family contexts. However, one participant did not mention her father in the interview. The way in which the participants spoke about their fathers differed, but there were some common experiences reported by the participants in relation to their fathers. Ashley was the only participant who said that she was extremely close to her father, and that this was the case for as long as she could remember. Ashley's parents got divorced when she was in junior school, and she opted to spend as much time as she could with her father after the divorce. This might indicate how maternal mental illness had an impact on her family system more broadly. This is aligned with literature that stipulates that family conflict is commonly reported in families with parents who have mental illness Allen-Meares, Blazevski, Bybee, Oyserman, 2010; Dunn, 1993; Engur, 2017; Gladstone et al., 2006; Mowbray et al., 2006)

However, Ashley noted that this stood in contrast to her brother who wanted to stay with their mother, and he became very angry with his father about the divorce. Ashley reflects on her relationship with her father below:

> *I am much closer to my dad strangely, maybe because he is more stable mentally because I can depend on him more.*

Ashley attributes her closeness to her father because she experienced him as more stable mentally. It is likely that this would have impacted her attachment pattern, as she may have felt as if he was a consistent and predictable caregiver, thus he may have helped her develop a secure attachment. Ashley's relationship with her father would thus have had a healthy effect on her as she was likely able to have a pro-developmental parental relationship with him. It appears that despite not living with her father after her parents got divorced, Ashley maintained

a sense of closeness with her father. The physical proximity did not seem to have a negative impact on her relational bond with her father. Ashley reflected on having a 'good enough' father which is very important for developmental navigation and is likely to have been a protective buffer for her in her life. This relates to research that suggests that having one healthy parent or caregiver available during childhood is a resilience enhancing factor (Beardslee et al., 1998; Kadish, 2015).

However, the other four participants who reflected on their relationships with their fathers did not report the same sort of good relationship that Ashley did. These four participants reflected on how their fathers were emotionally absent, irrespective of whether they were physically present in the house or not. This experience is reflected on in the literature as there are higher rates of divorce and separation in families with parents who are mentally ill (Allen-Meares, Blazevski, Bybee, Oyserman, 2010; Dunn, 1993; Engur, 2017; Gladstone et al., 2006; Mowbray et al., 2006; Oyserman et al., 2000). Josie's parents separated when she was in junior school and her father then passed away shortly thereafter. Josie did not feel as if her father was there to support her through her experiences of growing up with a mentally ill mother:

> *My father was very absent. Physically present but emotionally absent. Um he would work during the night and sleep during the day, so we would literally never engage with him.*

Josie's quotation illustrates how when her father was still physically present in her life, she did not experience him to be available on an emotional level. Josie reflected on her father's gruelling work patterns when he used to still live at their home. When she was awake, her father would be sleeping and when he was sleeping, she would be awake. Josie almost experienced a double loss in the sense of losing both an emotionally attuned mother and father. Angela expressed a similar experience of not spending a lot of time with her father as he worked extremely hard. She reflected on how she too did not experience her father as being present in her life:

> *My dad also was totally not present, he was just working too hard. And I had to deal with things with him as well, but that's not for this.*

Angela did not specify whether she felt as if her father was physically and/or emotionally absent. However, it is likely that Angela experienced her father as being absent in both spheres. During her interview she could also reflect on memories of her father sleeping at his office and

of him spending a lot of time at his office. Angela's quotation also explicitly implies that she had some difficulties in her relationship with her father but she did not want to elaborate on them. Angela's parents also got divorced when she was around the age of 12. Angela lived with her father post-divorce as her mother was declared unfit by the courts to take custody of the children. However, it seems like Angela experienced her father to be extremely invested in and distracted by his work, so much so that he sometimes forgot to tell Angela and her siblings about what was happening with the divorce, and also about what was going on with their mentally ill mother. She reflects on one of these occasions below:

> *This is so testament who my father is. I didn't actually know that I was going to court that day. Um, I think my dad just had so much going on. But it is not an excuse.*

In a way, it seems as if Angela's father was also finding ways to cope with the difficulties of the divorce by plunging himself into his work. Angela experienced her father as extremely work orientated which might have impacted her father's emotional proximity and his ability to be attuned to the needs of his children. Angela did not feel as if her father supported her and helped her make sense of what was happening with her mother and with her parents' divorce.

Mandy also experienced her father as being emotionally absent. Although this appeared to be for different reasons to Josie and Angela. She reflects on this in the statement below:

> *My father is an awesome person but emotionally closed off. You can't say anything bad my dad can't deal with that. He is a super big Christian, you know. You can't say anything bad about your neighbour.*

Mandy felt as if some of her father's values and ideals prevented him from speaking about the difficult things that were happening at home and about some of her difficult emotions. This might have been experienced as being quite a barrier in her relationship with her father which might have facilitated emotional distance. Ashley and Fiona also reflected on how they did not speak about their mothers mental illness with their fathers, or about any of their emotional difficulties for that matter. Ashley reflects on this:

> *My dad even, he has never really spoke about her depression as such like that. I think maybe everybody didn't want to accept it.*

This implies that even though Ashley and her father were very close, they were not able to be fully open with each other. This also might have been their way of trying to avoid reality. It feels as if so much was not said between Ashley and her father. It was maybe too scary and difficult for them both to accept that someone that they loved was severely mentally ill. This experience was also reflected on by Angela and Mandy as their fathers did not explain to these participants about mental illness. Fiona did not speak to her father (or her mother) about her experiences or emotions. She stated:

> *I've never really confronted them about it but I don't think that my mom and dad know the extent of what my brother and I went through.*

There appears to be some underlying anger from Fiona towards both of her parents in this quotation above. Fiona did not experience her father as being aware of the impact that her mentally ill mother had on the entire family system. She was left to handle and navigate her difficult experiences on her own and she has not been able to express how she truly feels with either of her parents. This experience was also reflected on by three of the participants, as they did not feel that their fathers were able to be open about the reality of their mother's mental illness and the participants did not reflect on the experience of having their fathers explain to them about maternal mental illness.

4.5.2. Turning to other members in the family for support

Three participants reflected on how they sought guidance and emotional support from other women in their families as a way to compensate from what they lacked from their own mothers. There did not seem to be other male caregiving figures such as uncles, or grandfathers that were referred to by the participants. Mandy expressed value and appreciation for having the experience of a supporting and validating grandmother:

> *The one person who was a great support was my grandmother. She was my mom's mom. She was extremely loving and supporting. She would always say it's ok you can cry when you are with me because she knew that when we were with my mom crying was not an option. Just being a normal child was not an option. So I think my grandmother knew how my mom was so she kind of tried to make up for that you know, to compensate*.

Mandy's quotation highlights how she found the experience of having a grandmother to turn to when she was in need of comfort and support extremely helpful. Mandy reflects on how she could be a child who was in need of affection with her grandmother rather than being

parentified. She could express how she was truly feeling on the inside with her grandmother, rather than trying to keep all of her difficult emotions and feelings hidden from sight from her mother. She had the experience of being able to truly express how she was feeling with her grandmother. In the presence of these family members their true self could be safely expressed rather than having to present as compliant and take the responsibility for their mothers (Mordoch & Hall, 2008; Winnicott, 1960). It was as also as if Mandy experienced her grandmother as a container, to contain her very difficult emotions that she felt that she could not always show her mother (Bion, 1962). The fact that she used one person reiterates her feelings of lack of support from others but it also speaks to a sense of relief that she did not need to go through the experience entirely alone. This experience is considered to be a protective factor because having someone else to act as a supportive system has the potential to override some of the effects of deficits in maternal functioning and symptoms relating to severe mental illness (Kadish, 2015; Oyserman et al., 2000, Perera et al., 2014).

Similarly, Michelle felt grateful that her maternal grandmother was living with her in the house and she experienced her maternal grandmother as being the second mother in the house. She experienced her grandmother as taking on the role of the mother. Michelle further reflects on the support that she received from her maternal grandmother:

> *I had a fantastic grandmother, and she lived with us while I was growing up so she was kind of like the second mother in the house. So even though I didn't have a great relationship with my mom and I didn't understand what was going on, I had a spectacular relationship with my grandmother and she was the one who really you know supported us*.

For what she had lost in the relationship with her mother, Michelle felt that her grandmother was like a mother to her, and fulfilled this role for her family. She reported feeling supported and taken care of by her grandmother. It seems that Angela turned to other females in the family out of a desire to look for role models, support and maternal figures that she craved. She was very fortunate that these existed for her. There also might have been an experience of relief that she could be a grandchild to her grandmother, rather than the experience with their mother where she had to be the parentified child. It is reported in literature that children who grow up with mentally ill mothers find great comfort in being able to listened to and care for by other family members (Duncan & Browning, 2005; Mordoch and Hall; 2008; Williams, 1998).

Angela also emphasised the importance of having the support of her maternal grandmother. However, it seems that Angela found support from various "*strong women*" in her family which

influenced her development. Her emphasis on the word strong highlights how she perceived them, and considered them in comparison to her mother, who was really struggling. Angela speaks more broadly of how her father turned to other family members to seek advice, which was an overall supportive structure for her. She reflected on this below:

> *The women in my family are all very strong women and I think that is why I have been able to sort of, become who I am now… looking back and seeing there were strong women around me and I think that if they weren't there I wouldn't have made the decision to do the things that I have done… But [my father] he pushed me and he took advice from those strong women about what to do within the family unit which was really important*.

Both Angela and her father found support from other women in the family. Three participants expressed how they found the experience of being able to turn to other women in their family comforting. However, Fiona never mentioned her grandmothers or any other women that she could turn to in her family for care, comfort and/or support. Fiona did not speak about any experiences of having other caregivers as a child and this might be why she struggles so much now. Unfortunately, she seems not to have accessed sufficient containment from any of her family members. This would not bode well developmentally. Indeed, out of all of the participants, Fiona seems to be suffering the most at present with her own psychiatric symptoms. However, linear cause and effect explanations should never be made in any categorical way. Development is highly complex and multi-layered.

Josie felt as if she could not turn to her grandmother, despite her being just down the road. Josie stated that her maternal grandmother was "*prim and proper*" and "*pretended that nothing was going on*". Both Fiona and Josie experienced no support from other women in the family and both participants reflected on how they felt completely alone, with no one to support them through the experience of growing up with a mentally ill mother. It appears that three participants were able to acknowledge the important role that one or more mentally healthy women had in their lives which provided at least some compensatory responses or experiences of secure attachment (Duncan & Browning, 2005). The importance of family members being available for support was also perceived as being very important by participants in Williams (1998) research.

4.6.Coping through control

All of the participants reported different coping mechanisms to help them handle their inner emotional turmoil and other environmental challenges. A common thread amongst four of the

participants' was the coping mechanism of control. Attempting to take control of their lives in a driven way, appeared to be a means through which the participants felt they could gain mastery of chaotic and unpredictable feelings and experiences. This is also reflected in literature (Gladstone et al., 2006; Mordach & Hall, 2007; Williams, 1998).

An example of this can be seen in the reflections of four of the participants, on their academic achievements. While Gladstone and colleagues (2006) referred to findings that children of mentally ill mothers may be over achievers, they did not specify that this was specifically in relation to academia. Despite the participants' external challenges and internal turmoil, they had well developed intellect and functioned well academically. Josie said that she was doing "*15 to 20% better than the next person in the school*", Maxine said that she did "*extremely well at school*". Angela stated similarly:

> *I liked being clever, I guess, I wasn't top of the class or anything, But I was an A student with work and I actually won a trophy in the final year in matric called the brave heart trophy and it's basically given to a girl through adversity was still able to succeed.*

Angela's quotation highlights how she enjoyed being clever. This indicates how academic success provided a form of recognition for Angela which she might not have received at home. Winning a trophy called 'Brave Heart' is literally a trophy that acknowledged that she was able to succeed despite adversity. This may attest to the extent of Angela's determination and investment in succeeding. Her academic prowess provided a means through which she could feel that she was coping, and this may arguably have provided a means to feel she was in control of her life, something she was desperately seeking. It also provided her with academic validation, but this might not have been the kind of validation she was truly wishing for. It could be that Angela really wanted to be validated by her mother. It is not uncommon for children who grow up in families that are characterised by high levels of conflict to be overachievers. Research attributes this to different reasons and it appears that overachievement in academia was also driven by different reasons for the participants in this research study. For example, Pacht (1984) suggests that children of mentally ill mothers may be propelled towards trying to find some sort of competency in a world that feels scary and overwhelming, Sorotzkin (1985) suggests that some children might turn to something that they are good at and put a lot of energy into this as a means to defend against some intrapsychic conflict relating to guilt and/or hostility. Stolorow & Lachman (1980) postulate that children often are overachievers because they want to avoid humiliation and to be recognised as valuable by other people.

Josie also reflected on how she used academics as a coping mechanism in the quotation below:

> *Ya, so I mean [*academia*] has always been my coping mechanism ... So I was consistently in a sense over achieving academically and achieving more than I needed to, so I could not have actually had fun. But to me that was, and I would really overdo it and there were diagrams all over the wall and it was like a wallpaper of it. I would rewrite notes obsessively, whole way through undergrad I would do the same and by the way, I got my PhD at 26 I mean that's not normal.*

Josie's relationship with her mother appears to have provoked severe anxiety. In the above quotation, Josie reflects on how she could get consumed by and totally caught up in her academic work which has been a coping mechanism for her since she was a young child. She has an understanding about the way this serves a defensive purpose against difficult emotions from within her inner world which felt desperately out of control.

This over-investment in her studies hindered her at another level as she indicated that her emphasis on academic work often prevented her from having fun. Her re-writing of notes to such an extent that they became like wallpaper in her room is a striking example of this. Josie further reflected:

> *The things that I did don't even look like coping mechanisms to the outside world because nobody looks at somebody who is achieving well, and says, oh they are just coping. You would look at somebody who is self-harming and that that's a coping mechanism*.

The above quotation indicates that Josie felt that her means of coping would sometimes prevent others from seeing her internal emotional turmoil. Josie did not only desire to be in control of her studies. She expressed wanting to be in control of many spheres of her life including her relationships and her future. She stated:

> *Maybe it's about control. I always wanted to control my future. I always saw life as temporary in whatever phase you in and I wanted to control my future. And I think being future-oriented also helps because you can't ever get caught up in the present you are always looking to the future*.

Implicit in Josie's quotation is that planning and trying to be in control of her future is less daunting than acknowledging the reality of the present which could be too painful for her. It seems that she would rather try and take control of her future than live in the present. She also

seems terrified of finding herself in a present that resembles her unpredictable and uncertain childhood. Angela also reflected on how ballet, which relates to the physical control of her body, provided her with a helpful means of coping. It is interesting that she decided to engage in a hobby that often required her to look at herself in the mirror when she was so acutely aware of her weight. Angela reflected on the importance of ballet in her life in the quotation below:

> *Ballet for me was something that I knew, something that I was good at, and it was I guess a distraction. Because when I was there you had to work hard, you know you have to dance I danced a lot. Two or three hours a day, five or six days a week.*

While on the one hand ballet provided a means of control, predictability of movement in relation to dance routines and a sense of mastery; it also might have tapped into Angela's desire to be in control of her body, weight and shape. Angela also reflected on the importance of daily routine and having a controlled daily structure in her life in the quotation below:

> A*nd although there was like shit flying everywhere and my mom was insane, and I knew that I had routine.*

The quotation above illustrates the way that routine provided comfort for her, against the external chaos that surrounded her. This relates to a desire to try to generate predictability in her life. This is attempted though the concrete control of developing a daily routine. As mentioned previously, Fiona has been diagnosed with agoraphobia. As a result, she avoids situations where she thinks that she will not be able to escape from or find help. This might also be her way of trying to control her environment which is driven by a deep fear of feeling out of control. She stated:

> *I got agoraphobia because constantly waiting for something terrible to happen and imminent death, and not being able to I know that nobody can do anything to stop an accident or death but it was drummed into me from that and I just I can't move I'm crippled you know.*

She elaborated:

> *I can remember the day when I realised that there was something wrong with me. I was 8 and my dad had booked a really cheap holiday in Majorca which is just off Spain. And I was 8 and I didn't want to go. I was so afraid of being on the aeroplane, and like what do the people drive like in Spain, and not wanting to go…I realised that this isn't right. You should be jumping up and down with excitement, not too afraid to move. And*

that's when I knew I didn't know what the word was but I was like no there's something wrong.

Fiona's statement highlights how she lives with constant anticipated anxiety. She tries to control the environment as much as she can to make her life feel less overwhelming and more manageable. She reflects on how she thinks that this was as a result of some of her mothers' psychotic behaviour. Her agoraphobia may have been driven by a deep desire of wanting to be in control and triggered by the terror of the thought of what might happen if someone else is in control.

Ashley also stated that she liked to be in control. This, together with her strong faith helped her through difficult times. Ashley reflects on this below:

Umm I have quite a strong character, I do have a dominant, I like to be in control. I have a very strong faith so those are the things that have helped. Ummm and I think it's just it is what it is. We've accepted it and just deal with that and go on. But I don't know if I have any characteristics, maybe it is just luck that I am strong in myself and I think it could have gone the other way.

Implicit in this quotation is that she feels that being in control protected her from "*go[ing] the other way*". This could refer to her not engaging in rebellious activities in order to try and cope with her emotional difficulties. Being in control of the way in which she handled her emotions was a protective shield for Ashley. It was important for her to be the good daughter, rather than engaging in, what she perceived to be, unhealthy coping mechanisms. Josie also reflected on trying to be in of control in her hobbies in such a way to help her transfer some of her difficult emotions in healthier channels. She said that her controlled behaviour resulted in a "*less risky life*" and prevented her from engaging in drugs and alcohol. Angela also reflects on this experience below:

I was always trying to be good and well behaved. And that really served me because it saved me from, you know, going off the rails and getting into drugs and going with the wrong people. It saved me but that's my temperament. I don't know where it came from. I don't really understand how temperament evolves. But that is innately it's my essence to be that way and I am very lucky for it.

Angela also reflects on her similar experience of trying to be the good daughter who was always well behaved. On the surface level this speaks to her desire to be in control of her behaviour and to be in control of the way in which she coped with her emotional difficulties. She feels

that this protected her from turning to unhealthy coping mechanisms. However, on a deeper level her desire to be the good daughter may have been an unconscious way of trying to be as well behaved as possible which was driven from an innate fear that she might have been inherently bad (Klein, 1946). She may have an unconscious fear that she caused her mothers' mental illness and thus strives to be the perfect child as a means of trying to repair something with her mother which she may blame herself for which is an experience that is also documented in literature by other children growing up with mentally ill mothers (Cogan et al., 2005; Dunn, 1993 & Garley et al., 1997).

4.7.Behind closed doors

Evident within the participants' narratives were feelings of shame and a desire to keep their home lives private and separate from their interpersonal relationships. All of the participants reflected on how they had to keep their experiences and emotions 'behind closed doors'. It was almost as if they had to shut off and hide different parts of themselves out of fear of being exposed or judged. This was attributed to the stigma surrounding mental illness which is very prevalent in literature (Cogan et al., 2005; Dunn, 1993; Knutsson-Medin, 2007; Gladstone et al., 2006; May, 2017; Trondsen, 2012; Williams, 1998). The desire to keep things 'behind closed doors' appeared to be driven by a deep sense of shame which was also acknowledged by Knutsson-Medin's (2007). Angela reflected on how she was often embarrassed by her mother and that she was often anxious when her friends came over to her house because she feared that her mother could have an episode. Shame and stigma of mental illness for offspring of mentally ill parents is widely documented in literature (Cogan et al., 2005; Dunn, 1993; Knutsson-Medin, 2007; Gladstone et al., 2006; May, 2017; Trondsen, 2012; Williams, 1998). Kadish (2015) noted how participants felt embarrassed by their mothers inappropriate or chaotic behaviour which made them feel different from their peers. Similarly in Cogan et al's (2005) research, participants reported avoiding inviting friends over to visit after school out of fear that their friends might judge them or not understand their mother's mental illness. Angela reflects on her experience of shame below:

> *Ummm I was always very maybe all children feel this way, but I was always really embarrassed by my mom. She was really eccentric and super inappropriate a lot of the time um… Like I remember I had a sleep over I think, and like so little effort was put in. it was never like a happy party, it was always like oh shit my mother might explode.*

Later in her interview, Angela reflected on how she avoided asking friends over out of her fear that they would see a different side to her mother which could be both scary and out of control. This could also be linked to feelings of shame that Angela experienced, as she feared a perceived or actual reduction in her social rank within her friendships which is something that May (2017) also refers to. A deep sense of shame also impacted Josie's interpersonal relationships. She specifically alluded to her romantic relationships in her quotation below:

> *I would keep a lot of the people that I was dating away from my mother for long. I wouldn't let them engage too often or too much with her. And I would often very carefully look for signs of judgement and if they judged her I would react really badly.*

Josie speaks about how she would limit the amount of engagement time between her mother and her social circle. This is a similar experience reported by Angela as they both kept their interpersonal relationships at a distance from their mothers. Josie was also hypervigilant to "*signs of judgement*" from others towards her mother, which could have been formed by her awareness of a broader stigmatising attitude towards mental illness that is also reported in literature (Cogan et al., 2005; Dunn, 1993; Knutsson-Medin, 2007; Gladstone et al., 2006; May, 2017; Trondsen, 2012; Williams, 1998). It feels as if Josie was also very aware of any potential signs of judgement towards her too. The fact that both Angela and Josie wanted to lessen the interaction between their social interpersonal relationships and their mothers was their way of protecting themselves from perceived or inferred devaluation of their mothers, and by extension, judgement towards them as being daughters of mentally ill mothers.

For Josie, her experience of shame was embedded in the broader cultural norms surrounding mental illness. Ashley also reflected on this awareness of the stigma when she was growing up but she acknowledged that she feels as if the perception surrounding mental illness has shifted slightly since she was a child:

> *Yeah, maybe because no one wants to admit to these things. Or, you know, it wasn't an acceptable thing or a public thing to do, I think we were so closed publicly in those days….I think we were a much naiver in that aspect society and less open you lived your private little life and that's just how it was it was no body's business. Time has changed a lot.*

Ashley did not feel as if she was able to openly speak about her experiences and her painful emotions because she believed that was not the accepted norm of society at the time. Later in

the interview she stated: "*I kept very quiet about my life*". She also reflected on how she never spoke about her experiences of growing up with a mentally ill mother before doing so in the research interview. She reflected: "*I didn't share that at all. Not at all…it never came out*". Ashley may have feared being judged by others if she spoke about her experiences of growing up with a mentally ill mother. It appears that her silence surrounding the difficulties was deeply formed by broader beliefs regarding mental illnesses at the time. She felt that she had to keep her emotional difficulties private, hidden and away from sight. This served to be even more isolating, as she was left on her own to handle her emotional difficulties. This is a similar finding to Brokington and colleagies (2011) as participants in their research also did not share their experiences with their social networks but rather kept their family secrets with them which was painful. This cycle of hiding emotions and secrets has been perpetuated, to a certain extent, by Ashley in her own life despite her feeling that society is less stigmatising towards mental illness:

> *Yeah, I don't show that down's publicly, definitely not. I look completely fine on the outside, but I have had a terrible time, or I am really struggling emotionally or something. So I think I have learnt to hide it maybe because of what I lived through.*

Mandy also found it difficult to speak about her emotional difficulties owing to the societal beliefs at the time when she was growing up which contributed to her feeling as if she needed to keep her difficulties 'behind closed doors' and away from the public eye. However, she also feels as if society has become more accepting of mental illness currently:

> *I had such a cloud of shame over me. But I was definitely not going to speak out, you know. And I think nowadays, I think there is a bigger awareness of mental health in schools. So I think if I was a teenager in today's time it would have probably been picked up and somebody would have spoken out to me but not at that point.*

Mandy's narrative concurred with Angela and Ashley as she felt as if growing up with a mentally ill mother brought about a "*cloud of shame*". Mandy explains how she felt as if this shame was always with her, hanging over her like a cloud. This illustrates how being aware of societal beliefs and norms surrounding mental illness can be linked to feelings of shame which is reported in literature (Bonnie, 1993; Garley et al., 1997; Trondsen, 2012).

Michelle also reflected, with sadness, on the impact that keeping things private and the stigma surrounding mental illness had on her mother. She said:

No one was ever willing to acknowledge or recognise that it was more…it if was accepted it would have made a big difference in my mother's life.

When Michelle stated the words "*no one*", her experience was that no one was willing to speak about what was happening to her mother. Michelle felt as though it was too difficult for people to acknowledge or speak about her mothers' mental illness because of the societal norms surrounding mental illness at the time. This inhibiting silence prevented her mother from being able to access and receive adequate treatment. Not only would the acknowledgement have helped her mother, but there is a sense that Michelle believes that it could have helped her too. This is a similar finding to Cogan and colleagues (2005) study who found that the effect of concealing their mother's mental illness often resulted in individuals not seeking effective support. This experience was also reported in Garley and colleagues (2007) research as participants expressed how stigma acted like a barrier to help seeking and openness with networks which could have been helpful for them. The literature supports the idea that the fear of stigmatisation can be a barrier to help-seeking behaviour on a formal and informal level (Cogan et al., 2005; Dunn, 1993; Garley et al., 1997; Trondsen, 2012; Williams, 1998).

4.8.Wishes for others in similar situations and ideas for interventions

This theme relates to participants' wishes for other children in similar situations and ideas for interventions. The subthemes within this theme will be discussed in the following order: keeping children in the loop, being 'seen' by professional services and sharing with another daughter.

4.8.1. Keeping children in the loop

All of the participants reflected on how they believed that it was important for children to gain knowledge and understanding about their mothers' mental illness so that they could be 'kept in the loop' about what was happening with their mothers. All of the participants reflected on how they were never provided with relevant and up to date information relating to their mothers' mental illnesses when they were children. This is aligned with literature as many authors have referred to experiences where children did not feel as though they were given enough information about their mothers' mental illness (Garley et al., 1997; Knutsson-Medin et al., 2007; Polkki et al., 2005). Despite the expressed need from children in previous research studies stating that they want to be informed and know more about parental mental illness, it is also commonly reported that neither family nor support systems facilitated open communication about maternal mental illness with the children of mentally ill parents (Dunn,

1993; Cogan et al., 2005; Knutsson-Medin et al., 2007; Polkki et al., 2005; Trondsen, 2012). Michelle states that it would be helpful to teach children about mental illness in a way that they could understand. She stated:

> *If I was more aware of mental illness from a much younger age. I mean even grade one would be perfect. I think there are creative ways in which you can explain is things to children. But, if I was more aware from a much younger age I would have had a very different relationship with my mother.*

This quotation highlights how Michelle wishes that she knew more about her mother's mental illness. She also reflects on how information could be shared with children from a young age in an age appropriate manner. This relates to Williams (1998) research where participants suggested that a story book which could be based on the story line that maternal mental illness is neither the fault of the child nor the parent could be an accessible and helpful way to teach children about maternal mental illness. Michelle feels that becoming more aware of her mother's mental illness could have positively impacted her relationship with her mother. Further information could also have helped Michelle put her mother's behaviour into context. This could have provided clarity in a bewildering and confusing time. Michelle stated that "*swip[ing] [things] under a rug"* and pretending that there were no family difficulties was more harmful. Rather than denial and hiding away from the reality of the situation, Michelle, Ashley and Mandy all opted for openness and honesty about their mothers' mental illness. They all believed that the process to decrease the stigma towards mental illness should start at home. Mandy stated:

> *I would say openness, openness and talking about it acknowledging that mental health is a thing. Acknowledge that depression is a thing, taking the shame away…you know so open communication within a family. Having the parents act in such a way that it is okay to communicate with your child, you know…so I would say I think it boils down to taking the veil of shame away, you know. It is what it is so let's deal with it you know that kind of thing.*

Mandy believes that her family should acknowledge that mental illness is a reality and something that they have to now live with in their family life. According to Dunn (1993), many children often blame themselves for their mother's mental illness. In Fraser and Pakenham's (2009) study many young children expressed that they had misconceptions about mental illness which perpetuated their concerns and distress. Similarly, research suggests that children of

mentally ill mothers sometimes perceive themselves as contributing factors for their mothers mental illness (Polkki et al., 2005; Trondsen, 2012; Williams, 1998). Being 'kept in the loop' about their mothers mental illness could challenge children's beliefs and perceptions that they may have created in their own internal world about causation of their mother's mental illness.

Both Ashley and Josie stated that perhaps children are not communicated with because they are overlooked in the process. For example, Josie reflected on how she felt as if the spouses and grandparents were much more 'in the loop' when it came to being told about mental illness, understanding medication and being made aware of the appropriate steps for recovery. She stated:

> *Don't overlook the impact that it can have on children. And you have to communicate and you have to say look you have been bearing the brunt of this for the past three years so basics: this is the diagnosis, this is the medication, when its gets changed notify the people in the family who are affected.*

This quotation reiterates how Josie felt as if children are sometimes overlooked when it comes bring provided with information regarding mental illness. This is aligned with O'Connell (2008) and Williams (1998) research whereby children of mentally ill mothers were considered as a neglected population in the process of maternal mental illness intervention. As Michelle stated above, perhaps health professionals could teach children about mental illness in a way that is age appropriate. The importance of communication and 'keeping children in the loop' about what was happening with their mothers was perceived as being very important for all of the participants in this research study. Indeed. mental health literacy has been documented as an important factor in helping children cope with their mother's mental illness (Fraser & Pakenham, 2009; Garley et al., 1997).

4.8.2. Being 'seen' by Professional services

The desire to be 'seen' by professional services was mentioned by all the participants. However, the way in which 'seen' is explained within this subtheme differs, ranging from noticing that a child was struggling at school to actual intervention with a social worker and psychological services. Ashley felt as if no one noticed that "*it was such a big issue for [her] when [she] was younger*". This relates to a finding in Gladstone et al's (2006) as children expressed that they felt invisible to the mental health professionals that treated their parents. Angela reflected on the value of someone noticing that she was struggling. She stated:

> *I went to an Anglican school and she said listen the school knows you are going to court today [*Angela was going to court for the legal custody proceedings during her parent's divorce*] and I was like what? I had no idea. And then she just said I want to pray for you. And I didn't expect it, I wasn't necessarily developed in my spirituality at the time and I will never forget that moment.*

Angela became slightly teary in this section of her interview, which could indicate how much it meant to her that someone was aware of, and made the effort to acknowledge, her emotional struggles. She elaborated:

> *I get a little bit emotional just thinking about it, um but I wasn't particularly close to the reverend. It was that feeling of support which was, it was paramount. She just prayed for me, she didn't pray for any outcome, she just prayed for me to feel safe and protected and um cared for like it was, and I felt so secure in that moment.*

For Angela, it was comforting to know that she was not going through the experience on her own. The school was aware of her home circumstances and she felt powerfully seen when the reverend prayed for her emotional wellbeing. Fiona also reflected on the value of her teacher being aware that she was struggling:

> *Back then my teacher's new this lovely, lovely teacher and as usual I was crying. I was 7 and I was crying. She came and she put her arms around me and she said to me like it's not always going to be like this, I promise it's not going to be like this forever. And that gave me such hope I was like really? I have never forgotten and it was really like 50 years ago.*

Fiona reflected on the vivid memory of a teacher telling her that circumstances may change which gave her hope. She reflected on how she will also never forget this moment of feeling noticed, not alone, and given hope. However, Maxine and Ashley did not report similar experiences as Angela and Fiona experienced at school. They felt as if their school teachers did not notice that they were struggling emotionally.

Fiona was the only participant who reflected on how social services should have been more involved. While Fiona wished that social workers had intervened, Josie said that she was scared that social services would become "*over involved*" in relation to her experiences of growing up with a mentally ill mother. It appears that Fiona and Josie had conflicting beliefs surrounding

being ‘seen’ by social work services. Fiona and Mandy wished that they had seen psychologists when they were children. Mandy stated:

> *I honestly wish that I had a counsellor or a psychologist as a child, you know, somebody that I could have spoken to help me deal with it. Yeah I went for many sessions of therapy but only, I was already married, only mid 20s I went for a lot of therapy to deal with my mum and all of that. But it would have been awesome if I had that as a child, somebody acknowledging that something is not right, you know. Someone trying to help me walk through everything. I think that would have been amazing.*

Mandy reflected on how it would have been helpful for her to speak to someone about her experiences and “*walk through everything*” with her. This relates to Bion (1962a, 1962b, 1970) whereby she expresses a desire for containment and a desire for someone to help her process her experiences in such a way so that she can make meaning of them. By implication, this means that she wishes that she experienced more containment when she was growing up in her life. On another level, she would have found this therapeutic process helpful because it would have been validating for her to have the reality of her home situation ‘seen’ and acknowledged.

4.8.3. Sharing with another daughter

All of the participants were asked if they had anything that they would like to share with another daughter who was growing up with a mentally ill mother. Two participants were slightly reluctant to reflect on what they would say to other children going through a similar experience that they went through. The reluctance appeared to be driven by different aspects. Michelle said that it was “*difficult to give advice*” because there are several factors to take into consideration such as context and personality. She elaborated and said that “*everyone experiences things in different ways*”. Ashley was also reluctant to give advice as she was fearful of saying the wrong thing to another child. Three participants reflected on how they would want to tell the children who were in similar situations that it was not their fault and that they were not to blame for their mother’s behaviour. Fiona said that she would say the following:

> *It’s not your fault, that they have not done anything wrong. It is not their fault it's their parents, they are the problem, it's not you. Talk to someone tell someone because if you feel deep down something here is not right then it is because it isn't right because you know it's your gut feeling.*

Fiona also stated how children should not be scared to reach out for help. Following a gut feeling was also perceived as being important to Fiona. Mandy reflected on how she would also want to shift the blame away from the child. She expressed the following:

> *It's not your fault. I would tell her that it is not her fault and I would acknowledge that it sucks, and it's awful, but unfortunately that was the hand that you would dealt but you are strong enough to make it. And, you are good enough, and you are beautiful, and you are pretty, and you are worthy, you know. So I would just try and build it into that person and say that, you know, yes it sucks but you can you can overcome it you know.*

Similar to Fiona, Mandy also began the statement with "*it's not your fault*". This could be influenced by an internal belief that she had contributed to their mother's mental illness and they wished that someone had told them that this was not the case. The second aspect to Mandy's quotation above also relates to acknowledgement of the reality of the situation. Perhaps she wishes that her difficult experiences of growing up with a severely mentally ill mother were acknowledged by others and considered to be valid. Mandy also reminds the individual of their inherent characteristics that could help them believe that it was going to be okay. Josie reflected on a similar sentiment on how she believed that is was important for children to have a certain outlook towards their mothers mental illness. She reflected on this:

> *Outlook is the important thing. And not allowing them to get stuck in this is forever. Because that's the way I moved through everything, is always looking beyond and thinking anything is temporary, anything could be resolved or manageable. So I think understanding facts, treatment plans, outlook is important.*

For Josie, having a sense of hope and a belief that things could get better made things more manageable amidst the state of chaos at home. Angela stated that she would want to remind other daughters that "*they are not their mother*". She reflected on this fear:

> *And I would want them to have, support, like I had, to be taught that they're not their mother. I was petrified for a long time that I had bipolar and that I was going to have bipolar, petrified. I said I just could never live, I could never live, with myself if I was going to be like that and do that to other people. I was petrified of that.*

A lot of what these participants wanted to share with other daughters in similar situations may be largely understood through Klein (1946). It appears that all of these participants may have

been exposed to projective identification which may have resulted in them feeling as if they were the object that made their mothers severely mentally ill. Klein (1949) proposes that sometimes children fear that their own inherent dependence or vulnerability by virtue of age and experience propel their mothers into madness. The underlying reason that the several of the participants placed emphasis on wanting to share with another daughter that they were not to blame for their mother's mental illness may have been born from this unconscious phantasy. The participants expressed a desire to help children relieve themselves from guilt, rather than being left with longstanding feelings of guilt which could perpetuate their own internal sense of badness (Klein, 1946).

5. Chapter five

5.1. Conclusions

It is widely documented in literature that the capacity to mother and can be negatively affected if a mother has a mental illness (Hipwell, Goossens, Melhuish, & Kumar, 2000; Manning & Gregoire, 2006; Oyserman, Mowbray, & Meares, & Firminger, 2000; Panos et al., 2006). The impact of maternal mental illness can begin in the perinatal phase of pregnancy and can continue to impact offspring even when they are adults (Brockington et al., 2011; Engur, 2017; Fraser & Pakenham, 2009; Hipwell et al., 2000, Manning & Gregoire, 2006; Oyserman et al., 2000; Trondsen, 2012). However, there is but a small number of qualitative studies that explore adult daughters' experiences of growing up with severely mentally ill mothers (Dunn, 1993; O'Connell., 2008; Kadish, 2015; Knutsson-Medin, Edlund, & Ramklint, 2007; Petrowiski & Stein, 2016; Williams, 1998). The aim of this research project was to explore adult daughters' experiences of growing up with a severely mentally ill mother. Six adult daughters of severely mentally ill mothers were interviewed.

Overall, the data conveyed that the participants' experiences of growing up with mentally ill mothers were multifaceted and complex for the participants. For instance participants reflected on their different experiences of growing up with a mentally ill mother as a child, as an adolescent and as an adult. The participants' experiences were cumulative and they reflected upon their experiences within various developmental stages which all had different milestones and challenges. This is aligned with literature that states that the interactions between the diagnosis of a mentally ill mother and a child's gender, age and developmental needs as well as the timing of the maternal psychopathology in terms of length of episodes is important to acknowledge (Brockington et al., 2011; Oyserman, Mowbray, Meares, & Firminger, 2000; Tarullo et al., 1994). The participants in this research reflected on how their experiences were formed within a myriad of other factors that related to inherent personal traits and the developmental cycle stages that they were trying to navigate. The participants reflected on how their mother's mental illness interacted with their family roles across their developmental stages (as children, adolescents and adults). As teenagers, the participants reflected on the interactions between having a mentally ill mother and their exploration of their sexuality and social spheres. There was less of an acceptance of taking on additional or parental roles and attempts to set boundaries with their mothers in order to establish a more autonomous and independent sense of self. As adults, the participants discussed the complex ways that their experiences of growing up with a severely mentally ill mother influenced the way that they

mothered, and brought up, their own children. This reiterates what is reflected in literature where genetic risk is only a small part of the total risk that children are exposed to as the subsidiary impact of maternal psychopathology on psychosocial and environmental factors cannot be denied (Brockington et al., 2011; Dunn, 1993; Hipwell et al., 2000; Knutsson-Medin et al., 2007; O'Connell, 2008; Panos et al., 2006; Trondsen, 2012).

Participants reflected that they had to 'put the puzzle pieces together' on their own when it came to understanding their mothers mental illnesses. This began with the participants identifying and noticing certain changes in their mothers behaviour. Over time, these changes became a pattern which helped them prepare for what is to come and it also helped them gain context into their mothers' behaviours. This is a similar finding to Garley and colleagues (1997) and Kadish (2015) where participants in their research recognised the signs of their mothers decompensating. It is commonly reported that children are extremely aware and responsive to affective states and needs of their mothers (Radke-Yarrow et al., 1994). However, this step by step process of meaning making for children growing up with mentally ill mothers is less documented in the literature. The patterns identified by the participants differed depending on their mother's mental illness. The participants mothers who were diagnosed with depression reflected on the experience of having their mothers present at times but distant and inaccessible at other times. For Jenna, whose mother was diagnosed with bipolar mood disorder, she experienced anxiety about two different states that her mother could be in, whereas for the participants whose mothers had depression there appeared to be one state that they were concerned about. It was hard for Fiona to identify a pattern in her mother's behaviour due to her bizarre psychotic behaviour but also due to Fiona acknowledging that it was sometimes hard to differentiate her mother's psychotic behaviour from some of her religious beliefs.

Through the process of trying to 'put the puzzle pieces together' they were able to gain insight into their mothers behaviour. However, these moments of insight were often precipitated by certain events after they had begun to put the puzzle pieces together on their own. For example, moments of insight were further entrenched by their mothers being hospitalised or after the participants became aware that their mothers were on medication. The participants also experienced relief when they became aware that their mothers were receiving treatment for their mental illnesses which was also reflected on by Garley and colleagues (1997) and Kadish (2015). This relief stands in contrast to other experiences documented in some literature where medication and hospitalisation of mentally ill mothers often induced fear and anxiety in children (Brockington et al., 2011; Cogan et al., 2005; Dunn, 1993; O'Connell, 2008). Through

this experience of putting the different puzzle pieces together, the participants also explained how they felt as if they gained a layered understanding into human difficulties and enhanced their empathy which is a common experience reported by children that have a mentally ill parent (Dunn, 1993; Knutsson-Medin et al., 2007; Trondsen, 2012; Williams, 1998)

The participants also spoke about their experiences within the mother daughter relationship. All of the participants experienced a re-assigning their family roles and they reported on how their roles in their families were in flux. For example, participants had to be the caretakers for their mothers and also had to look after their younger siblings. This role reversal is widely documented in literature (Dunn, 1993; Fraser & Pakenham, 2009; Garley et al., 1997; Gladstone et al., 2006; Knutsson-Medin et al., 2007; Mowbray et al., 2006; Petrowiski & Stein, 2016; Polkki et al., 2005; Trondsen, 2012). However, role reversal in relation to younger siblings is less reported in literature (Kadish, 2015; Petrowiski & Stein, 2016). The participants reflected on how they tried to protect their mothers' reputation and/or image for their younger siblings by shielding them from the reality of the situation at home. All of the participants described their relationships with their mother as being surface level and emotionally distant. They found it hard to share spontaneously and freely with their mothers. Rather, the participants shared filtered accounts of their experiences with their mothers. They felt as if they had to hide certain parts of themselves from their mothers in order to protect their mothers. This was also to protect themselves from further hurt and disappointment. The desire to implement emotional barriers with their mothers was also reported in Williams (1998) which is what the participants in this research study alluded to. Loss, sorrow and lack was also reported by all of the participants when they thought about their mother-daughter relationships which is aligned with the experiences reported in literature (Trondsen, 2012). In this research study, the participants' loss and sorrow was formed by their loss of childhood experiences and also formed from them having to mourn the loss of the experience of having a 'normal' mother. These feelings were was further perpetuated by participants feeling envious of 'normal families' which is reflected in Williams (1998) and Trondsen's (2012) research.

According to the literature, daughters are more vulnerable than sons to develop psychiatric disorders (Andrews et al., 1990; Jensen et al., 1990). Furthermore, it is reported that daughters of mentally ill mothers have more gender role identity issues in comparison to sons of mentally ill mothers (Tarullo et al., 1994). Participants reflected on how their experiences of growing up with a mentally ill mother impacted how they navigated different dimensions of their female identity. Kadish (2015) and Williams (1998) refer to adult daughter's fear that they might

become a mentally ill mother themselves. This experience was reflected on by all of the participants, even those who did not have children. Fiona, who was a mentally ill mother herself being diagnosed with agoraphobia, was acutely aware of the intergenerational cycle being repeated with her own daughter and tried very hard to give her daughter a different experience to her own. Adult daughters of mentally ill mothers in Williams (1998) research reported low self-esteem but the reasons for the low self-esteem were not stipulated. Participants in this research study also had low self-esteem and they attributed this to not having mothers who loved themselves. Three of the participants reflected on how their mothers poor self-esteem influenced their own low self-esteem and feelings of inadequacy. While this could be because they feel as if they are inherently bad and undeserving as a result of their phantasies (Klein, 1946); another aspect could be that they had no frame of reference on how to value and love themselves unconditionally. Another subtheme related to how participants did not experience their mothers as being in tune with their developmental changes in their female bodies which is not reported in the literature. The participants felt as if their mothers could not guide them when it came to intimate relationships, sexual intercourse and menstruation. Two participants said that their mothers placed an emphasis on being thin as a female, which made them feel as if their mothers were placing emphasis on external façade of being a woman, rather than being there to guide them through biological developmental changes. Five of the participants sought out maternal figures in their extended families to provide some relief and to compensate for their lack of maternal experiences.

The participants also reflected on different caregivers roles, and how different caregivers either helped them navigate their experiences with their mentally ill mothers or they did not. The participants reflected on levels of paternal involvement. Only one participant said that she was extremely close to her father, whereas four of the participants experienced their fathers as emotionally absent which is a common experience reported on in literature in children of mentally ill mothers (Oyserman et al., 2000; Perera et al., 2014). Furthermore, some of the participants experiences with their fathers also highlight how maternal mental illness can impact the family system more generally (Brockington et al., 2011; Dunn, 1993; Halsa, 2018; Hipwell et al., 2000; Knutsson-Medin et al., 2007; O'Connell, 2008; Panos et al., 2006; Trondsen, 2012). Two participants explicitly stated that they were not able to speak about their mothers mental illness with their fathers due to avoidance, denial and certain values and beliefs that were held by their fathers. Further, three participants reflected on how their fathers did not explain to them about maternal mental illness. Five of the participants reflected on the

importance of having other women to turn to in their family. They reflected on how having other 'maternal' figures to turn to provided them with a sense of comfort, support and safety. It is likely that this experience of having other women to turn to was a protective factor and resilience enhancing factor for these participants (Beardslee et al., 1998; Kadish, 2015). However, one of the participants did not have the experience of having anyone in her family to talk to about her experiences and it is interesting that this participant seems to be struggling the most herself psychiatrically. Having a good enough father or having other caretaking figures to turn to can play important protective roles for children growing up with mentally ill mothers (Kadish, 2015; Oyserman et al., 2000, Perera et al., 2014).

There have been various coping mechanisms reported in the literature that are used by children of mentally ill mothers (Kadish, 2015; Fraser & Pakenham, 2009; Garley et al., 1997; O'Connell, 2008; Trondsen, 2012). A common thread throughout all of the coping mechanisms used by participants in this research was the desire for control. This control was achieved through academic overachievement, controlling their outlet of emotions, daily routine, ballet and trying to plan their futures. Amidst their emotional turmoil, they turned to control (in various ways) to find a source of comfort. It felt as if the desire for control not only soothed the participants psychologically and emotionally but also provided them with a means of external recognition and validation. Sometimes the active coping style and resilient behavioural patterns may generate a sense of mastery in children amidst a chaotic home environment, which is often deeply desired by these children (Kadish, 2015; O'Connell, 2008). The pride in presenting as competent despite internal distress was reported on by Williams (1998) but it felt as if for these participants they desperately wanted their mothers to recognise them for their efforts. Despite presenting as externally 'put together' they were acutely aware of the stigma that surrounded mental illness. This made them feel as if they had to hide parts of themselves, behind closed doors, out of fear of being exposed or judged by others which is widely documented in the literature (Cogan et al., 2005; Gladstone et al., 2006; Williams, 1998).

The participants also shared their wishes for others in similar situations which was often influenced by their own denied wishes and denied experiences when they were growing up with a mentally ill mother. All of the participants expressed the importance of 'being kept in the loop' about what was happening with their mothers. Despite expressing that they wanted more information about their mothers mental illness, all of the participants felt as if they were left out from communications and there was a lack of openness about their mothers mental illness in their family. Both of these experiences are commonly reported in the literature

(Dunn, 1993; Cogan et al., 2005; Garley et al., 1997; Knutsson-Medin et al., 2007; Polkki et al., 2005; Trondsen, 2012). All of the participants expressed a desire for their difficulties to be 'seen' (noticed) by professional services but also to be 'seen' in terms of having actual psychology or social work consultations. When the participants were asked if they wanted to share a sentiment to another daughter who was in a similar experience to them, the majority of the participants wanted to remind the daughter that it was not their fault and that they were not to blame for their mothers mental illness.

5.2.Limitations of the research

This research aimed to understand the subjective experiences of adult daughters' experiences of growing up with a severely mentally ill mother. The small sample was drawn from a particular background and demographic information as all of the participants were white, English speaking and came from middle-income backgrounds. Thus, the findings are not representative of the broader population of South Africa. This means that the findings cannot be generalised. However, the aim of qualitative research is not to obtain generalizable results. This research aimed to explore adult-daughters subjective experiences in-depth and in a nuanced manner. In the future a broader sample of South African citizens could be used so as to understand the nuanced experiences that may have been found across different racial, social, economic and cultural groups, and possibly those that might more circumscribed to a particular socio-cultural group. This research also made use of a small sample.

This research has solely focussed on adult daughters' experiences of growing up with a mentally ill mother, and not sons' experiences. Thus, the experiences are not reflective of sons' experiences. Sons are likely to have different experiences in certain ways, that were not found in the adult daughters' experiences. However, there is strength in having a homogenous sample. To this end, future research might focus on sons with mentally ill mothers, or daughters of mothers who have suffered from a specific type of mental illness, for example psychosis or depression.

5.3.Recommendations for future research

Given the small sample size as befits qualitative research, and the fact that this research was based on a specific sample of adult daughters, it would be interesting to compare the experiences of adult children from different backgrounds in South Africa. This could extend the sample which could corroborate and enhance the interventions and advice to other adult children across different backgrounds. This would be important given the multi-cultural

context of South Africa. Given the limitations regarding the small sample size of this current research project, it would be beneficial to increase the sample size of this research.

Further research could also be done to explore experiences of sons of mothers who suffered from severe mental illness, to gain a deeper understanding of whether or not the experiences depend on gender identity, and the extent to which this is the case. It would also be valuable to understand son's experiences of growing up with mentally ill mothers as research indicates that they do not go unscathed by the experience. This research has explored adult daughters experiences of growing up with a mentally ill mother and how this impacted the way that they navigated different facets of their identity as women. However, further research needs to be done to understand this. Thus, a possible avenue of exploration could be to focus on this aforementioned aspect only, rather than the broader experiences of adult children. Additional research exploring adult daughters' experiences of growing up with a mentally ill mother could contribute to a greater awareness of this age groups unique and longstanding experiences and hopefully additional research can also inform resources aimed at these children.

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Appendix A: Semi-Structured Interview Schedule

Thank you for giving up your time to do this interview, I am very grateful. My name is Tracy and I am from the University of Witwatersrand. I am here because I am interested in hearing your experiences of growing up with a mentally ill mother. Before we begin, let's go through the consent form.

If you are comfortable to start, I will switch the recording on.

1. Perhaps you can start by telling me when you first had a sense that your mother had some sort of a mental illness?

2. How old were you when you had a sense of her mental illness?
- Do you recall what you thought and felt about what you observed?

3. How did you make sense of your mothers' mental illness then?
- How did you understand her emotions, behaviour, or the things she said?

4. Was your mother ever diagnosed by a doctor or mental health practitioners like a psychologist or psychiatrist? Do you know what diagnosis or diagnoses she has given?

5. How do you think that your mother's mental illness impacted your everyday life?
- Personal life, social life, academic life, romantic life?

6. Do you think your mothers' illness has affected the way you see yourself as a woman, your identity as a woman?
- Do you think it affected the way you felt about becoming a woman when you were growing up?

7. Could tell me a bit about your relationship with your mother, how it has been over the years?
- What was it like when you were a child? Did it change? What is it like now?

8. Growing up, did you feel as if you were adequately supported emotionally, in going through your experiences in general and in relation to your mother mental illness?
- Who gave you support? Family, teachers, neighbours, health services, social support? In what ways was this supportive for you/how did it help you?

9. What personal characteristics do you think helped you to cope with the challenges that you had?
- What do you think your coping mechanisms were?

10. Do you think your experiences with your mother have had any positive effects on you as a person, now in your adult life?

11. What sort of help or support do you think children in this situation need to help them cope with it?

12. What would be your advice to other children going through the same experience?

13. Is there anything more you would like to say on this subject that we haven't discussed?

Thank you for sharing your experiences with me I really appreciate it

Appendix B: Participant Information Sheet

Psychology: School of Human & Community Development

University of the Witwatersrand
Private Bag 3, Wits, 2050
Tell: 011 717 4503

Hello,
My name is Tracy Plant. I am currently a Clinical Psychology Masters student at the University of the Witwatersrand. I am conducting research for the purpose of obtaining this degree. The purpose of my research is to explore the experiences of the adult daughters of mothers who have suffered from severe mental illness.

I would like to invite you to participate in this study. If you agree to participate in this study, you will be asked to take part in a semi-structured interview which will take about 60 minutes. The interview will be conducted at a time and place that is convenient for you.

Participation is voluntary, and you will not be advantaged or disadvantaged in any way for choosing to go through with the interview. You are free to refuse to answer any question, and if you are feeling uncomfortable to continue, you have the right to withdraw from the research up until submission of the report. Everything you say during this interview will be kept confidential. I will assign a pseudonym to your information in the report. The interview will be tape-recorded and only my supervisor and I will have access to the tapes. The tapes will be kept in a password protected file on my computer and my supervisor's computer.

If you experience any distress or would like to have some free counselling after the interview, the following organizations may be contacted:

For face-to-face therapy, you can contact the Emthonjeni Community Counselling Centre at The University of the Witwatersrand: 011 717 4513. You should contact Renate Gericke (Renate.Gericke@wits.ac.za) to make a booking.

Telephonic counselling services:

- Life-line Johannesburg: 0861 322 322
- South African Depression and Anxiety Group (SADAG): 011 262-6396

Before we begin the interview, I will require two signatures: the first one is to state that you understand everything that we have discussed about confidentiality and privacy. The second signature is to confirm that you agree to have the interview audio recorded. I will be typing up the audio-recording after our interview. To protect your privacy, I will not use any identifying details when I write up the interview.

Thank you again for your time.
Regards, Tracy Plant

Appendix C: Consent Form (Interview)

Psychology: School of Human & Community Development
University of the Witwatersrand
Private Bag 3, Wits, 2050
Tell: 011 717 4503

I, _____ consent to being interviewed by Tracy Plant for her study exploring adult daughters' experiences of growing up with mentally ill mothers. I understand that:

1. My participant in this study is voluntary.
2. I may refrain from answering any questions, at any point.
3. I may withdraw my participation and my responses from the study up until the submission of the report.
4. There are no risks or benefits associated with this study.
5. All information will be confidential, although I may be quoted in the research report. A pseudonym will be used if I am quoted.
6. No identifying information will be included in this research report or in any publications that arise out of this research project.
7. I am aware that the results of the study will be reported in the form of a research report for the partial completion of the degree, Masters in Clinical Psychology.
8. This research may also be presented at a local/international conference by me or my supervisor. This research project may be published in a journal and/or book chapter. Your personal details will always be kept confidential.
9. All of the audio recordings and the anonymized transcripts will be archived by the researcher and her supervisor (Dr Yael Kadish) in a secure password protected computer file.
10. Your interview will form part of a broader research project on this subject. All of the interviews that are recorded under the broader research project will be safely and securely archived in a password protected file for use in the larger, ongoing research project.

Signed: _____
Date:_____

Appendix D: Consent Form (Recording)

Psychology: School of Human & Community Development
University of the Witwatersrand
Private Bag 3, Wits, 2050
Tell: 011 717 4503

I, _____ give my consent for my interview with Tracy Plant to be audio recorded for her study. I understand that:

1. The audio recordings and transcripts will not be seen or heard by anyone other than the researcher and her supervisor.
2. The audio recordings and the anonymised transcripts will be kept on a password protected computer which will be accessed by the researcher and/or her supervisor.
3. No identifying information will be used in the interview transcripts or the research report or any presentations or published article.
4. Although direct quotes from my interview may be used in the research report, I will be referred to by a pseudonym (Respondent X, Respondent Y etc.).
5. Your interview will form part of a broader research project on this subject. All of the interviews that are recorded under the broader research project will be safely and securely archived in a password protected file for use in the larger, ongoing research project.

Signed: _____

Date: _____