



Psychology

School of Human & Community Development

University of the Witwatersrand

Private Bag 3, WITS, 2050

Tel: (011) 717 4500 Fax: (011) 717 4559



Researcher: Nishara Govinda

Supervisor: Dr Yael Kadish

Research Title

Adult daughters' reflections on their affective experiences growing up with a psychotic mother: A psychodynamic exploration.

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, 7 January 2015.

Declaration

I declare that this is my own unaided work. It is being submitted for the degree of Masters in Clinical Psychology at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination in another university.

Nishara Govinda

_____ Day of _____, 2015

Abstract

The aim of the research was to investigate adult daughters' retrospective accounts of experiences with their mothers with reference to their emotional or affective experiences. The second aim of the research was to explore these daughters' views of how their experiences have impacted their day-to-day lives, including how they relate to significant others in their lives, such as life partners and their own children. Four adult daughters who were raised by psychotic mothers were interviewed, using a semi-structured interview schedule. Through the process of Interpretive Phenomenological Analysis, six themes and nine subthemes emerged from the data. The themes that emerged from the data included: (1) 'Present nature of the mother daughter relationship'; (2) 'Adapting/coping', comprising of three subthemes; 'Support', 'Escaping' and 'Psychological boundaries'; (3) 'Perceived impact of past', which comprises of three subthemes, 'Perceived impact on life', 'Perceived impact on sense of self' and 'Taking responsibility'; (4) 'Fear' the fears that resulted from participant's experiences of growing up with their psychotic mothers; (5) 'Secrecy and stigma'; (6) 'What to say to another daughter' which comprises of three subthemes, 'Support', 'Coping', 'Professional services'. Powerful overwhelming feelings were notably expressed through the participants' narrative, including guilt, shame, fear, anxiety, disappointment and confusion. The means through which these children managed their powerful feelings, has indeed left a prevailing impact on their sense of selves as well as their lives. Some of the powerful feelings that daughters raised as currently experiencing in relation to their psychotic mothers include anger, disappointment, sadness, guilt, shame, loyalty and resignation. The findings of the research were interpreted using a psychodynamic framework. The psychodynamic findings were that participants remember experiencing strong overwhelming feelings that they had to manage themselves in response to a failure in the reciprocity with their relationships with their psychotic mothers (Klein, 1926; 1935; 1940; 1946; 1956). They emphasised the

necessity of having a parental figure who could contain their overwhelming feelings (Bion, 1959; 1962; 1963; 1967; 1993). Furthermore, participants highlighted having had to adapt themselves in order to meet the needs of their environment, culminating in the development of the self (Winnicott, 1960a; 1960b; 1963; 1965).

Word count: ± 35 000

Acknowledgements

I would like to express my sincere thanks to the following people who have contributed to this research:

Dr Yael Kadish, my supervisor who has tirelessly guided this research process. Your patience, guidance and support have been invaluable. My most sincere thanks to you for your sincere dedication to this research project. Your willingness to share your knowledge and facilitate my thinking, as well as focus on improving my writing skills is most appreciated.

The Psychology department for the opportunity of conducting this research, the experience has been most rewarding.

My participants, who willingly offered their time and valuable information, without whom this research would not have been possible.

My family (my mom, Nirmala; my dad, Nathan; my brother, Kiran), each of whom provided me with support in their own ways. Thank you for all the encouragement and your prevailing confidence in me.

My aunt, Dr Shama Padayachey, a medical practitioner, who eagerly offered her assistance in the sampling process and continuously voiced her readiness to assist in whichever way possible.

My life partner, Wojciech Antoni Urban, who has remained truly patient and supportive throughout this process. Your undoubted belief in me and constant encouragement has been relentless.

Ciara Ann Gatonby, my dearest friend, who has accompanied me throughout this journey with an attentive listening ear, warmth, and constant eagerness in supporting me in whichever way possible throughout this journey and always.

The 2013 Masters in Clinical Psychology class, who taught me a lot about myself and offered their assistance whenever needed.

Table of Contents

Chapter one – Introduction	1
1.1 Introduction to the research area	1
1.2 Research aims.....	5
1.3 Research rationale	7
Chapter two – Literature Review	10
2.1 Introduction	10
2.2 Research investigating parental mental illness.....	10
2.3 Resilience	15
2.4 Defining psychosis	18
2.5 Research investigating maternal psychosis on offspring of both sexes	20
2.6 Research investigating maternal psychosis and some possible emotional consequences for daughters.....	22
2.7 Theoretical framework	24
2.7.1 Object relations theory.....	24
2.7.2 Klein	24
2.7.3 Bion	29
2.7.4 Winnicott	33
2.7.5 The mother-daughter bond	35
Chapter three – Research Methodology.....	39
3.1 Research design.....	39

3.2 Research questions	40
3.3 Sampling strategy.....	41
3.4 Procedure.....	42
3.5 Data collection.....	44
3.6 Reflexivity.....	45
3.7 Analysis.....	46
3.8 Ethics.....	48
Chapter four – Findings	50
4.1 Introduction	50
4.2 Present nature of the mother daughter relationship.....	51
4.3 Childhood reflections: adapting and coping.....	55
4.3.1 Support.....	55
4.3.2 Escaping.....	59
4.3.3 Psychological boundaries.	62
4.4 Perceived impact of the past.....	65
4.4.1 Perceived impact on life path/choices/opportunities	65
4.4.2 Perceived impact on sense of self.....	69
4.4.3 Taking responsibility.	72
4.5 Fear.....	75
4.6 Secrecy and stigma.....	79
4.7 What to say to another daughter.....	82

4.7.1 Support.....	82
4.7.2 Coping.	84
4.7.3 Professional services.....	87
Chapter five – Discussion of the Findings.....	91
5.1 Introduction	91
5.2 Synopsis of the findings	91
5.3 Psychodynamic exploration of the findings	100
Chapter six – Conclusions	109
6.1 Research report conclusions.....	109
6.2 Limitations of the research.....	114
6.3 Recommendations for future research projects.....	115
Reference List	117
Appendix A: Participation Information Sheet	i
Appendix B: Consent Form for Participation	iii
Appendix C: Consent form for Audio-Recording	v
Appendix D: Interview Schedule.....	vi

Chapter one – Introduction

1.1 Introduction to the research area

The mother-infant dyad is considered to be the most significant relationship in the developmental outcomes of human beings. Psychoanalytic writers have noted different ways in which this relationship affects development. Melanie Klein (1926; 1935; 1940; 1946; 1965), founder of the school of Object Relations Theory, emphasised the importance of the mother-infant relationship in the development of the infant's personality. Wilfred Bion (1959; 1962; 1963; 1967; 1993) emphasised the importance of the mother-infant relationship in the infant's learning to process emotional experiences, learning to think, and the infant's experience of the self (Waddell, 1988). Donald Winnicott (1958; 1960a; 1960b; 1963; 1965; 1982) emphasised the importance of the mother's attunement to the child in the child's developmental outcomes. Attunement refers to the capacity to be receptive to the infant's communications of feeling states and subsequently appropriately reflect these feelings back to the infant through nonverbal behaviours (including facial expressions, tone and body language) (Jonsson & Clinton, 2006). Attachment theorist John Bowlby (1953; 1969; 1973; 1979; 1988) theorised about the infant's attachment behaviours towards her mother based on the mother's pattern of care and availability to her infant as influential on the child's future relationships. This attachment pattern develops through the interaction between care-seeking infant and caregiver and the result is a specific attachment pattern. Infancy is characterised by care-seeking which must be received and acted upon in a care-giving manner (Bowlby, 1988). Appropriate care-giving enables the infant to display secure attachment behaviours – healthy development (Bowlby, 1988). Although mothers are traditionally understood to be the primary care-giver of an infant, the role of the father as a caregiver is gaining increasing

attention and thus it is becoming increasingly accepted that parenting behaviours, including that of the father, are crucial to development.

In addressing the importance of parenting in the outcome of a child's development one must keep in mind that parenting behaviours and abilities are affected by the mental health of the parent (Berg-Nielsen, Vikan, & Dahl, 2002). Indeed it is widely understood that parental mental illness has numerous risk factors for children and is associated with children's poorer developmental and adjustment outcomes (Berg-Nielsen et al., 2002; Brown & Roberts, 2000; Donatelli, Siedman, Goldstein, Tsuang, & Buka, 2010; Fraser & Pakenham, 2009; Hipwell, Goossens, Melhuish, & Kumar, 2000; Stallard, Norman, Huline-Dickens, Salter, & Cribb, 2004). Some of these studies have focused on the effects of psychiatric disorders (inclusive of both psychotic and non-psychotic disorders), while others have focused on the effects of psychotic disorders specifically. For example Berg-Nielsen et al. (2002) and Hipwell et al. (2000) are two studies in which there was a broader focus on the effects of parental mental illness (with no differentiating between psychotic and non-psychotic disorders) on the outcome of the child's development. While, for example, research by Donatelli et al. (2010) focused on whether there are distinct behavioural problems experienced by all children who are raised by parents who suffer from different forms of psychoses. Over the last three decades research has also aimed at understanding children's experiences of parental psychosis (Brown & Roberts, 2000; Dunn, 1993; Hipwell et al., 2000; Mohit, 1996; O'Shaughnessy, 1981; Renault, 1987; Zeitz, 1995).

The key differentiating factor between psychotic disorders and non-psychotic disorders is that of the individual's perception of reality. A psychotic person is, to a greater or lesser extent, out of touch with external reality (American Psychiatric Association, 2013). Psychosis can be understood as a highly disturbed state of mind (Berg-Nielsen et al., 2002) and a detachment of the self from the world or a loss of contact with reality, hence impacting on the

individual's ability for intersubjective relating (which refers to the capacity to draw links between self and others to assumptions and desires of other subjects) and inter-intentional relating (which refers to the ability to recognise the intentions of others) (Rosenbaum & Harder, 2007). Consequently psychosis is understood to have a dramatic impact on the individual's ability to maintain close and reciprocal relationships (Berg-Nielsen et al., 2002).

Previous research has documented numerous implications for children raised by a parent with psychosis; some studies have documented these implications with the specific focus of maternal psychosis. For example it is understood that the environmental implications (such as chaos, uncertainty and isolation) of parental mental illness exert a significant impact on the developmental environment of the child, resulting in poor developmental outcomes, including emotional, behavioural and cognitive effects (Brown & Roberts, 2000; Donatelli et al., 2010). Given that the parent's ability to relate attentively to his/her child is of critical importance to healthy developmental outcomes, and that psychosis impacts on an individual's capacity to form and maintain close relationships, (Berg-Nielsen et al., 2002) it seems fair to query whether a child raised by a parent suffering with psychosis might experience emotional developmental consequences.

With regards to maternal psychosis specifically, research has for example found that schizophrenic mothers are typically more remote, insensitive, intrusive and self-absorbed than non-psychotic mothers (Riordan, Appleby, & Faragher, 1999). Various research studies have investigated the impact of maternal psychosis on the mother's ability to be attuned to her child's needs (Forbes, Evans, Moran, & Pederson, 2007; Goodman & Brumley, 1990; McNeil, Naslund, Persson-Blennow, & Kaij, 1985; Naslund, Persson-Blennow, McNeil & Kaij, 1985; Persson-Blennow, Naslund, McNeil, & Kaij, 1986); which will be elaborated on in the Literature Review. The available qualitative research that focused on the impact that psychotic mothers have on their children and children's experiences with parental psychosis

over the last three decades include that of: Renault (1987), Dunn (1993), Zeitz (1995), Mohit (1996), and Hipwell et al. (2000). However, Kadish (2003) and Williams (1998) are among the few studies have explored this specifically with regards to the experiences of daughters of severely mentally ill mothers (inclusive of psychotic disorders). However the impact of maternal psychosis on daughters' emotional experiences is an area of research that requires additional focus. The current research sought to explore these children's experiences in depth rather than statistically. It is the use of the Interpretive Phenomenological Analysis (IPA) method of data analysis in combination with the interpretation of the data through the use psychodynamic theorists which makes this study unique.

As previously mentioned, psychosis is defined as a state of mind where there is a loss of contact with reality and detachment from the world and the self (Berg-Nielsen et al., 2002; Rosenbaum & Harder, 2007). It thus seems likely that psychosis will impact upon a mother's parenting abilities. Crucial to the child's development is the parent's ability to be attuned to her child's needs including the alleviation of difficult affective states. Psychodynamic literature emphasises that through the child's development affective states need to be managed by the mother for the child (Waddell, 1988). One example is anxiety which needs to be managed and alleviated in accordance with developmental phases (Winnicott, 1960a). This process is in part determined by the emotional/inter-psychic 'fit' between mother and child; the mothers capacity to make sense of the infant's communications and respond accordingly so as to alleviate and assist the infant in managing experienced anxieties (Winnicott, 1982). Through the mother's assistance in this way, the infant is able to make use of the mother's ego strength and internalise this ego strength and thus contributes to her psychological development (Winnicott, 1982).

In the case of a less optimal mother-infant fit, and as a result of not having the experience of being contained or being adequately held, the child is understood to be vulnerable to

developing a relational pattern characterised by the dominance of the false self structure (Winnicott, 1960b) or experience constant fear within her relationships regarding her mad-making needs (Bion, 1962). In the case of parental psychosis, the mother's part in the mother-infant fit is severely compromised, as she is seriously mentally unwell. Her ability to be attuned to her child's needs and respond to her child in a developmentally appropriate and containing manner is blighted.

The research chose to focus of the experiences of daughters raised by a psychotic mother as literature clearly indicates that maternal psychosis impacts on the mother's capacity to be a good-enough mother, which impacts on the psychological development of the child. The research aims follow below.

1.2 Research aims

Literature widely documents that children of mentally ill parents are at risk for poorer developmental and adjustment outcomes (Aldridge & Becker, 1999; Berg-Nielsen, et al., 2002; Brown & Roberts, 2000; Cogan, Riddell & Mayes, 2008; Donatelli et al., 2010; Fraser & Pakenham, 2009; Hipwell et al., 2000; Polkki, Ervast, & Huupponen, 2008; Reupert & Mayberry, 2010; Stallard et al., 2004). It is understood that the parent's capacity to parent has a significant impact on childhood and adult outcomes (Mowbray, Bybee, Oyserman, MacFarlane, & Bowersox, 2006). According to Bowlby (1988) the quality of the mothers' care-giving is crucial to healthy development. Failure by the mother to respond with appropriate care-giving responses leaves the infant with the experience of distress and anxiety, possibly leading to the development of an insecure attachment pattern (Bowlby, 1988).

Psychosis is defined as a state of mind, a loss of contact with reality and detachment from the world and the self (Berg-Nielsen et al., 2002; Rosenbaum & Harder, 2007). It has been found that the parenting of a psychotic mother is likely to exhibit a lack of emotional warmth and impaired maternal sensitivity and responsiveness to the child (Goodman & Brumley, 1990; Oyserman, Mowbray, Meares, & Firminger, 2000). A psychotic parent is unable to empathically attune him/herself to reality and provide a more coherent and emotionally receptive other to which the child can relate in aiding of development. Given this, it is understood that these children are often left to manage difficult emotional/affective experiences him/herself as well as adjust him/herself with the intention of minimising disruptions in the home environment (Mordoch & Hall, 2008; Rosenbaum & Harder, 2007). Furthermore, in line with psychodynamic literature it is understood that anxiety is integral in the process of development (Waddell, 1988) and therefore needs to be managed and alleviated in accordance with developmental phases (Winnicott, 1960a). In the case of a less suitable mother-infant fit the child is understood to be vulnerable to developing a relational pattern characterised by strong or overwhelming affect (Bion, 1962; Winnicott, 1960a). Some of the overwhelming affect emphasised in literature include feelings of guilt, anxiety, and feelings of disintegration (Dunn, 1993; Klein, 1965; Reupert & Mayberry, 2010; Robert & Brown, 1993). Given such findings the primary aim of the research was to investigate adult daughters' retrospective accounts of experiences with their mothers in relation to their emotional or affective experiences.

Object relations theory states that early patterns of relating form the foundation of later relational processes despite the external reality of the relation being non-representative of the early relational pattern, in which anxiety may have played a realistic role (Segal, 1978). Thus the second aim of the research was to explore these daughters' views of how their

experiences have impacted their day-to-day lives, including how they relate to significant others in their lives, such as life partners and their own children.

1.3 Research rationale

This research project focused on the reported psychological and emotional impact that growing up with a psychotic mother has on daughters. Despite research indicating the general resilience of some children of mentally ill parents (Foster, O'Brien, & McAllister, 2005; Fraser & Pakenham, 2009; Gladstone, Boydell, & McKeever, 2006; Masten, Best, & Garnezy, 1990; Tebes, Kaufman, Adnopoz, & Racusin, 2001; Werner, 1984), it is widely understood that parental mental illness has numerous risk factors and is associated with the children's poorer developmental and adjustment outcomes (Berg-Nielsen et al., 2002; Brown & Roberts, 2000; Donatelli et al., 2010; Fraser & Pakenham, 2009; Hipwell et al., 2000; Stallard et al., 2004). In addition research indicates that children of mothers who suffer from mental health problems are at risk for disturbances later in life. For example, a child of a parent suffering with an affective illness has an increased likelihood of experiencing an episode of major depression, feelings of guilt, and interpersonal difficulties as well as problems with attachment, and increased likelihood of exhibiting general difficulties in functioning (Beardslee, Versage, & Gladstone, 1998). With regards to attachment, there seems to be an association between insecure/disorganised infant attachment styles and severe maternal psychopathology (Hipwell et al., 2000; Wan & Green, 2009). Gladstone et al., (2006) highlight that children who live with a mentally ill parent are considered to be 'at risk' of developing a mental illness themselves, while those who do not are considered extraordinarily resilient.

As mentioned previously, the regulation of emotional affect is, among others, a crucial part of development. Object relations theorists Klein (1965) and Bion (1962) highlight the importance of affect regulation within a reciprocal relationship between mother and infant for the infant's capacity for thought and the infant's sense of integration. Winnicott (1965) lends the understanding that in the case of the mother being unable to be empathically attuned to her infant and to be unable to provide her infant with good enough 'holding experience', the infant will be left enduring feelings of unmanageable affect. Furthermore, Bowlby (1988) emphasised the importance of emotional affect regulation (particularly the alleviation of the infant's experience of anxiety) in determining attachment behaviours.

Of the few research projects that wished to explore whether participants feel they have experienced serious emotional consequences as a result of having a psychotic mother it was found that this to be the case in this general cohort (Brown & Roberts, 2000; Dunn, 1993; Kadish, 2003). The strong affective states found to have been experienced by children of psychotic parents include emotional shock, confusion, grief, guilt, fear, insecurity, alienation, hyper-vigilance, feelings of entrapment and, emotional numbness (Brown & Roberts, 2000; Dunn, 1993; Hipwell et al., 2000; Kadish, 2003; Mohit, 1996; O'Shaughnessy, 1981; Winnicott, 1965; Zeitz, 1995). Thus children of psychotic parents are understood to be secondary victims to maternal psychopathology (Brown & Roberts, 2000).

In addition, with regards to daughters specifically, Brown and Roberts (2000), Oyserman et al. (2000) and van Buren (2005) states that the impact maternal mental illness has on a girl child may be unique due to the daughter's identification with her mother as a woman, and

¹ Holding experience: A Winnicottian concept referring to the role of the mother in the development of the infant, which involves the mother's signalling to the infant that the infant's communications are being heard and understood (Winnicott, 1955).

may thus be especially challenging, the details of this will be briefly discussed further in the Literature Review.

This research project aimed to explore the recalled experiences of adult daughters of psychotic mothers from childhood to the present. This included their recollections of strong emotions or emotional states they remember experiencing, and possibly still experience, in relation to maternal psychosis. Adult daughters were chosen as the sample for the research as it was anticipated that they would be able to reflect on the way that they perceive their experiences with their mothers to have affected their lives and relationships. Research data was obtained through the use of semi-structured interviews, and the data was analysed through the use of IPA and interpreted with a psychodynamic framework in mind (particularly the work of Bion, Klein and Winnicott).

Chapter two – Literature Review

2.1 Introduction

For the purpose of clarity the Literature Review is divided into six sections and will be presented in the following sequence. The first section of the Literature Review will focus on parental mental illness more broadly, including parental mental illness of both a psychotic and a non-psychotic nature. The Literature Review then briefly highlights the significance of resilience of children growing up with a mentally ill parent. The third section of the Literature Review provides the reader with a definition of psychosis and highlights the varying nature of the presentation of psychosis. The fourth section of the Literature Review focuses on maternal psychosis and addresses research on both sons and daughters, underpinning for the chosen focus of the research, i.e. daughters' perceived experiences of being raised by a psychotic mother and the emotional consequences perceived to follow from these experiences. The fifth section of the Literature Review will cover literature pertaining to daughters' experiences of maternal psychosis. The sixth and final section of the Literature Review introduces the theoretical framework of the research project. This section will focus on psychodynamic theory, particularly the work of Melanie Klein (1926; 1935; 1940; 1946; 1956), Wilfred Bion (1959; 1962; 1963; 1967; 1993) and Donald Winnicott (1960a; 1960b; 1963; 1965). This adumbration will be restricted to aspects of their work most relevant the current study.

2.2 Research investigating parental mental illness

This section of the Literature Review focuses on research conducted on parental mental illness in general, including disorders of a psychotic as well as a non-psychotic nature. In

order to understand the context and value of the current research (focusing on maternal psychosis) it is necessary to briefly discuss some of the studies focusing on parental mental illness more broadly. Literature highlights that children of parents with mental illness are at increased risk for poor developmental outcomes (Aldridge & Becker, 1999; Berg-Nielsen et al., 2002; Cogan et al., 2008; Polkki, Ervast, & Huupponen, 2008; Reupert & Mayberry, 2010); these studies, among others, will be discussed below. The nature of interventions directed at children of parents with a mental illness is also considered below (Beardslee & Poderefsky, 1988; Cogan et al., 2004; Garley et al., 1997; Reupert & Mayberry, 2010; Magliano, Fiorillo, Malangone, De Rosa, & Maj, 2006; Mowbray et al., 2006; Stallard et al., 2004). Studies conducted in the area have also considered the factors that contribute to resilience; the issue of resilience will be covered in the subsequent section of the Literature Review.

Manning and Gregoire (2006) note that parental mental illness impacts on the child from the time of the child's first exposure to the parent when ill, through to adulthood and affects children even subsequent to the parent's recovery. They highlight risk factors associated with parents who are mentally ill, such as socioeconomic disadvantage, unemployment, and marital conflict, associated with adverse childhood outcomes. Furthermore literature widely documents that children growing up with mentally ill parents are at increased risk for developing a mental health problem themselves (Beardslee, et al., 1998; Gammon, 1983; Mowbray, Bybee, Oyerman, MacFarlane, & Bowersox, 2006; Hall, 2004; Rutter, 1989; Rutter, 1990; Smith, 2004; Warner, Weissman, Fendrich, Wickramaratne, & Moreau, 1992; Weismann, Prusoff, Merikangas, Leckman & Kidd, 1984). Aldridge and Becker (1999) highlight children's fear of separation from their parents as a result of hospitalisations or social welfare removing them from the care of their ill parent. Of direct interest to the current research, was the finding that there were some characteristic affective states experienced by

these children, these were: stress, uncertainty and anxiety; which are related to a disruptive and chaotic environment (Aldridge & Becker, 1999).

Children of mentally ill parents are at increased risk of poorer social adjustment (Farrell, Handley, Hanke, Hazelton, & Josephs, 1999; Goodman & Brumley, 1990; Jacob & Windle, 2000; Oyserman, et al., 2000; Thomas, Forehand, & Neighbors, 1995). For example, Aldridge and Becker's (1999) study investigated the lives of children of parents with a mental illness and found that some feared stigma and alienation from members of society regarding their being identified as the child of a mentally ill parent. Stigma and isolation are perhaps factors that contribute to the findings of Williams and Corrigan, (1992). In this study it was found that children of parents with a mental illness may be at increased risk for more social avoidance and lower self-esteem. Furthermore as a result of social isolation these children may be less likely to be in committed relationships. This may be associated with the finding that children of mentally ill parents may be at greater risk for increased work and marriage problems as well as lower overall functioning (Weissman, Warner, Wickramaratne, Moreau, & Olfson, 1997).

Goodman and Brumley (1990) and later, Oyserman and colleagues (2000) investigated and compared the parent-infant interactions of depressed and schizophrenic mothers. It was found that schizophrenic mothers displayed some deficits in parenting such as such as a lack of emotional warmth and impaired maternal sensitivity and responsiveness to the child (Goodman & Brumley, 1990). It was found that children of depressed mothers were less responsive, less attached, more negative, more critical, more anxious, disorganised, inconsistent, and ineffective than infants of mothers who are not depressed (Oyserman et al., 2000). Goodman and Brumley (1990) found parenting practices to be associated with intellectual and social competence of the offspring (Goodman & Brumley, 1990).

With regards to educational development, studies document increased risk for poorer development in academic domains found in children of mentally ill parents (Davies & Windle, 1997; Garber & Little, 1999). In a study by Stromwall and Robinson (1998), it was found that children who care for their mentally ill parents may be less likely to establish their own vocational or educational goals. Oyserman et al. (2000) found that having a mother with schizophrenia, seems to primarily impact on the child's cognitive development and behaviour problems.

Behaviourally, Mowbray, Lewandowski, Bybee and Oyserman, (2004) report that literature consistently documents male offspring of mentally ill parents displaying more behavioural problems than female offspring of mentally ill parents. Another study documents that infants of parents with psychosis exhibit more behavioural problems relative to children of parents who are unaffected by mental illness (Donatelli et al., 2010). These behavioural problems were found to manifest by the age of seven (Donatelli, et al., 2010). This study also found that the pattern of behavioural problems exhibited by children differed according to types of parental psychosis (Donatelli, et al., 2010). Offspring of parents with affective and non-affective psychosis were found to be at increased risk for externalising behaviour (Donatelli, et al., 2010). Children of parents with affective psychoses were at marginally increased risk for internalising behaviours (Donatelli, et al., 2010).

With regards to mental health service interventions aimed at aiding children of mentally ill parents, the literature highlights the importance of education about the parent's mental illness (Beardslee & Poderefsky, 1988; Cogan et al., 2004; Garley et al., 1997; Reupert & Mayberry, 2010) and the adopting of a more family orientated approach in interventions (Magliano et al., 2006; Mowbray et al., 2006). For example, Reupert and Mayberry (2010) investigated the education component of a program for children of parents with a mental illness found that informing children of the nature of their parents mental illness was of great value within

intervention. Overall it is understood that education offered these children the opportunity to hold less feelings of guilt as well as a decrease of feelings of anxiety and confusion (Reupert & Mayberry, 2010). Stallard et al. (2004) conducted a descriptive study focusing on the views of both the children of parents with a mental illness and the views of the parents with regards to the effects of parental mental illness on the offspring. This study found that it is vital that mental health services adopt a collaborative approach in dealing with families in which there is mental illness; with intervention integrating child and adult mental health services and with the focus being more family-centred. Furthermore, Mowbray, Bybee, Oyserman, MacFarlane and Bowersox (2006) found that it is vital to focus on the parent's capacity to parent given their mental illness, as modifying parenting behaviours is often an effective preventative strategy of childhood and adult outcomes.

This section of the Literature Review has highlighted some of the characteristics 'common' to the developmental contexts of children of parents with mental illness and factors considered to influence the developmental outcomes of the child, including that of educating the child on the parents mental illness, adopting a collaborative approach in intervention strategies, and considering the influence of maternal clinical characteristics and family demographics. However, given that children are at increased risk for poorer developmental outcomes and not condemned to poorer developmental outcomes the topic of resilience warrants attention. In the following section of the Literature Review the concept of resilience will be discussed. It seemed necessary to dedicate a separate section to this topic given that literature emphasises the likelihood of adverse developmental outcomes of children of parents with mental illness.

2.3 Resilience

In this section of the Literature Review, the concept of resilience is considered. Resilience has been defined as “the process of, capacity for, or outcomes of successful adaptation despite challenging or threatening circumstances” (Masten et al., 1990, p. 426). Resilience in general is broadly understood to be a factor that impacts upon the outcome of various circumstances through which a child develops. This section of the Literature Review briefly considers children’s resilience within the context of growing up with a mentally ill parent.

Literature indicates that gender plays a role in resilience, and that women are at less risk for the development of behavioural problems (Mowbray, Lewandowski, Bybee, & Oyserman, 2004). Furthermore, according to Berg Nielsen et al. (2002) the impact of parental mental illness on offspring varies according to the child’s temperament. The researchers investigated parental psychopathology and parenting with the study’s results conveying a need to regard disturbances of children from an interactionist viewpoint. Their findings point to child disturbance as being a result of an interaction between the parent and child and not simply a linear process of dysfunctional parenting of a mentally ill parent resulting in child disturbance. Rather, childhood disturbance was found to result from the interaction between the child’s temperament and behaviours with the parents parenting behaviours, which may be influenced by parental mental illness. This interaction relates to the issue of risk and resilience, an issue that has been investigated by numerous studies, including Fraser and Pakenham (2009), Masten and Tellegen (2012), Manning and Gregoire (2006), Polkki, Ervast and Huupponen (2008), Reupert and Maybery (2010); these studies will be discussed below.

In a study conducted by Fraser and Pakenham (2009) resilience was conceptualised as a process by which harmful or detrimental effects of risk factors, present within the face of adversity, are mediated or removed by the influence of protective factors (including mental

health literacy, social connectedness, coping strategies as core factors of resilience). They investigated the relationships between these resilience factors (mental health literacy, social connectedness, coping strategies) frequently targeted in interventions, and both adjustment (depressive symptomatology, life satisfaction, prosocial behaviour, emotional/behavioural difficulties) and caregiving outcomes in children (12 – 17 years) of a parent with mental illness. Of relevance to the current research the findings of the study indicated that mental health literacy (defined as knowledge and beliefs about mental disorders which influences recognition, management or prevention) was not a strong influencing factor of resilience but did in fact strongly relate to greater life satisfaction (Fraser & Pakenham, 2009). Another study investigating the implications of mental health literacy was that of Reupert and Maybery (2010). This study found that the educational component of interventions targeted at children of parents with a serious mental illness was beneficial to these children. According to them, providing children with age-appropriate information about their parent's mental illness does in fact aid the child in having "language" through which to effectively communicate with others regarding their circumstances, facilitating the child's access to relevant support more efficiently. It seems that mental health literacy does contribute to resilience, although the extent of the effect of mental health literacy on resilience is unclear (Reupert & Maybery, 2010).

Social connectedness/competence and social support are closely related interpersonal resources and thus strongly influence resilience (Fraser & Pakenham, 2009; Garmezy, Masten, & Tellegen, 1984; Masten & Tellegen, 2012). Social connectedness can be defined as the individual's self-perception of being capable of having close interpersonal relationships with others (Fraser & Pakenham, 2009). Furthermore, within the domain of social connectedness, religious/spiritual systems have also been found to contribute to resilience (Masten & Tellegen, 2012; Walsh, 1996)

The literature indicates that there are some specific coping mechanisms adopted by children who grow up with mentally ill parents. Coping strategies can be defined as the constant monitoring and of external and/or internal demands experienced or perceived as taxing or exceeding personal resources and responding accordingly by changing cognitive and behavioural efforts in order to manage the stressors (Lazarus & Folkman, 1984, p. 141, cited in Fraser & Pakenham, 2009, p. 5). Research conducted focusing on adaptive responding to the developmental context in which there is serious parental pathology highlights how resilience may be positively influenced by the child's intelligence (Garmezy et al., 1984). For example it has been found that the child's ability to problem solve contributes to resilience (Masten & Tellegen, 2012). Furthermore, research in this area highlights how resilience may be positively influenced by adopting good practical coping skills, such as for household chores (Pölkki, Ervast, & Huupponen, 2005), 'finding a rhythm' and 'maintaining the frame' (Mordoch & Hall, 2008).

For example Mordoch and Hall (2008), in a qualitative study, identified two core variables (or coping mechanisms) that children of parents with a mental illness perceived as part of their childhood experiences with their mentally ill parent; the variables identified were 'finding a rhythm' and 'maintaining the frame'. There are two stages associated with finding the rhythm were monitoring and adjusting. The first stage, "monitoring" refers to the child's observing of the parent's behaviours and daily routines and "adjusting" refers to the child's attempts to modify their behaviour with the intention of minimising the effects of the parent's mental illness at a given time (Mordoch & Hall, 2008). Maintaining the frame (or ensuring that that there are minimal disruptions to the home environment) entails the child's attempts to develop irrespective of the developmental context, including seeing to the child's own basic needs. Maintaining the frame also includes the process of deciding whether looking after oneself is more important than limiting any disruptions in the environment that may

disrupt the home environment (Mordoch & Hall, 2008). This study found that the foundation of finding the rhythm and maintaining the frame are daily patterns that such children experience in relation to their parents and the home environment. These two variables are understood to have operated as a means through which these children were able to cope and manage the disruptive and chaotic environment (Mordoch & Hall, 2008). Furthermore, successful attempts at finding the rhythm and maintaining the frame limited the eliciting of painful, strong emotions for these children (Mordoch & Hall, 2008).

In light of the research highlighted above, it is important that no assumptions are made regarding children of mentally ill parents; the resilience of each child plays a significant role on developmental outcomes and thus resulting in different experiences and outcomes among children of mentally ill parents. Thus far the literature reviewed has discussed research that pertains to the impact of parental (including paternal as well as maternal) mental illness (of both a psychotic nature as well as a non-psychotic nature) on their children.

2.4 Defining psychosis

Psychosis is a symptom of several psychopathologies such as Schizophrenia, Schizoaffective disorder, Bipolar disorder and other psychotic disorders highlighted in the Diagnostic and Statistics Manual fifth edition (DSM 5) (American Psychiatric Association, 2013). Psychosis may also result from general medical conditions (American Psychiatric Association, 2013).

Psychosis might be associated with mood symptoms, and present as a feature of mania or depression (American Psychiatric Association, 2013). According to the DSM 5 (American Psychiatric Association, 2013, p. 124), mania is defined as “distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased goal-directed activity or energy, lasting at least one week and present most of the day, nearly

every day (or any duration if hospitalization is necessary)”. Mania as defined by the DSM 5 is distinct to that of ‘manic defences’ as defined by Klein; an explanation of manic defences is provided in the section on ‘*Klein*’ in the ‘*Theoretical Framework*’ (p. 28).

The term psychosis implies the loss of reality testing (American Psychiatric Association, 2013). Psychotic disorders are defined by abnormalities in one or more of the five domains: delusions, hallucinations, disorganised thinking, disorganised or abnormal motor behaviours and negative symptoms (American Psychiatric Association, 2013). Each of these domains is briefly detailed below.

Delusions refer to strong beliefs that are held onto with significant conviction despite the presence of clear and reasonable evidence regarding its validity (American Psychiatric Association, 2013). The content of delusions may include a variety of themes, including persecutory, referential, grandiose, erotomanic, nihilistic, somatic and bizarre (including delusions that express a loss of control over mind or body) (American Psychiatric Association, 2013). *Hallucinations* are defined as perception-like experiences that occur without an external stimulus (American Psychiatric Association, 2013). Hallucinations can occur in any sensory modality, including auditory, visual, olfactory, taste, and touch (American Psychiatric Association, 2013). Hallucinations mostly found associated with psychotic disorders specifically include auditory and visual hallucinations (American Psychiatric Association, 2013).

Disorganised thinking, typically inferred from the individual’s speech, may occur in a variety of ways and impair the individual’s capacity for effective communication (American Psychiatric Association, 2013). Examples include derailment or loose associations, tangentiality, incoherence or word salad (American Psychiatric Association, 2013).

Disorganised behaviour or abnormal motor behaviour may also manifest in a variety of ways

and result in deficits in goal directed behaviour (American Psychiatric Association, 2013). Such behaviours may include decreased reactivity to the environment, excessive and purposeless movement and behaviour without obvious cause (American Psychiatric Association, 2013). *Negative symptoms* include deficits in various areas of functioning, including diminished emotional expression, asociality, anhedonia, avolition, and alogia (American Psychiatric Association, 2013).

It is clear that the presentation of a psychotic disorder can vary significantly. Psychosis makes it very difficult for the psychotic individual to relate to others as he/she is less able, or even unable, to interact meaningfully or appropriately.

2.5 Research investigating maternal psychosis on offspring of both sexes

There is a growing body of research into serious maternal mental illness and its effects on the nature of attachment. In a few research studies maternal psychosis has been isolated as an area of research in its own right, due to the understanding that mother's usually play the role of the primary caregiver (Brown & Roberts, 2003; Dunn, 1993; Williams, 1998). According to Bowlby (1988) the quality of the mother's care-giving is crucial to healthy development. Failure by the mother to respond with appropriate care-giving responses leaves the infant with the experience of distress and anxiety, possibly leading to the development of an insecure attachment pattern (Bowlby, 1988). In a secure attachment the child is confident that her care-giver will be "available, responsive, and helpful" in the possible encountering of adverse or frightening situations, while in an insecure attachment the child is uncertain or has no certainty as to whether the caregiver will be "available, responsive, and helpful" (Bowlby, 1988, p. 124). Keeping in mind the definition of psychosis and its presentation (as explained

in the preceding section), this section of the Literature Review will consider literature investigating maternal psychosis on offspring.

Indeed, research indicates that maternal psychosis is characterised by interactive deficits, such as demonstrating uncertainty regarding the infant's or child's needs, having less interactive social contact with her child, being less involved with the infant/child and being less able to create a positive emotional climate. All of these relational and caregiving deficits have implications for the attachment style of the offspring and the offspring's overall development (Forbes et al., 2007; McNeil et al., 1985; Naslund, Persson-Blennow, McNeil, & Kaij, 1985; Persson-Blennow, Naslund, McNeil, & Kaij, 1986).

Brown and Roberts (2000) and Dunn (1993) and are of the few researchers that have focused on the recalled lived experiences of children growing up with a psychotic mother. Dunn (1993) focused on reflections by both sons and daughters who grew up with a psychotic mother. This study sheds light on the impact of maternal psychosis on offspring. Parental attunement and the parent's management of the child's affect informs childhood development (Dunn, 1993). The child's development of a sense of self is facilitated and nurtured, or not, by the parent and is directly affected by parental attunement and appropriate affective responses (Dunn, 1993).

In addition to concerns of parenting, parental mental illness also implies environmental disruption (Dunn, 1993). Dunn (1993) highlights the idea that some of the environmental implications of mental illness within a family include marital difficulties, stress discord among family members, and social alienation and lack of social supports. This would arguably lead to feelings of distress in affected children. In agreement with the results obtained in Dunn (1993), Brown and Roberts (2000) provided findings that some of the environmental implications of maternal psychoses include environmental chaos, social

isolation, abuse and neglect. These environmental implications, as highlighted by both Dunn (1993) and Brown and Roberts (2000), are likely to contribute to the experience of strong, difficult emotional experiences, that may be experienced over a child's lifetime; an idea that is supported by Manning and Gregoire (2006).

2.6 Research investigating maternal psychosis and some possible emotional consequences for daughters.

The familial environment in a family with a parent suffering from a psychotic mental illness has been described as disruptive and chaotic for family members (Mordoch & Hall, 2008). Mowbray and colleagues (2006) highlight the importance of considering the interaction of maternal clinical characteristics (age of onset, duration of mental illness, hospitalisation history and separations during childhood) and demographics (marital status, education and number of children in the family) in the psychosocial outcomes of children of mothers diagnosed with psychosis.

In contrast to 'adequate' parenting, dysfunctional parenting is defined as "anything the parent does, or fails to do that may adversely affect the child" (Berg-Nielson et al., 2002, p. 531). In the case of parental psychosis, or more specifically maternal psychosis, parenting characterised by inappropriate affective response to the environment, rendering those in the environment subject to these responses (Cleaver, Unell, & Aldgate, 2011). It would seem that psychosis could have a significant and direct impact on parenting abilities (Dunn, 1993; Goodman & Brumley, 1990; Johnson, Cohen, Kasen, & Brook, 2006; Manning & Gregoire, 2008; Masten et al., 1990). The affect of a parent presenting with psychosis ranges from severely restricted or inappropriate, or is out of touch with reality (Dunn, 1993). This is

understood to have a negative impact on the child's development, with strong affective states being felt in response to the parental psychosis.

For example, Williams (1998) conducted a qualitative study focusing on adult daughters' recollections of growing up with a psychotic mother. Frequently recurring themes highlighted were: *'Hatred of self and mother'*, *'Current lack of extended family support'*, *'Current parenting difficulties'*, and *'On-going stigma and isolation'*. Implicit in these themes is the necessity of managing difficult affects. In an unpublished study by Kadish on daughters of psychotic mothers, (2003), the researcher focused on whether these daughters perceived their mother's psychosis to have had an impact on their own psychological development. This study found that the participants did indeed perceive their mothers' psychosis to have had an adverse effect on their psychological development. Some of the strong affective states documented by this study included fear, confusion and embarrassment, in relation to their mothers' odd/inappropriate behaviours (Kadish, 2003). According to psychoanalytic writers such as Klein (1965), Bion (1993) and Winnicott (1960b), researchers such as Dunn (1993) and authors such as Brown and Roberts (2003) strong affective states may be defined as feelings of helplessness, psychological disintegration, anxiety, anger and guilt. A psychotic parent is unable to empathically attune him/herself to reality and provide a more coherent and emotionally receptive other to which the child can relate in aiding of development. Given this, it is understood that these children are often left to manage difficult emotional/affective experiences him/herself as well as adjust him/herself with the intention of minimising disruptions in the home environment (Mordoch & Hall, 2008; Rosenbaum & Harder, 2007).

2.7 Theoretical framework

The following psychodynamic theoretical framework underpins the research project. Melanie Klein's (1926; 1935; 1940; 1946; 1956) theory of object relations, Wilfred Bion's (1959; 1962; 1963; 1967; 1993) concept of 'containment' and Donald Winnicott's (1960a; 1960b; 1963; 1965) concept of the 'holding environment'.

2.7.1 Object relations theory

Melanie Klein's object relations theory is rooted in Freud's psychoanalytic theory but stands as a theory in its own right (Gomez, 1997). Object relations theory emphasises the role of 'objects', which can be defined as the internalised representations of parental figures. These 'internal objects' may act as a source of comfort, pleasure, pain, censorship or anxiety (Mills, 2010). Internal objects play a crucial role in psychological processes in psychic development (Mills, 2010). Object relations theory proposes that each individual has an unconscious world of internal relationships (Flanagan, 2011). The outer world informs the development of this inner world and visa versa (Holmes, 1992). The theory refers to intrapsychic processes and the internalisation of the experiences of the infant in early development shapes the way in which the individual at any stage of life relates to others (Flanagan, 2011; Mills, 2010).

2.7.2 Klein

Melanie Reizes Klein, a British psychoanalyst, is considered the founder of Object Relations Theory (Kristeva, 2013). According to Klein the infant experiences all bodily impulses or emotional experiences in the form of mental representations, or phantasy (Gomez, 1997; Segal, 1978); 'Phantasy' is not to be confused with the term 'fantasy' which is not a term

used by Klein. Klein theorised about the infant's mental life through the use of phantasy (mental expressions of instincts) and emphasised the significance of the ego as well as life and death instincts in relational processes (Gomez, 1997; Segal, 1978).

The infant's emotional and mental functioning is established through the interaction between her internal world in relation to external objects, one of which being the infant's mother. It is through the interaction between internal and external objects that the infant's experiences are coloured, and in return experiences colour the infant's internal world (Watts, Cockcroft, & Duncan, 2009). Key concepts within Klein's theory regarding the way that the psyche is structured are that of projection and introjection (Gomez, 1997). Projection is a defence mechanism through which the infant can expel bad objects (unmanageable affective states such as fear, anxiety and confusion) into the external world (Klein, 1946). Introjection is a defence mechanism through which the infant can take in good objects (pleasurable affective states) from the external world (Klein, 1946). Through the concepts of projection and introjection Klein views the self and the external world as mutually influential and the child's experience becomes a product of the individual's internal and external reality (Klein, 1935; 1940; 1946).

Klein (1935; 1956) refers to two developmental positions in her theory: the paranoid-schizoid and the depressive positions. The paranoid schizoid position is the infant's state of mind from birth to three months, subsequently the infant moves into the depressive position (Gomez, 1997). These two positions are states of mind and can be held by any person at any stage in life and, are in constant flux throughout life (Klein, 1935).

The first, paranoid-schizoid, position is a state of mind in which the infant relates to the external world in a part-object manner (Gomez, 1997). This manner of relating to the world involves the infant's organising of her experiences into either good or bad (Gomez, 1997;

Heimann, Isaacs, Klein, & Riviere, 1989). Given primitive nature of the ego she was originally born with, part object relating allows the infant to deal with or manage disruption, deprivation and anxieties (Gomez, 1997). Through the use of defence mechanisms the infant can expel bad objects into the external world (projection) and take in good objects (introjection). Thus allowing the infant to feel that she holds goodness within herself and she protects this goodness by expelling badness. Through this process she is able to keep bad objects away from good objects (Klein, 1946). Projection of unbearable feelings/affective states into the other creates the phantasy of having gotten rid of these unbearable feelings and thus alleviates anxiety (Klein, 1946). This however would not always be possible if the mother/environment stimulates an excess of disruptive experiences, as may be the case with a psychotic mother; this will be discussed further down in this section of the Literature Review.

The infant also experiences persecutory anxiety within this position. Persecutory anxiety refers to the “fear of being destroyed by the malevolent external force”, the fear of being attacked by external aggressive impulses or objects which comes about through the death instinct (Gomez, 1997, p. 37). Persecutory anxiety manifests through the interaction between projection and introjection. The infant’s projections of bad part objects, or aggression, are feared to retaliate and attack the infant and be introjected by the infant, which is perceived to result in the destroying of the infant’s sense of self (Bronstein, 2001; Gomez, 1997); this is elaborated on in understanding guilt.

The beginning of the capacity for depressive functioning occurs from about three months after birth and onwards. Central to the depressive position is the capacity to relate to whole objects; the capacity to perceive previously disparate phenomena as parts of a coherent whole (Gomez, 1997; Heimann et al., 1989; Klein, 1956). It is considered psychologically healthy to relate to the external world from the depressive position most of the time (Gomez, 1999). In the depressive position the infant begins to relate to the objects as whole rather than part-

object relating (Gomez, 1997). Klein (1956) states that it is the infant's realisation of the good part-object and the bad part-object as a whole object that gives rise to the feelings of anxiety and guilt (Bronstein, 2001). The infant realises that the bad part object to which the infant directed hateful and destructive impulses were actually attacks that may have wounded or destroyed the good object; as there is the realisation that the good and bad objects actually are part of the same whole object (Klein, 1956). Early depressive anxiety emerges as a result of the fear of phantasised destruction of the good object leading to destruction of the self and losing the love of the good object (Klein, 1935). Depressive functioning is characterised by the capacity to be in touch with feelings of love for the good object despite the possibility of losing the whole object (Gomez, 1997; Heimann et al., 1989; Klein, 1935; 1956).

The infant feels a great sense of responsibility to preserve the object, due to a fear of losing the object as a result of its destructive attacks against what was thought to be a bad (part) object (Klein, 1956). If the infant perceives the loss of the object then the infant will feel wholly bad as there will be no goodness to introject (Gomez, 1997). This guilt of having projected anger towards the object leads to the development of a new capacity, that of reparation. Just as the infant learnt that anger can damage, the infant learns that love can mend (Gomez, 1997). It is this belief in reparation that keeps the individual from experiencing depression (Gomez, 1997). However if the individual functions more often in the paranoid-schizoid position, and lacks belief in her ability to repair, she may feel unable to access good parts of herself capable of repairing the (internal and external) object. This may result in feelings of intense guilt and pain as if the good object has been destroyed. Thus it is imperative in development that the mother allow the infant's reparative attempts to feel successful so that the infant feels less destructive and bad.

Through understanding Klein's theory it might be inferred that a psychotic mother may be unable to facilitate for the infant, the experience of successful reparation, thus leaving the

infant with the experience of overwhelming guilt and anxiety over a perceived loss of the object. This may relegate such a child to more of her experiences being in the paranoid schizoid position associated with overwhelming affective states (guilt, pain, hatred and anger). In this regard, Klein proposed specific forms of anxiety characteristic of psychosis: paranoid anxiety, the fear of destruction from outside, annihilation anxiety, the fear of psychic fragmentation and of losing the feeling of inner cohesion (Rosenbaum & Harder, 2007, p. 19). These forms of overwhelming affect are associated with defensive processes that of splitting and projecting the raw affect into the other (Rosenbaum & Harder, 2007). The depressive position is emotionally challenging (as it comprises feelings of guilt, loss and mourning) and thus requires ego strength. If the ego is unable to manage the emotional challenges of the depressive position, if these emotions are anticipated to be unbearable should she allow herself to experience them, then the individual will resort back to the paranoid schizoid position. The individual may also reside in the 'space between' the paranoid schizoid position and the depressive position by assuming the use of manic defences, in an attempt to alleviate intense feelings of guilt. Klein (1935; 1940) defines reparation-tendencies as a manic defence when the individual makes obsessional attempts of reparation in a state of manic-omnipotence (a state of strong desire for overpowering the external object) in the endeavours to alleviate the overwhelming guilt and anxiety experienced at having destroyed the good object. Klein specifies that manic defences are used predominantly against persecutory feelings and are of a very sadistic and forceful nature, and are not necessarily an attempt to avoid pining for the loved object (Klein, 1940, p. 143). Manic defences in the way that Klein regards them should be clearly distinguished from mania which is a disturbance in mood over a distinct period of time and is a key criterion of Bipolar Disorder; refer to section '*Research investigating maternal psychosis on offspring of*

both sexes' (p. 19) of the Literature Review for a fuller discussion of the characteristics of Bipolar disorder and mania

2.7.3 Bion

Wilfred Ruprecht Bion was a British psychoanalyst who is well known regarding his work on group dynamics, his theory of thinking, and his model of the development of a capacity for thought. Container-contained is a model offered by Bion (1962; 1963) to explain the relational processing of the infant's emotional experiences by the mother. In the case of a mentally healthy mother (container) the infant's early attempts to communicate, expel, perceive, organise, and manage his internal and external experience (beta elements) are received by the mother (reverie) and given back to the infant in a more manageable and meaningful form (alpha function) – this is the process of containment (Bion, 1959; 1962; 1993; Ogden, 1979). These concepts are further explained below (pp. 29-30).

This processing is crucial for the development of the capacity for thought and the evolution of a sense of internal emotional security (Bion, 1963). Bion's theory offers a way to conceptualise how an individual attempts to know or think thoughts through dynamic experience of the conscious and unconscious (Flaskas, 2005). Knowing or having thoughts is referred to as 'K'. When the capacity for thought is lost in the experience of overwhelming affect, the capacity for thought needs to be restored through the containment of overwhelming affect. Central to containment is the restoration of the infant's ability to think (Douglas, 2007) and the infant's experience of psychic integration, which is achieved intrapsychically through the mother. The mother's mental state is sensed by the infant, which affects the infant's mental state, thus the infant's capacity for thought is intricately intertwined with the mother's capacity for thought (Waddell, 1998). It is through the mother

that the infant develops his/her own particular internal container, the capacity for self-containment and the capacity for thought (Waddell, 1998). It is important for the mother to be adaptable and to respond accurately and to be empathically attuned to the infant's needs (Glover, 2009) which implies that the mother has a firm grasp on reality. The mother's ability to successfully contain the infant is founded upon reverie and alpha-function (Bion, 1993; Douglas, 2007), which will be explained below.

'*Alpha-function*' and '*reverie*' are important processes for the mother's containment of her infant (Bion, 1959; 1962; 1963; 1967; 1993). Reverie is a preceding condition to alpha function and refers to the attuned state of the mother towards her infant (Douglas, 2007). Alpha-function refers to the active holding and 'translating' of the infant's mental state, that of communicating a manageable experience (a meaningful experience) to the infant, thereby allowing the infant to feel contained (Douglas, 2007). The infant communicates her intolerable experiences through the projection of what Bion refers to as beta elements (Douglas, 2007; Waddell, 1998). Containment is achieved through the process of the infant's projective identifications and the mother's alive receptivity to and transformation of these. Projective identification refers to the process of locating intolerable experiences (referred to as '*beta elements*') into or onto another. This process relies on the receiver of the projections digesting the intolerable experiences (beta elements) into a tolerable form and subsequently returning these experiences and feelings in their processed form to the infant. The process of containment relies on projective identification, alpha function and reverie. It is through this process that the infant's capacity for thought is developed and restored (Waddell, 1998). A mother who wants to know about her child and who responds to her child from that need to know and nurture results in the child learning to know how to know (Flaskas, 2005), in this way the infant develops the capacity for thinking. Perception of experience or being able to think about one's affective states is understood to be formed through alpha-function (which is

the mother's mindfulness). The infant's parts of self (otherwise referred to as beta-elements) need to be received by the mother and given back to the child in the form of alpha-elements (that is verbal and non-verbal responses or parenting behaviours). A process akin to mental digestion takes place in this way.

As part of the container-contained process between mother and infant it is necessary that the mother has a grasp on reality; it is likely that this relational process would be adversely affected by maternal psychosis. Bion (1967) states that the mental apparatus can perform in two essential ways: transformation and evacuation. The process of transformation refers to coherent and integrated thought and relies on the ability to tolerate frustration/tension/arousal long enough for this process to take place (Rosenbaum & Harder, 2007). On the other hand evacuation, referring to a psychotic state of mind, is the process of attempting to rid the self of thought of the capacity for knowing; this may be achieved through hallucinations or through delusions (Lucas, 1993; O'Shaughnessy, 1981; Rosenbaum & Harder, 2007). Delusions are understood to be formed through splitting and projective identification; the use of an external object as a container. Through hallucinations and delusions the elements of thoughts become unavailable and thus thinking is disabled, hereby forming the foundation of a psychotic state (Lucas, 1993; Rosenbaum & Harder, 2007); in severe cases of evacuation the diagnostic criteria of psychosis is met (Rosenbaum & Harder, 2007).

As previously mentioned, the infant internalises the mothers containing function, thus an infant who is cared for by a mother whose containing function lacks the capacity to hold and process overwhelming affect is likely to internalise such a containing function. This does not mean that the fate of the infant is psychosis, rather this means that the infant may rely more so on this form of mental processing; keeping in mind that it is only in severe cases of evacuation that psychosis is diagnosed (Rosenbaum & Harder, 2007). The mother who is experienced as a psychotic container 'refuses' the infant's projections, and leaves the infant

with overwhelming affect and confusion (Hopkins, 1992; O'Shaughnessy, 1981). Bion states "the psychotic part of the personality hates all emotional links and ties, fragments any capacity to perceive or register emotional difficulties, or conflicts, operates in an omnipotent way and hates the recognition of dependence upon others for help" (Evans, 2008, p. 254). Bion (1963) states that if the mother's mind is preoccupied with delusional thoughts then containment is impossible. In some cases the child may be used as a container for the mother's anxiety. The mother's role is to process experiences into something that the child can tolerate and think about is crucial for the development of thought, discrimination and differentiation and for a sense of internal emotional security. If mother is unable to process affect and does not leave the child feeling contained, then the child is left exposed to panic and anxiety.

The experience of panic and anxiety as a result of not having a reliable external container to process overwhelming affect is even more deleterious when child is used as a container for mother's anxiety (Hopkins, 1992). The result of this dynamic in the container contained will leave the infant feeling the intensification of her own overwhelming affects; these projections are returned to the infant as even more inexplicable/chaotic by the psychotic container (Bion, 1962; 1963). Bearing in mind that the infant makes use of projection as a means of communication whereby the infant is assisted by the mother in making sense of her experiences it seems that by the infant's receiving (introjection) of these projections there is the possibility that the infant feels that she is comprised of these overwhelmingly bad elements. Having introjected these projections from the mother the infant is left with the experience of herself as even more chaotic and thus feels severe anxiety regarding her own 'badness' (Bion, 1962). The mother-infant bond may turn into one characterised by emptiness and disintegration (O'Shaughnessy, 1981).

2.7.4 Winnicott

Donald Winnicott was an English paediatrician and child psychiatrist and as a result was in the position to observe psychologically disturbed children and their mothers/families. One of his main theoretical focuses was the real impact of the mother in development. Winnicott (1960a; 1960b; 1963; 1965) highlighted the importance of the mother-infant bond explaining that this bond was the foundation to the infant's psychological development (Watts, Cockcroft, & Duncan, 2009).

Infancy is characterised by an inability to control the developmental context. Thus it is the mother's ego support that enables the infant to survive and develop, despite the helplessness characterising infancy (Winnicott, 1960). The development of the infant is dependent upon '*holding*'; this refers to the physical holding of the infant and maternal empathy toward the infant, as well as the broader context of the developmental environment (Winnicott, 1960a; 1965). '*Primary maternal preoccupation*' refers to the mother's ability to be vigilantly and empathically attuned to her infant; it is a significant factor in the infant's development (Winnicott, 1960a). The mental state of the infant is determined by the awareness and empathy of the mother; continued and reliable maternal care are essential factors in the development of the infant's mental abilities (Winnicott, 1965) as well as a dominant true self (Winnicott, 1960b). The true self refers to the infant's ability to recognise her natural and spontaneous needs as expressions of parts of the self or experiences.

Winnicott (1960b) emphasised the formation of both a '*true*' and '*false*' self, as both serve a relational purpose; however it is crucial that the false self is not the dominant personality. The development of a true self is assisted by the mother meeting the infant's need for a mirroring and idealizing object (Newman, 2013). An idealizing object is an object felt to be ever-present and responds precisely upon the infant's demands so as to leave the infant feeling as

if she is omnipotent and determines the instant gratification of her needs. Winnicott (1960b) explains that the development of the true self requires the mother's mirroring of or maximum adaptation to the infant's omnipotent and spontaneous gestures or expressions; the mother is required to be an idealizing object. Furthermore, a healthy balance between the psychic structures of the id, ego and superego culminates in the existence of a true self, while a poor balance and dominant superego culminates in the existence of the false self (Winnicott, 1960b). The superego acts as a moral agent and asserts itself over id impulses, resulting in the infant's compliance with environmental demands, to the neglect of the true feelings and desires of the infant (Winnicott, 1960b).

Winnicott emphasises the notion of the 'good enough mother'. The good enough mother offers her infant developmentally appropriate and adequate security (Winnicott, 1960a). The mother's ego support, the mother's ability to be a good enough mother, allows the child the space for the formation of the true self and appropriate failure of meeting the infant's needs (Winnicott, 1960b). This failure is crucial to development and is a natural process of a mother who is attuned to her infant's needs; this is not to be confused with a perfect mother, the good enough mother is necessary for development while a perfect mother impedes development, as she prevents the infant from developing a differentiated self (Watts, Cockcroft & Duncan, 2009). In the case of a mother who is not good enough, the infant's weak ego cannot be strengthened and thus gives rise to a false self (Winnicott, 1960b). Therefore the mother's inability to sense the needs of her infant and respond as a good-enough mother leads into the development of a compliant infant, an infant that acts from the false self and where the true self is repressed (Winnicott, 1960b). The nurturance of the infant's true self is impeded as the infant's need for mirroring and the validation of the infant's omnipotence are left unmet (Newman, 2013). This can be seen through the study by Mordoch and Hall (2008), which

possibly indicates the use of the false self as a means of coping with the environment. This study is elaborated on below.

The study conducted by Mordoch and Hall (2008), can be discussed in relation to compliance with the environment so as to avoid difficult affect that cannot be dealt with should the true self be expressed (Winnicott, 1960b). Finding rhythm and maintaining the frame were found to be the means through which children of parents with mental illness were able to cope and manage the disruptive and chaotic environment (Mordoch & Hall, 2008). This is contrary to a healthy developmental context where the mother adapts herself to meet the infant's needs. Monitoring the parent's behaviours and daily routines and adjusting their behaviours in order to minimise the effects of the parent's mental illness at a given time and the child's attempts to develop irrespective of the developmental context, including seeing to the child's own basic needs and limiting disruptions to the developmental environment sometimes to the neglect of the child's own basic needs were prominent features of the lives of children of parents with mental illness (Mordoch & Hall, 2008). The child denies the expression of her true self and instead adopts a false self, so that the needs of the environment are met.

2.7.5 The mother-daughter bond

The mother daughter relationship is crucial for the girl's female identity development. This can be seen psychodynamic literature. In this short section of the Literature Review some aspects regarding the formation of a feminine identity or self-identity are highlighted.

According to Jacobs (2007) Klein brought forward a different perspective to understand the mother-daughter relationship through primitive envy. Klein theorised that the girl child particularly fantasised about the mother as 'all-powerful' and 'retaliatory', an omnipotent

object that has the power to both create and destroy life. Through the transition into the depressive position, the daughter's hateful and destructive projections towards the bad breast are understood to be an attack on the mother as a whole omnipotent object (comprising both good and bad parts). The daughter is faced with the realisation that she has injured the good breast in her attempts to rid herself of the bad breast, as they are both parts of the same mother. As a result the infant experiences a profound sense of anxiety regarding retaliatory attacks from the mother. As mentioned previously (p. 27), it is at this point that the infant begins her attempts at reparation (Gomez, 1997; Klein, 1935; 1940). It is crucial that the mother receives the infant's reparative gestures and herewith allow the dissipation of the infant's anxiety. However, in the case of the mother rejecting these reparative gestures (as may be the case at times with maternal psychosis given that psychosis often is associated with impairments in relational capacities) then the infant may be left to face the exaggerated badness she perceives herself to hold as she does not experience successful reparative attempts. She must also face the guilt that overcomes her knowing the damage she has directed against her mother, and thus the damage that she has caused her mother.

In addition to the above, Klein (1956, p. 210) states that while the boy child "possesses in reality a penis" and thus experiences a sense of certainty of his male identity, the girl child is left with an unsatisfied desire for womanhood, as there is no concrete object that can be possessed to symbolise womanhood (Klein, 1956). In fact the lacking of a psychical object (a penis) is identified as womanhood, and thus a deficit in the feminine identity, which may be understood as yet another way in which the mother is damaged.

It seems, the difficulties of the girl child's sense of womanhood is a result of this uncertainty she feels as well as the guilt she feels due to the destructive projections she once made against both the mother and the mother's body in its physical form (Jacobs, 2007). It can be understood that the daughters development of guilt (a part of the move into the depressive

position) (Klein, 1935) is complicated by the daughters search for her female identity and her potent phantasies of the mother as omnipotent, along with the realisation of the female identity as deficit in some way. Bernstein (2008) argues that the daughter's superego is naturally subject to a struggle with ambivalence toward her mother. This struggle is argued to resurface with every developmental step, reviving anxiety and guilt over her own aggression, including the threat of loss (Bernstein, 2008). Furthermore a daughter's ever present need to be nurtured by her mother is amplified by her profound sense of feelings of responsibility for her maternal introject (Bernstein, 2008). Through the aging process of her mother the daughter's feelings of responsibility toward her mother have an increasing influence on her. Bernstein (2008) states that the daughters struggle with a psychotic mother can result in several outcomes, including pathological, and even remarkably adaptive.

Conclusion

This Literature Review has highlighted some of the research around the areas of parental mental illness more broadly, resilience, maternal psychosis specifically and its effect on sons and daughters, and the effects of maternal psychosis on daughters specifically. The Literature Review has also highlighted pertinent aspects of object relations theory, which forms the theoretical framework of the current research. Klein, Bion and Winnicott provide an in depth understanding of how childhood experiences with a mentally ill parent creates obstacles to the emotional development of the child; and possible implications in adult life. Lastly the Literature Review discussed the relevance of unique nature of the mother-daughter relationship, in regards to a daughter's sense of self and feminine identification process. The current research intended to explore how strong emotional affect manifests as a result of

psychotic mothering as well as the indirect impact on the developmental environment as a result of maternal psychosis.

Chapter three – Research Methodology

3.1 Research design

This study utilised a qualitative method (Fossey, Harvey, McDermott, & Davidson, 2002; Merriam, 2009). Qualitative methodologies allow for investigation into the subjective experiences of individuals, which is the focus of the current research project. The current research is therefore idiographic in its orientation. The focus of qualitative research lies in observing and describing phenomena, behaviours, experiences and interactions, as they naturally occur, in a deep, nuanced way, rather than using quantification and statistical procedures. In qualitative research personal meanings and experiences shared by participants become the research data (Denzin & Lincoln, 2003; Fossey et al., 2002; Stangor, 2011; Willig, 2008).

This study made use of an inductive qualitative research design (Merriam, 2008) using of an open-ended, semi-structured interview to obtain data. The Interpretive Phenomenological Analytic Method (IPA) was used to analyse the data. This method emphasises the uniqueness of each interview as well as the similarities across the interviews (Smith, 2004; Smith & Osborn, 2003).

IPA was developed by Jonathan Smith to allow rigorous exploration of idiographic subjective experiences and social cognitions (Biggerstaff & Thompson, 2008). IPA stems from symbolic-interactionism (Biggerstaff & Thompson, 2008). The phenomenological underpinning of IPA is that the meanings an individual ascribes to events are of central concern and that these meanings are accessible through an interpretative process (Biggerstaff & Thompson, 2008). IPA recognises that the researcher's engagement with the data has an

interpretative element, through which it becomes possible to access an individual's cognitive inner world (Biggerstaff & Thompson, 2008).

The research design allowed for an exploration of daughters' recollected experiences of having been raised by a psychotic mother, and additionally, the manner in which they perceived these experiences to have impacted on their lives currently. The current research falls loosely under an interpretivist framework, as the focus of the research rests on understanding and accounting for the meaning of human experiences and actions from the participant's viewpoint (Fossey et al., 2002, p. 4; Smith & Osborn, 2003). The interpretation of data has been guided by a psychodynamic theoretical perspective.

3.2 Research questions

Based on the research rationale and the existing literature the following research questions were identified:

1. What are participants' recollections and reflections on their childhood experiences of being raised by a psychotic mother?
2. What are the different affective states recalled by participants as having been experienced as a result of, or in response to, maternal psychosis?
3. What is the nature and quality of any strong affective states (associated with maternal psychosis current or recollected) that adult daughters of psychotic mothers still experience?

3.3 Sampling strategy

Participants were recruited using purposive sampling (Smith & Osborn, 2003). Purposive sampling is frequently used in qualitative research where the intent of the inquiry is to understand the worldview of an individual or a particular group of individuals (Smith & Osborn, 2003). The criteria used to define potential participants were (1) participants were able to articulate their experience in English; (2) a participants mother would have suffered from a mental disorder which included psychosis or psychotic features; (3) participants were raised by the above described mother during their childhood and adolescent years; (4) participants must be willing to share their experiences; (5) participants must be over the age of 18 years; and (6) participants should not have suffered from any serious mental illness, so as to avoid ethical considerations regarding vulnerable populations.

Participants were obtained through convenience sampling whereby the researcher addressed students in their lectures at the University of the Witwatersrand, explaining the study to them and asking for volunteers. The researcher recruited one participant through approaching third year psychology students in this way. About two weeks later the researcher approached several psychiatrists in the Johannesburg area to request that they introduce the research study to potential participants and provide them with the researcher's details should they be interested in participating in the research. Three participants were recruited in this way. In total, the researcher obtained four participants and after data collection it was felt that data saturation was reached (Merriam, 2008). This sample size seemed to allow this research to reveal enough data for a detailed account of the phenomena of interest (Merriam, 2008) and to obtain sufficient and in-depth data (Smith & Osborn, 2003). It is typical for studies using the IPA method for sample sizes to be relatively small but to have considerable depth (Smith, 2004; Smith & Osborn, 2003).

3.4 Procedure

The researcher first approached the psychology Head of Department at the University of the Witwatersrand for permission to conduct her research. Once permission was granted the researcher requested permission from the third year psychology course coordinator and three third year psychology lecturers to approach the third year cohort during a lecture. It was decided that third year psychology students should be the student cohort as they were thought to be likely to be more mature and thoughtful (all things being equal) than more junior undergraduate students. Once permission was granted the researcher approached the identified classes to obtain participants. In light of the sensitive nature of the research the researcher simply requested that anyone interested in participating in the research contact her via e-mail. Interested participants were provided with a participant information sheet (Appendix A) that stipulated the researcher's contact details, the nature and purpose and conditions of the study. As previously mentioned, the researcher obtained one participant in this manner. Two weeks later the researcher approached the Wits general honours course coordinator and lecturers, requesting to be allowed to approach the honours students to recruit participants. Once permission was granted the researcher approached the honours classes following the same process as with the third year psychology students. One individual volunteered her participation and the interview we scheduled. However the researcher was unable to include this volunteer in her sample as her mother's mental illness did not fit the diagnostic criteria of psychosis.

As a result of having only one appropriate participant after her recruiting efforts at Wits, the researcher and her supervisor came to the decision that she should approach psychiatrists to request permission to leave a bulletin (in the form of a slightly modified participant information sheet) to try to attract participants. The researcher also requested to leave a few

copies of the participant information sheet which potential participants could take and then contact the researcher should they be interested in participating in the research. It was anticipated that adult children might bring their ill parent/s to the appointment with the psychiatrist and potential participants could be discreetly informed about the research by the psychiatrist. The researcher obtained three participants through this sampling strategy.

Once individuals volunteered their participation through e-mailed communication, the researcher arranged a suitable time and place for the interviews to take place. The researcher conducted one-on-one interviews with participants, lasting approximately one hour; all the interviews were conducted over a period of approximately four weeks. On the scheduled days each participant was provided with the information participation sheet again, in order to familiarise them with the studies aims of the research, and two consent forms, requesting consent for participation in the study and for the researcher to audio record their interviews. Participants were informed of the confidentiality of the research process and their interview recordings; that only the researcher and her supervisor have access to the data and the audio recordings, which are kept in a password protected folder on the researcher's and supervisor's computers. They were also informed that they had the right to withdraw at any time during the interview, should they wish to do so. The researcher conducted the interviews using the interview schedule (Appendix D). As per the IPA method, the researcher took note of non-verbal responses that were elicited during responses to particular questions (Smith & Osborn, 2003). Once the interview was complete the researcher debriefed participants as required; spending some time speaking to participants about how they felt during the interview and briefly reflected upon the process with them, checking that participants were not distressed. They were all provided with the numbers of free counselling services in case they became distressed after the interview process. The researcher thanked the participants for their

contributions and informed them that if they were interested in the results of the research they may contact the researcher for the written report when the research has been concluded. The contact details of the researcher are provided on the participant information sheet, which participants were told to keep.

3.5 Data collection

Semi-structured interview

The research made use of a semi structured interview schedule which serves as a useful research instrument from which data obtained can be thoroughly analysed through Interpretive Phenomenological Analysis (Smith & Osborn, 2003). This interview schedule as instrument allows for both structure and flexibility, allowing the researcher to obtain pertinent information as well as permitting the researcher to be reactive to and follow up on relevant issues that were raised by the participants (Legard, Keegan, & Ward, 2003). An audio recorder was used to record the interview and the researcher also took notes to record participants' non-verbal expressive reactions during the interview (Smith & Osborn, 2003). The interview consisted of questions intended to allow an exploration of recalled affective experiences of participants in relation to their experiences of having been raised by their mothers. Interviews lasted approximately an hour. The interview consisted of approximately ten questions, intended to facilitate participants' recollections and reflections on their childhood experiences, and the feelings associated with these memories. These questions were developed according to the main ideas and themes identified in the existing literature (Smith & Osborn, 2003). One of the advantages of utilising a semi-structured interview is that its flexibility provided the researcher an opportunity to establish a rapport how with the participants' as the researcher was able to be responsive and reflective of participants content

rather than focusing on strict adherence to the interview schedule (Smith & Osborn, 2003; Stangor, 2011). This in turn allowed the participants to become comfortable with the researcher and enhance sharing of information in the interview. Using an interview for the purpose of data collection also allowed the researcher to accumulate in-depth information (Smith & Osborn, 2003; Stangor, 2011). However, one of the limitations of using interviews was that the data collection process relied mostly on the interviewer, as the interviewer is considered the primary research instrument (Smith & Osborn, 2003). The interviewer's biases and assumptions may intrude upon the research enterprise. To avoid the impact of the researcher, she made use of reflexivity (bracketing), with the intention of reducing personal bias during the interview (Merriam, 2009), which is discussed below.

3.6 Reflexivity

Reflexivity is “the process of reflecting critically on the self as the researcher”, the researcher being the research instrument (Lincoln & Guba, 2000, p 183 cited in Merriam, 2009). Reflexivity is an important element of qualitative research which relates to the integrity of qualitative research (Merriam, 2009). There is a necessity for the researcher to strive to be as neutral as possible throughout the research process and to vigilantly defend against her own biases. Reflexivity involves in part explaining the researcher's biases, dispositions and assumptions regarding the proposed research (Merriam, 2009). The researcher has carefully documented her impressions of participants that arise during the interview. This involved paying attention to states of feelings which were experienced during the interview, as well as the perceptions associated with these feelings (Cartwright, 2004).

In order for reflexivity to take place the researcher made use of a journal, in which notes have been made. This journal has documented the feelings and thoughts that were experienced

throughout the research process, as well issues pertaining to the individual interview processes. The journal was used to identify biases and assumptions that the researcher has. This journal was consulted continuously during the process of analysis and the compilation of the research report, serving as a reflective tool. It served to aid the researcher in the compilation of a research report that acknowledges the influence that the researcher may have had on the process of the research and the findings of the research.

3.7 Analysis

Interpretive Phenomenological Analysis (IPA) emphasises an idiographic approach to data analysis and is conducive to a small sample size (Smith & Osborn, 2003). IPA is inductive by nature and emphasises the use of narratives in two different ways: cross examination of the themes that emerge within the data and the shared features across the narratives, and the use of the unique aspects of individual narratives in relation to previous literature within the focus of the research (Smith, 2004). Thus IPA allows the researcher to develop understandings of the important generic features of the data in light of previous literature, and allows the research to reveal the life worlds of participants (Smith, 2004). Furthermore for the purposes of maintaining the integrity of the data as well as adding depth to the data, the researcher pays close attention to observing of the non-verbal behaviours and emotions of participants through their relaying of their experiences and the researchers own responses to the content revealed through the interviews (Smith & Osborn, 2003).

After transcription of the audio recording the data yielded was analysed through Smith and Osborn's (2003) abovementioned method of Interpretive Phenomenological Analysis (IPA). Furthermore data analysis required attentive consideration of Cartwright's (2004) emphasis on the participants' representations and object relations, which have been interpreted through

the use of psychodynamic theory. The aim of IPA is to explore in detail the ways in which participants make sense of their personal and social world; the perception of and meaning attributed to particular experiences/events/states to the participants is the interest of IPA. Furthermore IPA emphasises that the researcher acknowledges and his/her own conceptions and that these may play a role in the data obtained and the interpretations made. The steps of IPA are outlined below (Smith & Osborn, 2003).

Data analysis steps:

1. Looking for themes in the first case

The first case was read repeatedly allowing the researcher to familiarise herself with the account (Smith & Osborn, 2003). The researcher made notes about the account during the reading of the case and commented on the use of language, similarities and differences, amplifications and contradictions (Smith & Osborn, 2003). After thorough reading and commenting the researcher returned to the beginning of transcript and noted the emerging themes; making theoretical connections within the case (Smith & Osborn, 2003).

2. Connecting the themes

Emergent themes were listed in chronological order and then the researcher looked for connections between themes; the process involved themes clustering together and the emergence of new concepts (Smith & Osborn, 2003). Then the researcher ordered the themes and clusters of themes coherently (Smith & Osborn, 2003). Clusters of themes were named, representing superordinate themes (Smith & Osborn, 2003). This process also involved the fine tuning of themes and even the dropping of themes in the case of

the theme not fitting in with the structure of the data analysis or a theme lacking richness in contributing to the study (Smith & Osborn, 2003).

3. Continuing the analysis with other cases

The researcher treated subsequent transcripts as if they were the first transcript to be analysed and performed the two stages of analysis described above with each subsequent transcript (Smith & Osborn, 2003). The key issue within this phase in the process of data analysis was that of respecting and acknowledging convergences and divergences within the data; thus theoretical connections were made within and across cases but not without respecting and acknowledging the individual and unique account of each transcript (Smith & Osborn, 2003).

4. Writing up

The final write up conveyed six key themes and nine subthemes that emerged in the data, these were named and described, illustrated by participants' quotes. The quotes presented were chosen carefully as exemplars of the specific theme, bringing it to life, in order to provide the reader with a true sense of core issues that participants presented (Smith & Osborn, 2003). As befits IPA (Smith & Osborn, 2003), the researcher has attempted to highlight the uniqueness of the cases as well as highlight the similarities between cases.

3.8 Ethics

The researcher obtained ethics clearance from the Human Research Ethics Committee of The University of the Witwatersrand. The ethics clearance obtained fell under the non-medical category. The researcher obtained written informed consent from the participants before participation. Participants also received a participant information sheet (Appendix B), in which they were informed of the purpose of the study. Appendix C is a copy of the informed

consent form, where participants were informed of their right to withdraw from the study without any consequence to themselves among other issues (Stangor, 2011). The researcher also obtained consent from the participant to make use of an audio recording device (Appendix D; Stangor, 2011). Only the researcher and her supervisor have access to the data and the audio recordings, which are kept in a password protected folder on the researcher's and supervisor's computers. In the case of publications arising from the research, data will be destroyed two years after any publications; if no publications arise the data will be destroyed five years after the submission of the report. The final research report has been written with the use of thick disguise i.e. omitting any information that allows the identification of participants by readers of the report. The information that was omitted included the specific locations spoken about and the names of people and schools, as well as other information that may lead to the identification of participants or the people whom participants referred to during the interview. Furthermore pseudonyms have been used in the report, further protecting the identity of participants. If participants are interested in the results of the study, a summary of the results will be made available to them upon request; the researchers contact details are present on the information participation sheet (Appendix A). The researcher acknowledges that this is an emotionally sensitive topic thus after the research interview she briefly debriefed the participants. The researcher reminded participants about the free psychological services that they could access if they wished (contact details were provided on the form). These services would allow participants to process any distress aroused through the interview process. The researcher told participants that if they had more general concerns about the research process or write up they could contact the researcher or her supervisor.

Chapter four – Findings

4.1 Introduction

This chapter will present the findings of the research interviews. Through the process of Interpretive Phenomenological Analysis (Smith & Osborn, 2003) six themes and nine subthemes emerged from the data. The order in which the themes are presented serves to facilitate the readers understanding of the data. Quotations from the transcripts are presented to illustrate each theme or subtheme. It is important that the contents of this chapter are not taken out of context, otherwise compromising the integrity of the data. Thus, where necessary, quotations from participants are explained in order to contextualise the content so as to avoid misinterpretations of the data.

The first theme presented is the ‘Present nature of the mother daughter relationship’. This theme revealed participants’ current feelings towards their mothers, while the second and third themes highlight participants’ reflections on their childhood, how participants perceived their childhood to have influenced their lives as well as their sense of self. The second theme, ‘Childhood reflections: adapting and coping’, includes three subthemes; ‘Support’, ‘Escaping’ and ‘Psychological boundaries’. The third theme, ‘Perceived impact of past’ also contains three subthemes; ‘Perceived impact on life path/choices/opportunities’, ‘Perceived impact on sense of self’ and ‘Taking responsibility’. Theme four, ‘Fear’ the fears that resulted from participants’ experiences of growing up with their psychotic mothers. Theme five is ‘Secrecy and stigma’. Lastly, theme six, ‘What to say to another daughter’ relates to one of the questions in the interview schedule and their responses to this question were divided into three subthemes; (‘Support’, ‘Coping’, ‘Professional services’). Pseudonyms have been used throughout the report.

4.2 Present nature of the mother daughter relationship

Participants shared various experiences to exemplify the current relationships they have with their mothers. Natalie has contact with her mother when necessary. Praveena and her siblings share the responsibility of taking care of their mother, and thus Praveena has contact with her mother upon structured arrangements. Nadira and Michelle both have their mothers living with them. Nadira's mother and younger brother both stay in a cottage on Nadira's premises. Michelle's mother stays in Michelle's home, in an extended and cordoned off area, which comprises of a bedroom, bathroom and small lounge. Notably, all participants displayed strong affect when talking about the current relationships with their mothers. Most participants expressed anger, remorse and guilt whilst detailing the current nature of their relationships with their mothers. Two participants expressed the necessity of being numb in relation to their mothers upon interaction. Three participants highlighted feelings of loyalty and feeling responsible for their mothers.

Natalie described her relationship with her mother as "weird" and as being one in which she has had to enforce firm psychological and emotional boundaries. She elaborated that she feels "closed off" to her mother. She compared her relationship with her mother to her relationship with her father, stating:

"I think that now I feel nothing towards her. I know I say it, and I know it sounds horrible, but if something had to happen to her and something had to happen to my dad, with her I think I would be able to overcome the pain, because she was never nice to me. And with or without her, my life doesn't really change..."

As seen above, Natalie highlighted that she has in fact has experienced strong affect in relation to her mother and that as a way to protect herself she has to enforce a boundary between herself and her mother, or numb any emotion that she may experience towards her.

Natalie also expressed significant anger whilst explaining how she felt that her mother is a “very stressed woman” and that because her mother “doesn’t know what to do with her stress and how to deal with it she just kind of throws it on [Natalie], ‘you must deal with my stress, because I can’t deal with it.’” Natalie further stated that she felt as if her mother could not be a present and attentive mother for her, “I think there is just too much going on in her own life for her to kind of deal with my [stress]...” Natalie referred to this experience of her mother in both Natalie’s childhood and at present.

In a similar regard Praveena angrily explained that her current relationship with her mother necessitates a sense of distance for self-protection. However she emphasised simultaneously experiencing a strong sense of obligation in relation to her mother:

“... You become numb and all you want to do is just the right thing and that it’s actually out of your hands, and you want to get on with your life... It really takes a lot of battering, when you come to a point when you actually realise that there is actually nothing I can do for you now and you are starting to affect my life negatively.”

Praveena, who became emotional during the interview, although she regained her composure quite quickly, discussed feelings of anger related to wanting to rid herself of her mother. She stated:

“So you really become, you get angry, irritated and sometime you just wish – and I am just being very frank – you wish that someone would just take her away and take care of her, go and dump her in a government institution.”

She elaborated:

“I am being very frank about this – but really we don’t want to deal with this, we really don’t want to deal with it. If there was another way in which we could make

sure that she is taken care of, that her health is taken care of, she has some friends, she has some joy and happiness, and it would make us all very, very happy.”

In this statement, whilst Praveena wants her mother to be taken care of, she also alludes to a need to in some ways rid herself of the responsibility of her mother, perhaps there is an implicit sentiment of feeling burdened by her relationship with her mother. Inherent in Praveena’s narrative is the experience of strong conflictual emotions; loyalty towards her mother and yet simultaneously anger at her mother’s illness. This sentiment was similarly expressed by Nadira, she feels a sense of responsibility towards her mother recalling that mother worked hard to rear her children (Nadira and her siblings), whilst facing the challenges of mental illness. Her mother lives with her, occupying a cottage on Nadira’s premises. Nadira tearfully stated that “sometimes I say, maybe I shouldn’t have taken her with me - maybe when you angry you think those things. But you can’t, at the end of the day she is our mother and she worked hard.” She further explained that “I do feel her sorry because she worked very hard, she would sell flowers and she would go late at night and she would, at about 11 or 12, and she would... Excuse me...” At this point in the interview Nadira got extremely emotional and excused herself, she went to the bathroom to recollect herself. It seemed as though recalling how hard her mother worked in order to financially support her children brought to the surface painful, difficult and strong feelings. Perhaps this is because Nadira feels somewhat guilty as sometimes a part of her thinks that she should not have brought her mother to live with her. However, she still feels responsible for her mother and exhibited a strong sense of loyalty towards her mother. It appears that Nadira experiences strong conflictual feelings; feelings of loyalty, and feelings of guilt regarding moments of wanting to be free of her mother.

Michelle expressed a sense of resignation she held towards her mother (and her brother):

“And up until now I have taken responsibility for my mom and my brother (who has the heart condition); they live with me... So it has been a lifelong thing for me. It’s something that I have just come to learn to live with, it’s not about choice anymore, it’s just my life.”

Michelle seemed to express a deep sense of sadness and burdened acceptance with regards to having to care for her mother, and expressed less anger towards her mother than that expressed by the other three participants.

Nadira, takes responsibility of the daily care of her mother. She cares for her mother with regards to her physical and mental health. Nadira tries to monitor and enforce some moderation of her mother’s cigarette smoking, and tries to assist her mother managing her spending. She also tries to ensure that her mother is physically safe and tries to enforce her mother’s compliance with her prescribed psychiatric medication. It seems necessary to highlight that although Nadira tries to maintain the physical and mental health of her mother her mother is extremely non-compliant with her medication and resists Nadira’s efforts. Nadira expressed regret as she highlighted having to parent her mother: “It is a bit annoying, sometimes it [Nadira’s mother’s stubbornness] does get to you, you know. I have become so firm because the psychiatrist always tell me ‘don’t let them sit on your head, stick to your word, because they take advantage.’” Whilst relaying this piece of information Nadira expressed significant regret and sadness, and perhaps even disbelief with regards to the continued emotional difficulties she experiences in relation to her mother.

In summary, two of the participants (Natalie and Praveena) described their current relationship with their mothers as emotionally distant in some ways and implied the necessity for this ‘numbness’ in response to their mothers as a means of self-protection. Praveena however explained having a strong sense of loyalty or responsibility towards her mother. This

was also highlighted by Nadira and Michelle in response to their mothers. Both Praveena and Nadira shared their experience of frustration at their sense of responsibility towards their mothers, and in a sense implied that their lives would be easier if they cared less about carrying out with what they felt were their duties to their mothers were. Nadira also highlighted feeling as if she had to parent her mother.

4.3 Childhood reflections: adapting and coping

This theme brings together the various recollections and difficult experiences that participants highlighted regarding how they coped during periods of maternal psychosis. The support from family, friends, romantic relationships, and even religion was raised by participants. Psychological knowledge of their mothers condition was also raised as having a supportive function. Another important part of surviving their childhood was that of having another actual geographical place to go, a place where they could escape the reality of maternal illness, a place where they could have “normal” people around them. Lastly there is the issue of psychological and emotional boundaries; participants spoke of mental blocks, emotional and physical boundaries as means of having coped and as a means of currently being able to cope with their mothers’ psychosis.

4.3.1 Support.

In regards to social supports, participants spoke about family members (immediate and extended family) as either supportive or as not providing support. Participants also made reference to knowledge or understandings about their mothers’ conditions as having acted as or having the potential to act as mental supportive structures.

It is useful to keep in mind the following so as to further contextualise data reported on within this subtheme. Both Michelle and Nadira's fathers divorced their mothers and left them and their siblings with their mothers'. Natalie's father divorced her mother when Natalie was in her teenage years; she however resumed a relationship with her father in her late adolescent years and experienced this relationship with her father as supportive. Praveena was the only participant of this study whose father remained married to her mother, and remained present within the family until his passing away, this was in Praveena's adult years.

Michelle and Nadira both highlighted the lack of support they received from immediate and extended family structures, for example, Michelle stated "...they [members of the extended family] actually didn't fulfil what your elders in your life is supposed to fulfil." However, both expressed the value of religion in helping them cope with the challenges they faced emotionally; religion served as a source of strength. Nadira stated:

"I think it's good to have some belief, because that's where my comfort was, going to church and praying and things like that. Always, just going to church and praying... so maybe that was my strength and that's what I used to do."

Similarly, Michelle expressed the value of religion as a source of emotional support for her:

"So I think for me a lot of my faith has been my support and it has been my crutch, because I always leaned over to my religion to sort of give me the strength to cope. And up until now I have taken responsibility for my mom."

The implication beneath Michelle's narrative is that of having experienced significant emotional challenges or strong affects with which she required some emotional support. Despite having felt unsupported by her family during her childhood, looking back she highlights the invaluable support she currently receives from her husband:

“You kind of speak to your friends, or your cousins, but it’s not the same. Being able to come home to your husband, I mean it’s not just the emotional support, it’s the loving support, and it’s the physical support. And for me that really made a big difference.”

Once again, implicit in the content of Michelle’s narrative is the experience of significant appreciation for experiencing support by her husband within her current life, as well as significant anger and disappointment at her extended family for not having provided her with the support she required in her childhood. When experiencing powerful emotions such as anger, fear and confusion Michelle is able to look to her husband for support, she elaborated:

“... When I don’t feel good, or when I wanna just cry, you know, I just get so frustrated, when everything just feels too much, there is always him. And I can just be myself with him and I can cry, and I can let it out, and I can let the frustration out...”

In this way Michelle felt that she could take off her mask of “brave[ery]”, which could mask the impact of the powerful feelings she experienced. Removing this mask is something that she feels she could not have done as a child.

Having had a different experience to Michelle and Nadira, both Praveena and Natalie reported how they felt supported by their fathers. Praveena spoke about the importance of support from ones immediate family; “The only support you actually need, well, the first line of support you really need comes from your direct and immediate family.” Praveena explained how supportive her father was to his children, and she emphasised how her father had to take on the role of being a mother to the youngest child as well as be a father. Praveena implies having experienced strong affect (including powerful guilt and anger) in relation to her mother and thus warranting the support of her father. Her father tried to relieve his children as much as possible from the responsibility of caring for their mother.

Natalie also reported feeling supported by her father, she elaborated that she would seek comfort from him, she stated "... if something did go wrong I would go home and I would cry to him, and tell him 'don't tell mom.'" Natalie also highlighted the support she received from her godmother stated "you have to now do something about this, because this is your life too and you are old enough now to kind of go your own path" and in this way almost gave her 'permission' to take responsibility for her own future, guiding her in emphasising the necessity for Natalie to move away from her mother, instead of remain subject to her strong emotional experiences resulting from her mother's behaviours (impacted by maternal psychosis).

Natalie highlights how she required the emotional and psychological support of others in order to manage her strong affect (including powerful feelings of guilt and anger) experienced in relation to her mother, and to make sense of her experiences. Natalie also explained how she reached out to the mothers of her closest friends as well as psychologists as part of the way she coped with her mother's mental illness. In particular she expressed gratitude toward her godmother (who is in the medical field), who validated her concerns about her mother; her godmother stated "Natalie, your mom definitely has a problem."

Apart from social support, or the lack thereof, both Natalie and Michelle highlighted the value of understanding and knowledge in aiding one's ability to cope, and perhaps even manage conflictual feelings of guilt and confusion or be able to make sense of these affective experiences. Natalie spoke about the 'power' she felt she had gained from studying psychology; "I think because I study psychology, if I didn't I wouldn't have been able to gain this much power. And you apply a lot of this stuff to you own life...", while Michelle stated:

“And I think over the years, as I grew older, I understood the bipolar illness better and I was able to cope with it better. Though I think that because I could handle it better I could cope with it better.”

Social support or the lack of social support thereof was experienced differently between participants. By implication it appears that all participants highlighted the importance of support with regards to managing strong affect (such as guilt, anger and confusion) and making sense of their experiences of their mothers, and thus a necessity for facilitation of adapting to and coping with to their home environments. Both Michelle and Nadira reported the lack of support their extended family provided, and instead they found their support through religion. Later in Michelle’s life, Michelle found herself being able to lean on her husband for support. Praveena however reported experiencing invaluable support by her family and stressed the importance of having this support in the face of growing up with a psychotic mother. Natalie also reported having a strong support structure in her godmother, as well as psychologists and the mothers of her close friends. Natalie and Michelle also found value in having psychological knowledge.

4.3.2 Escaping.

This theme highlights the how participants felt the need to psychically and/or emotionally escape from their home environments. This was highlighted by three participants particularly; with regards to escaping to ‘normality’ or to a place in which they felt emotionally supported.

Natalie highlighted the search for and the comfort found in a ‘normal’ mother figure and compared her childhood to that of her friends, stating “I see my other friends and think ‘you’ have had such a normal upbringing.” She elaborated that she sought comfort in her

boyfriends 'normal' family, in which the mother figure was not attacking and persecutory, but rather displayed a more attentive and caring way of relating to her:

"I used to attach myself to my boyfriend at the time when I was in school; I attached myself to his family... I attached myself because I was trying to gain a secure environment, where I can be me and not be judged and not be told I am fat by another woman who is the mother..."

Natalie added to this and explained a need to have a "normal mother," "If I could have got another mom, I would have wished it. Because she is just crazy, I can't. It's just that I am embarrassed." Natalie expressed her feeling of shame with regards to the comparison between her own mother's mothering and behaviour and the behaviour of her boyfriend's mother. She explained:

"...because she is such a calm 'I love my family', 'kids come first, before anything', and you know I get so attached to his mom, because she's a normal, normal mother, the mother that I would have sort of wanted."

Nadira also explained the comfort she found in spending time away from home, and being around 'normality', which she found in her grandmother's house. Within this lies the implication of having needed to escape from an emotionally stressful and difficult environment. She stated:

"And my granny used to live down the road from us. She was quite old. I used to always go there, to try and get away from things. I would spend more time with her. But I suppose that also helped me a bit, getting her guidance, being around her, doing normal things that you should be doing with your mother."

Michelle however found herself coping alone in her childhood while valuing the support she has received from her husband in her adulthood. She stated “my husband is a really great support and I don’t think that I would be able to accomplish half, if not more, if it wasn’t for him.” She elaborated on the extent of the support that she receives from her husband, that he sacrifices the freedom of the family as well so as to accommodate Michelle and her mother. She expressed concern that her husband willingly shares the responsibility of taking care of her mother with her. She explained how unfair she feels this to be:

“My husband has had to deal with it and it has been very unfair on him. I mean for a man who is coming into your life who knows nothing about this sickness and having to deal with it. I mean, we can’t do things freely as a family, there is always the consideration of my mother and my brothers. And when any of them do have an episode it always falls on my husband and me, to deal with it.”

She further emphasised the value of being able to escape from ‘everything’, when she experiences powerful feelings, and reside in the comfort of her husband’s presence, if only for a short while. Escaping into the presence of her husband meant that Michelle could escape from having to always be the figure of support, she could escape to having a place in which she could be supported. She stated:

“And like with my husband now, there is him, and when I don’t feel good, or when I wanna just cry, you know, I just get so frustrated, when everything just feels too much, there is always him. And I can just be myself with him and I can cry, and I can let it out, and I can let the frustration out and the next day I can put on my strong face again and I can feel like I can take on the world again.”

Three participants reported a tendency towards some form of escapism from possibly extremely emotionally challenging environments. Natalie and Nadira reported a tendency to

escape to ‘normality’; Natalie would spend as much time as possible at school, or escape to ‘normal’ environments of her boyfriend’s house while Nadira would find comfort in the ‘normality’ of her grandmother’s house (a place in which she felt she could receive some guidance and support). Michelle reported escaping to the comfort of her husband’s arms, a place in which she could just express her true feelings and not have to mask her feelings.

4.3.3 Psychological boundaries.

Participants spoke about various ways in which they have coped with their mothers’ psychosis, such as the importance of creating psychological boundaries (including blocking memories out). It must be noted here that the defences that participants are understood to allude to are not necessarily pathological, and rather considered an adaptive response in order to survive and develop through adverse circumstances (van der Kolk & Kadish, 1987; Freyd, 1994).

Two of the participants explained that they mentally ‘blocked out’ things from their childhood. Nadira stated numerous times within the course of the interview that she had blocked out many memories; “I have blocked out so much of things.” Perhaps this is a result of having experienced such powerful emotions, to the extent that the memories associated with these emotions could not be held in mind. Similarly, Michelle struggled to recall parts of her childhood and highlighted the possibility of having blocked many memories out, “maybe that’s because I have blocked it.” She also explained the possibility of this block being a deliberate process; “I think maybe because there is a block, and maybe I haven’t realised it or maybe I have deliberately put it there.” She elaborated that she suspects that this is part of a coping mechanism, “I think that when you develop coping mechanisms to deal with things, you tend to block things in your mind, because if you don’t do that then something is going to

come crashing.” Blocking out painful memories comes as an adaptive response to the experience of significant emotional trauma (van der Kolk & Kadish, 1987; Freyd, 1994); thus Nadira and Michelle highlight strong affect (possibly including significant anxiety, confusion, fear and guilt) experienced during their childhood.

Michelle further explained that recalling her childhood she felt extremely “emotional” and further explained how distant she feels in relation to the experiences of her childhood, so much so that she feels that the adult she is not the same as the child she was, “speaking about it, it’s like I feel like its two different people, because I am actually sitting and thinking about that child, and I am actually feeling like, sorry for that child.” Here, Michelle possibly highlights how the extent of her powerful emotional experiences warrant the necessity to distance herself from the memories so as to alleviate the potency of the affective experiences recalled.

It seems that both Natalie and Praveena highlight the necessity of refusing emotional sensitivity in relation to their mothers and the necessity to implement psychological or emotional boundaries between themselves and their mothers. Perhaps this is an attempt to avoid the further experiencing of strong feelings. Natalie explained that she has implemented a boundary between herself and her mother so as to protect herself from being hurt by her mother. Natalie explained that she has implemented firm emotional boundaries between herself and her mother so that she does not allow herself to be affected by her mother’s behaviours or her mother’s emotional states. Natalie stated “I don’t let it affect my life now... I have put that boundary there, and I will not let her overstep it and I won’t overstep that boundary, because then it will continue to affect my life.” She added “Like she has cut me out, she has destroyed me, she can’t destroy me anymore, I won’t allow it to happen.” Here, it seems that Natalie highlights that she has experienced her mother as emotionally insensitive towards her and that this emotional insensitivity is how Natalie has come to relate to her

mother in turn. It is in this way that Natalie seems to manage or avoid the experiences of strong affect in relation to her mother. Similarly to Natalie, Praveena stated “this time around I decide that she is not going to have that power over me, it’s just not going to happen.” Praveena alludes to experiencing her mother as having a powerful impact on her, that her mother’s feelings towards her are important to her and have influence on her life. In order to reduce the power she feels her mother to impact on her she explains that “you literally create a rock in your heart for the most part.”

Michelle however spoke about creating a boundary between her past and present with the intent of not letting her past control her future; and not letting her strong emotional experiences of her past impact on her future. Michelle stated:

“I am a realist, I don’t wallow in pity, there are things in my past that I know that I can’t change, and I am not going to allow those things to influence my future with my circumstances, to the best of my ability that I can. But we are all human and we all have emotions and when it comes to the emotive part of it there are still things that I carry with me and maybe it’s not healthy, but it’s there. There are a lot of unanswered questions.”

In summary, all participants reported the protective function of boundaries. Both Natalie and Praveena emphasised the necessity of having an emotional boundary excluding the possibility of letting the environment have an impact on one’s emotional state. Both Nadira and Michelle reported blocking certain memories out and thus excluding the recall of emotionally painful memories and thus protecting oneself. Michelle also highlighted having implemented a boundary between her past and present.

4.4 Perceived impact of the past

Participants spoke of the impact that their mothers mental illness has had on themselves and their lives.

4.4.1 Perceived impact on life path/choices/opportunities

Participants described the ways in which they feel that their mother has impacted their lives, with regards to their relationship choices, the roles that they tend to assume in their lives and family. Participants also highlighted how they have taken responsibility for themselves and/or their mothers and how ‘responsibility’ has a lasting impact.

Praveena expressed deep sadness and regret at the end of a romantic relationship due to the pressure she felt with regards to her mother’s bizarre beliefs in response to race. Praveena explained that her mother “doesn’t like to be around any people who are sick or ill or who she believes is ugly. So if you are dark skinned, if you are not good looking, or not slim, if you are fat, she will have nothing to do with you because she believes that that’s what you will bring into your life.” Praveena’s mother believes that by associating with people who she believes are unwell or ugly she will attract illness and ugliness into her own life. Praveena’s mother disrupts family get-togethers with her behaviour, by for example insulting family members based on their skin tones or refusing to eat in front of Praveena’s aunt (who is ill with cancer). Praveena expressed her deep sadness, regret and anger at having ended a long term relationship with her boyfriend who was black due to the influence her mother’s opinions have/ have had on her. Praveena believes that her mother’s knowing of this relationship would have had a significant impact on her mother, and she expressed a feeling of not having a choice in the matter. Praveena explained that she could not even help the

impact the her mother has on her romantic life, she stated: “to be honest with you, part of the reason I am not with that person, if I had a choice, he would have been the person I would have married, is because of her.” It seems that Praveena’s mother has a significant impact (influence) on Praveena’s decisions based on the strong feelings that she experiences in relation to her mother; in order to avoid a painful reaction from her mother which would in turn cause significant pain to Praveena that her mother would not be able to accept and support Praveena in her choice of partner. Perhaps Praveena managed or limited experiencing intense emotional pain by terminating the relationship with her partner; thus not having to endure the emotions elicited by her mother’s rejection of this partner.

The topic of relationships was further highlighted by Natalie, she explained how her romantic relationship is also affected by her mother; however this is in a different sense. Natalie explained how she sees herself relating with her boyfriend in a dependant like fashion, which is how her mother relates to her. She stated: “I actually see it with my boyfriend a lot, because, again this is something that I am still working on... I can see it in my relationship with him that I depend on him like she depends on me.” Natalie expressed some anxiety with regards to resembling her mother and wants to work on this aspect of herself so as not to be like her mother.

Three participants also questioned how their lives could have turned out differently had their mothers not been ill, or how their lives would have been different had they had support from other elders in the environment. Nadira, with regret and immense sadness, reflected on how her mother’s mental illness and the lack of support from the other adults in her life had left her in the situation where she was taking care of her younger sibling. She regretfully explained how she had no parents to enforce discipline, she stated “I think it would have been important to have maybe some [rules and discipline enforced by her mother, or any authority figure]...” She further explained:

“And sometimes you do need that guidance... We could go to clubs, me and my sister, and walk back at 2 or 3 in the morning, there was no one to shout us and ask why we coming back so late... I suppose it is [hard]... because like I don’t want my children to be brought up that way. Sometimes you get so focused on everything else that you forget to look after yourself.”

Nadira left school after standard 9 and then went straight into the working world. Tears ran down her cheeks as she reflected on how no one had guided her and encouraged her to finish her schooling, or allowed her the opportunity to finish her schooling. With significant regret and disappointment, Nadira reflected on not having a tertiary education. She stated:

“... maybe I would have studied, or gone to university or made it through school. Because I finished standard 9 and then I went to go work. Maybe I would have still stayed and then studied further. Maybe done things a bit differently, you know.”

In a similar respect, although more generally, Michelle wondered about a possible different outcome to life had she received support from family members instead of have the family take advantage of her and her mother. With deep disappointment she questioned how having the support from the other adults within her environment could have led to different outcomes in her life. She stated “because you know my life has been very difficult and very hard and you can’t help but wonder, and question, would things have been different, you know.”

Both Nadira and Michelle questioned how their lives would have been different had their mothers not been ill, or had they had adequate support from other adults with whom they had contact. However, despite questioning how their lives could have turned out differently, they expressed the necessity to just accept circumstances and refrain from ruminating. It was however clear that both Michelle and Nadira experienced this acceptance as burdensome; in some ways a resignation to circumstances. Michelle explained how her assuming

responsibility for her mother (and her brother, who has bipolar) is a part of her life and does not feel like a choice: “It’s something that I have just come to learn to live with, it’s not about choice anymore, it’s just my life.” Similarly Nadira explained that although there are these considerations of a different outcome to her life, she just has to move on. Nadira stated:

“I suppose the older you get you maybe start thinking about things, maybe I should have done things a bit differently, not do all this stuff. Because I basically just put everything on my shoulders. And I suppose that it does come to a point when you have had so much – when you have had enough of everything. And, ag, you just pick yourself up and move on...”

All participants highlighted the profound impact they felt growing up with a mother who suffered with psychotic mental illness to have had on their lives and expressed anger, disappointment, resent, regret and sadness. Michelle explained how she often questioned her current circumstances and wondered how different things could have been had she received the necessary support from elders in the environment. Nadira questioned if she would have possibly completed her schooling had they received support from others within the community or the family. Despite these regretful questions, both Michelle and Nadira emphasised the necessity of just accepting circumstances as they are and not dwelling on the past. Praveena reported believing that due to her mother’s conduct she lost an important romantic relationship. Natalie disclosed her awareness of her behaviour within her relationship with her boyfriend, that she sees herself depending on her boyfriend like her mother depends on her.

4.4.2 Perceived impact on sense of self.

Participants spoke about how they felt that their relationship with their mothers had impacted their sense of self, particularly with regards to the means through which they cope with and manage themselves in day to day lives. Three participants highlighted how their strong emotional experiences (including that of guilt, anger and confusion) through their childhood and the lack of support and attentiveness from their mother's as well as those around them influenced their sense of selves. One participant highlighted having to be psychologically strong and independent, another participant described herself as parentified, and the last participant highlighted how her constant taking on of responsibilities through her childhood remains with her today.

Michelle explained how her life has moulded the person she is and how the lack of support from those around her pushed her to become psychologically strong:

“And I think that maybe psychologically that is why I have become the person I have become, because I am extremely independent. And I don't take nonsense from people, and I tend to answer back and I am always on the defence. And I am always standing up for Michelle... I always say, people don't know me, and people don't understand me, because if they knew the real me then they wouldn't say the things that they do. And for me it is so important for people to really know the real me because it's... My life has determined the person that I am now. And my whole life I have always felt like I have no one to depend on, so now in my life, when there are people who are really close to me, and really love me, if in some way I feel like they are not fulfilling their role in being there for me I would make a big deal of it and nobody would understand – ‘what is she on about, why is she going on like this about a small thing’. No one will understand that it's not just about that, but that it's about so much more.

It's about, my whole life I have had to stand on my own two feet, and defend myself in the face of so many things for as long as I can remember. And now I want somebody to take care of me, because I am always taking care of Michelle, but I want someone to take care of Michelle now."

Within this there is the implication that Michelle had to adjust herself in order to meet the needs of her environment rather than have the environment adjust to meet her needs. Michelle alludes to a strong sense of self-reliance and independence as well as a longing to let these qualities go and to be looked after rather than be the one who 'looks after' others. Furthermore she believes that no one really knows who she is, that she portrays only the part of herself that she chooses to let people see, and her more vulnerable side is not one of the parts of her that she is comfortable with others seeing. Perhaps Michelle experiences vulnerability or dependence as frightening, and thus she may defensively hide her vulnerability and feelings of dependence in an attempt to avoid the experience of significant fear.

The possible defensive nature of Michelle's emphasis on self-reliance is highlighted when she explained that she believes strongly in not letting people see her weaknesses as she recalls how her family took advantage of their situation in light of her mother's illness (or weakness, so to speak). Michelle stated:

"You know the world sees you in a certain light and we all portray parts of our persona that we want people to see of us. And for me, what I have always wanted to be perceived as is strength... It is very important to me. I don't like to display weaknesses, because for me, I always perceive weakness as a negative trait. And I think that is a lot to do with, because of my mother."

Natalie also highlighted the sense of independence which she feels to have gained as a result of growing up with her psychotic mother, she stated: “I would never cry to her because she was the child, so if I am the parent, how can I cry to the child.”

Natalie elaborated that she felt that she could not be a child and that she had to become a parent to her mother in some ways; “I had to deal with it in an adult way when she was being a child.” She further stated:

“Parentified child, ya. That’s what it is, you know. So it is interesting. And I must say yes ok I do regret what happened and I am sad that that’s the way my life is but at the end of the day it has just made me unique and it has just made me be able to deal with life more seriously, because now I am more mature than I would have been had nothing happened.”

Natalie highlights the process of growing up before her time – that of being a parentified child. Similarly to Natalie, Nadira highlighted a ‘parentified’ self. Nadira explained how used to shield her younger sibling from the “crazy stuff” and assumed the role of taking care of everyone. She elaborated that this is something that she continues into her current life: “So me and my sister we used to take on the roles and we used to cook, clean up the house and those sort of things”. Nadira explained that she feels that till today she continues to take on the responsibilities, she stated “I found in my adulthood that eventually I thought it was my responsibility to do everything. And I started working and taking on all the burdens...”. Nadira explained “I am a person like that – keep it in keep it in and until you can’t keep it in when things build up... and then you try and get a grip of things and you try be strong and keep going.”

It appears that participants alluded to the significant impact that their management of difficult affective experiences through their childhood have shaped their sense of selves. Two of the

participants felt that their experiences' of growing up with a psychotic mother has made them strong and independent. Three participants expressed a belief that their childhood circumstances pushed them into quickly acquiring a sense of independence – such as having to care for themselves from a very young age, and thus building a strong sense of self-reliance. Michelle and Nadira, in particular highlighted their belief that the care taking roles that they assumed in relation to their mothers and to their siblings is something that they continue to display in their current lives. They view themselves as care takers and tend to take on the responsibilities of the family. Natalie in particular emphasised her strong self-reliance due to not having been able to rely on her own mother when she was younger.

4.4.3 Taking responsibility.

The subject of responsibility also came up in various ways through the interviews, including that of taking responsibility for one's self or for others in the environment. Participants highlighted taking responsibility for themselves at a young age as well as taking responsibility for their mothers and their siblings. Although taking responsibility for one's self and/or for siblings and of the mother is something that participants allude to as a factor impacting their sense of self and their life, it seemed that this of taking responsibility deserved a separate theme on its own.

Natalie highlighted how she felt that she had to parent herself, or take full responsibility for herself, she angrily stated "I don't need her because I have become a mother to myself". Perhaps it is through reflecting on her childhood that she experiences anger at the absence of her mother's mothering of her.

Nadira, however, expressed a sense of deep-seated sadness at having to parent her own mother "...she has been so stubborn like that since we were small... It is a bit annoying, sometimes it does get to you, you know. I have become so firm." She explained how at a young age she took responsibility for her younger sibling, perhaps this was a way in which Nadira was able to manage the environment so as to limit disruptions within the home environment, and thus limit occurrence of overwhelming feelings. She stated:

"I was the child – the strong one that looked after them... they just don't appreciate, I used to water the plants, go buy the groceries, they didn't really pay any part. I am the one who looked after my brother – made sure he went to school and made his lunch in the morning."

Nadira regretfully stated "today, if I look at my life... I see myself as always being the person to support everyone – as a child." Michelle highlighted a similar sentiment, stating:

"So I am not the youngest, but in the household I am the youngest [Michelle's younger brother was taken away from her mother shortly after his birth, leaving Michelle as the 'youngest in the household'], growing up with the rest of my siblings. I have always had to take the responsibility. There were times where I became extremely angry. And I felt, not only angry, but resentment, because I felt 'why is it always just my burden.'"

It seems that Michelle is left with the experience of painful feelings (including anger and resentment) which she has had to manage, whilst still taking responsibility for her mother and remaining loyal to her mother. Perhaps not caring for her mother would leave Michelle with even more powerful affective experiences. Thus in order to manage her own emotional experiences and lessen the emotional strain she chooses to continue taking responsibility for and caring for her mother.

Nadira further explained how she used to protect her younger sibling for the bizarre behaviour her mother displayed, and felt that she enabled her youngest sibling the chance of being as normal as possible. She stated:

“I always think in my mind, the only two normal people, if you look at everybody, is me and my younger brother – because I used to look after him. I used to always keep him away, my mother used to do funny stuff, I would always close her room door and let her do all her funny stuff, and I would take him into another room and play with him just to block that out. Even with him when he was small he would refuse to go to the school and such.”

Perhaps Nadira experienced strong affect, namely, significant fear and confusion, in relation to witnessing her mother's behaviour. As a result she experienced a need to protect her brother from the same sort of experiences. Perhaps she felt she could prevent her brother from the fear and confusion she once experienced and struggled to manage. Perhaps Nadira longs to have had someone in the family who would do for her what she did for her younger brother.

Michelle and Nadira both explained how they had taken responsibility for their mothers in their adulthood. Nadira resentfully stated “I found in my adulthood that eventually I thought it was my responsibility to do everything.” Michelle stated with anger and regret:

“I mean, we can't do things freely as a family, there is always the consideration of my mother and my brothers. And when any of them do have an episode it always falls on my husband and me, to deal with it.”

Praveena highlighted that herself and her siblings share the responsibility of taking care of their mother. Now with her intention to immigrate she feels guilty to leave her siblings with

the full responsibility of taking care of their mother. She stated “It is very difficult for me because now I feel like I have to leave the burden on my sister and my brother.”

All participants highlighted the topic of taking responsibility. Natalie reported believing that she had to take responsibility for herself from a young age, and mother herself. However in the cases of Nadira and Michelle, there is a sense of responsibility that extends beyond themselves to their mothers. Furthermore, they feel as if their rigid image of being the figure that takes responsibility and cares for those around them has even extended into their current role in their own families today. Praveena directly highlighted the burdensome nature of the sense of responsibility that she feels with regards to caring for her mother.

4.5 Fear

Participants raised fear in two different ways, a fear of becoming like their mother, and a fear of having children; fears were found to be related to psychosis.

Three of the participants raised a fear of becoming like their mothers. Michelle anxiously stated “you also fear, like what if I become like that.” When asked to elaborate on this she explained “I am still trying to make sense of it till today, to be honest with you, it’s a lifelong battle.”

Similarly, Nadira (who laughed insecurely while tears ran down her cheeks), explained her fear of becoming like her mother. She explained that when she becomes emotional or depressed she wonders if she has the potential to become ill like her mother. It seems that the thought of becoming like her mother elicits powerful feelings of fear and distress; perhaps these thoughts elicit feelings so powerful that she laughs in order to distance/manage the experienced fear. She stated:

“I think with the hormones and things going and sometimes I get very emotional. Sometimes I also wonder if I am going mad like my mother. The doctor said that it’s normal... You start thinking, what if you land up like your mother, then what will you do...”

Natalie also highlighted this fear and further explained how she strives towards doing things differently from her mother as a result of a fear of becoming like her. She stated:

“And I fear myself that I am going to be like that, like her. I do things and I think, what did you just do, don’t ever do that again, and in my own head I am like ‘don’t do that because that would be what she would have done, and you don’t want to be like that, because people don’t like that. So it’s become like a thing that I am scared, myself, to become like her...” “So everything she would do, I do the opposite to try and better, because I am trying to teach myself, after all those years of seeing what she does.”

Possibly as a result of recalling significant emotional distress in relation to her mother, Natalie explained that she is fearful of becoming like her mother and worries that if she were to have a child then the child would have to go through what she has gone through:

“... Ya, big fear. I mean I have always wanted so many kids, but after this I am like ‘gosh, I don’t actually know if I want kids, what if I am like... before I ever get married I want to get a full check because if there is something wrong with me I wouldn’t find it fair for somebody else to be with a person like me, because I see how my dad suffered with her, and only late after did I see it.”

Natalie seems to imply the need to prevent another person, whether it be her future spouse or her future children, from having to live through some of the experiences and associated

emotional challenges she and her father experienced in relation to her mother. Nadira expressed a similar sentiment of needing to protect her children from having to face some of the painful emotions she recalls from her own childhood in relation to her mother. She has two children of her own and has found herself extending herself as far as possible, to the extent of sometimes forgetting about herself, with regards to the caring of her children due to a need to have her children not live through the same experiences that she had to live through as a child. She cried as she compared her mothering to that of her mother's mothering:

“We used to make our own lunch and go to school. And if we did our homework... nobody really cared. Like it's so different with my kids, I make sure that they do their homework. I sit with her [Nadira's daughter], my husband sits with her [Nadira's daughter] sometimes. And we didn't have that.”

Praveena expressed fear regarding having children, she explained that her fear of having children is related to that of having a child that is mentally ill like her mother: “I mean I won't have children, and maybe part of the reason why I never married, I would just not be able to deal with having a child that has a mental disease.” Here, Praveena highlighted the significant impact that her affective experiences in relation to coping with her mother have had on her. She experiences significant fear of having to endure such affective experiences again in her life, and as a result she fears marrying and having children of her own; concerned that she may have a psychotic child.

Nadira and Natalie highlighted the issue of their children having a psychotic grandmother. Nadira regretfully explained her daughters concern or interest regarding the pressured relationship between her and her own mother:

“Me and my daughter were talking the other day, she is 8 years old, she said to me “you know I never knew that Deena is your mother” – she looks at the relationship

between him [Nadira's husband] and his [Nadira's husband's] mother and she looks at me and my mother... She doesn't do any of those things. She doesn't phone any of her children, her grandkids to wish them happy birthday and things like that, whereas on his [the husband's] side it is completely different."

Natalie also thought about what her children's experience of their grandmother might be. She explained regretfully that if she were to have children she wouldn't be able to send her children to her mother: "I just thought, one day when I have kids, I actually want them to go to their grandmother, because right now, if I had a child I definitely wouldn't send them there, because I am scared." Natalie highlights her need to protect her future children from powerful emotional experiences, which she had experienced growing up.

Three participants (Natalie, Nadira and Michelle) highlighted a fear of becoming ill like their mothers. Natalie expressed fear of causing a future spouse and future children the pain and other strong affective experiences that she herself experienced in relation to her mother and witnessed her father experience in relation to her mother. Nadira expressed significant sadness and regret whilst reflecting on how the comparison between how her husband's mother treat of her grandchildren to how her own mother treats her grandchildren. In this way she reflected on how emotionally challenging it is to have children, and in some ways witness her own struggles with her mother through witnessing her children's experience of their grandmother. Two of the participants expressed a fear of having children; both these participants do not have children. For Natalie there was the implication of a need to protect her children from having to experiences the unbearable affective experiences that she had to experience for herself. For Praveena there was a fear of having children, as a result of fearing having a psychotic child. Perhaps Praveena is attempting to avoid any re-experiencing of some of the strong affect within a relationship with a potentially mentally ill child, parallel to what she has endured in relation to her mother.

4.6 Secrecy and stigma

Participants highlighted the topic of secrecy within the family in various ways as well as the topic of stigma and the role that stigma has played in the victimising of the participants. Secrecy within the family seems to have emerged in the data with regards to the management of powerful emotions.

Nadira reported her need to protect her younger brother from their mother at times, and keep her mother's behaviour a secret:

“I used to always keep him away, my mother used to do funny stuff, I would always close her room door and let her do all her funny stuff, and I would take him into another room and play with him just to block that out”.

Perhaps Nadira experienced powerful emotions (such as fear, confusion, guilt and shame) in relation to her mother's behaviour and thus she felt a need to protect her brother from experiencing the same affective experiences. Secrecy was also raised by Praveena, who explained how her sister made her best efforts to hide her pregnancy from her mother. She explained that her sister was fearful as to how her mother would respond to the news, and if she would behave in an extreme and bizarre way: “And my sister is pregnant now, she is five months pregnant after four years of marriage. She is terrified for my mom to know because my mother does all her little prayer things.” Praveena understands her sister to currently experience significant fear in relation to their mother.

Praveena further highlighted a sense of secrecy within in the family when she explained that no one really spoke about mental illness within the family, and that much of this information was uncovered only subsequent to her mother's admission into hospital (this was during Praveena's adulthood):

“And I think from that time onwards we started to ask a bit more questions to my grandmother, to my aunt, to find out what was really going on. But what we realised was that her sister was even in a much worse condition than her... No one ever talks about this; no one ever tells you that there might have other incidences earlier down the line in the family. So I started to ask a couple of questions, and by that time my sister was studying medicine, and I was finished with my honours degree in psychology, and after this hospitalisation we all started getting a little more nosey and asking more questions. Also she had gotten a lot worse.”

Natalie reported having feelings of shame regarding her mother and having a need to hide her mother from her boyfriend's family: “It's just that I am embarrassed. Three years I have been dating my boyfriend and his mom and my mom have maybe met twice.” In an attempt to avoid the experience of strong feeling, such as embarrassment, Natalie limits the contact that her mother has with significant others in her life (such as her boyfriend's mother). In this way Natalie is able to manage her environment, and thus her experiences of powerful emotions.

Both Michelle and Nadira highlighted how they were victimised by others who took advantage of their mothers 'inability' to defend them. Michelle expressed significant anger whilst she explained how her family victimised her and her siblings, perhaps the stigma of mental illness contributed to the family's justification of their treatment of the family:

“So coming from a situation where my father was very disrespected in the family, and my mother was looked upon as a bipolar patient and automatically we lived with my grandparents. We were made, by the things that were said in the family we were always made to feel – I don't know how to explain it – but the family always looked down on us... I resented the way that they treated her, I resented the way they treated us, because we were just victims of circumstance”.

Here, Michelle recalled her experience of strong affect, possibly including shame as a result of how she and her mother were treated, and resentment towards extended family with regards to how they treated her mother.

Nadira, cried as she explained how she and her sister were victimised by the neighbour; she and her sister were molested by the neighbour on a regular basis for a period of time. She stated: “People see that a family is not right and you have these bad animals in the community who take advantage.” It appeared that even as Nadira recalled her traumatic experiences and the associated emotional responses, she also experienced it in the room during the interview. As she relayed this piece of information tears rolled down her cheeks and she looked away from the interviewer. Perhaps some of the strong affect she experienced and still experiences is that of shame and extreme fear of her own vulnerability.

In summary, two participants (Natalie and Praveena) highlighted how secrecy manifested within the family as a result of their mothers mental illness. For Natalie, the shame experienced with regard to her mother in comparison to other ‘normal mothers’ was indeed significant. For Praveena there was the experience of deep sadness in her current life, of having to keep certain events on the family a secret from her mother. In this way Praveena could avoid re-experiencing strong feelings which would inevitably arise as a result of her mother’s response to the events. Nadira spoke of the having to protect her younger brother from their mother’s bizarre behaviour and hide her mother from her brother in these times. Here again, is the implication of the strong affect she experienced with regards to witnessing her mother’s behaviours and a need to protect her younger brother from having to experience the significant fear and confusion. Perhaps in this way she too could manage her own powerful emotions by focusing on her younger brother. Two participants (Nadira and Michelle) highlighted how the stigma of mental illness allowed for people to take advantage of them; Michelle explained that this went further, and that her mother was also taken

advantage of. In recalling how mental illness is associated with being taken advantage of, these participants expressed deep sadness and disappointment.

4.7 What to say to another daughter

Participants were asked what they would say, if anything, to another daughter of a psychotic mother. Interestingly participants all highlighted the importance of responding in a certain way to, or having a particular understanding of their mother's psychosis, as well as the issue of support from ones family and the use of professional services (including that of support groups, therapists and medical practitioners).

4.7.1 Support.

Support was highlighted in different ways through the interviews. Two of the participants spoke about the value of the support from a trusted individual. All participants highlighted support or the lack of support from family.

Praveena emphasised the importance of having support from ones family: "The only support you actually need, well, the first line of support you really need comes from your direct and immediate family." It seems that Praveena's family were a particular source of support for her and she emphasises the importance of family in dealing with the complications of growing up with a psychotic mother. Her emphasising of the necessity of support highlights the possible emotional challenges that she may have faced whilst growing up with regards to her mother.

Natalie, however, emphasised the importance of support from a person that the child trusts, whether or not it is a family member, she stated “you have got to find somebody that you can speak to, even it’s a family member who you are quite close to, to try and speak to her to see that it’s not just you that is like that.” Interestingly Natalie spoke more directly about helping the child; she seemed to go one step further than the other three participants and offered herself as a supportive structure in the form of someone who could listen to the child. She stated “I think that I would offer as much support as I could to that child, to lend a listening ear and say ‘we can talk about it, and I can maybe help you know how to respond to her.’”

Nadira spoke more generally about who she thought would form the supportive structure for the child. She stated “get some support and guidance from someone who will assist you. It is quite a bit for one person to take on.” Nadira spoke with deep regret, perhaps this is related to her feeling as though she received no support from those around her and felt that she had to fend for herself. Michelle shared a similar sentiment, she stated:

“So in the beginning you think that you can take on the world and that you can handle this and that, and that you can make the difference that everybody else couldn’t make and you are going to be the one who is going to change the world. And for a long time you think you can do that. But it is just not possible, because you are human, you know... You just can’t. And also, importantly she [daughter of a psychotic mother] needs a good support system, someone that she can talk to.”

While Praveena highlighted the importance of family as a support system, three participants did not specify the support system but still highlighted the importance of having some form of support. Two of these participants mentioned that the conditions of growing up with a psychotic mother necessitates support and cannot be dealt with on one’s own, and that it requires tremendous emotional strength and support.

4.7.2 Coping.

The means through which coping with growing up with a psychotic mother may be facilitated was highlighted by all participants. The promotion of knowledge and understanding of the mothers condition was highlighted as an important factor that facilitates coping. Another important factor was having the understanding that the mother is not intentionally trying to hurt their child. One of the participants however implied that being the daughter of a psychotic mother cannot be coped with and thus the child should be removed from the care of the parent.

Three participants emphasised the importance of understanding the illness as a means to coping with their mothers' psychosis. Nadira stated "the main thing to do is to educate people, where there is someone you can go to, to get that kind of help; people who can understand what is going on..." Similarly, Praveena stated "I think the first thing is, please understand that this is actually a condition, a disease" and Michelle stated "I think the most important thing is to equip yourself with enough knowledge and understanding about the illness so that you can be better prepared to cope with it." Through the emphasis that these three participants have placed on the importance of having an understanding of psychosis there is the implication that the lack of this knowledge leaves the child with significant confusion or strong affect.

Two of the participants highlighted the importance of understanding that the child's mother is not intending to be hurtful. Herein, the implication that growing up with a psychotic mother can in fact leave the child feeling extremely hurt, thus experiencing significant emotional pain. Natalie stated "your mom doesn't really understand what is going on so you can't take it all in too seriously." Praveena stated in a similar regard "you have to constantly remind yourself that this person does not mean to hurt you" and "have no expectations; except plan

for the worst in a way. But that shouldn't stop you from showing a little bit of compassion.” Praveena cautions the daughter of a psychotic mother to even expect to be hurt, but elaborated:

“... understand that it is never directed to you, personally, it is never intended to harm you or hurt you. You have to do your absolute best to see it from the perspective of the persons mind. You know. They actually love you and care for you dearly.”

“... just at least learn a little bit more about what it's about, that you understand that she is not doing it to harm you or to hurt you. With anything, especially with this person being your mother, where she is ok and then suddenly she changes, you keep thinking ‘why are you doing this to me, what have I done to hurt you, or upset you, why are you being so vicious.’”

It appears that Praveena explains that in order to manage the powerful emotions that may be experienced in relation to the mother the child may have to coach herself into understanding that she is not the reason for the rejection experienced, and that the mother does in fact love her. Praveena also explains how the inconsistency of the mother's behaviour can leave the child feeling responsible for the change in behaviour, but also feeling confused at feeling responsible as the child has done nothing to hurt the mother. The child may be left experiencing significant guilt among other experiences of strong affect. She also explains (below) how to deal with the one's own feelings of anger towards the mother who is experienced as hurtful without reason, and the numbness that the daughter may feel, perhaps as a means of protecting herself from the pain that she expects to experience in relation to her mother:

“... I think you have to practice some self-compassion. So, its ok to get angry, its ok not to feel anything from time to time, it's ok to want her to be dead from time to

time. You will go through phases like that and that's ok. So you have to practice some self-compassion."

Praveena highlighted the necessity to figure out a way to cope in the situation, she stated "I think the next step would be that you literally have to figure out a way in which you can survive in this situation and in this scenario." Nadira suggested rather that the child should not be subject to the trauma of the environment, she stated "I mostly think that those kids should be taken away from that person completely. And, ah... Sorry man [apologises for crying]..." Perhaps it can be understood that Nadira's experience of her mother was indeed at times emotionally unmanageable and thus she suggested that the child have no contact with the mother. Evidently Nadira still experiences strong affect in relation to her mother, and when recalling her experiences and the affective component of these experiences she believes that it is indeed unmanageable and thus should not be dealt with at all, but rather avoided.

All participants highlighted how having knowledge facilitates the child's ability to cope, and two participants further highlighted the importance of understanding that the mothers behaviour is not intended to hurt the child personally, but that it is rather a consequence of a mental illness. It seems that there is the implication that children growing up with a psychotic mother face strong affect (including rejection, pain and guilt) in relation to their mothers. These powerful emotional experiences may be managed through the knowledge that the mothers behaviours towards the child are not as a result of the child herself. One participant did not advise on a specific means to cope with the mother, but did explain that the child needs to figure out a way in which the child can survive the situation. Once again there seems to be the implication that there is strong affect that needs to be managed, and it is necessary for the child to find a means to survive and emotionally challenging environment. One participant however felt that the child should simply be removed from the environment;

perhaps indicating that growing up with a psychotic mother is significantly emotionally challenging and is in fact beyond the coping capacities of any child.

4.7.3 Professional services.

Professional services were discussed with regards to the mother as well as with regards to the daughter. This was a topic raised by all participants. There were however mixed feelings and beliefs regarding the use and effectiveness of the different types of professional services which could potentially be made use of.

Both Nadira and Praveena highlighted the importance of getting help for the mother. Nadira stated “I would say to her, first get help for your mom”. Praveena emphasised the importance of getting the right kind of help for the mother, and raised the concern of finding a good psychiatrist. She stated:

“But if there is anything you can do right, try and get care as early as possible and be careful of the doctors you select. Because if they are just going to drug your mother and put her on anti-psychotics, there is no point in that, because there is going to be no development. You need someone who can do the right amount of counselling and that can actually give you a proper progress report. Because sadly enough most of the darn doctors today, that’s what they do. The pharmaceutical companies pump their drugs and they feed your mother, or they feed them as much of the drugs as they can. And understand how those things work.”

Two of the participants mentioned getting help from a professional; that therapy is important for the daughter of a psychotic mother with regards to dealing with the emotional experiences that the child faces. Michelle stated:

“... it is not easy, it really is not easy... And as much as you can, as much as you can deal with it academically and intellectually in your mind and you can try and explain it, unfortunately the emotional part far outweighs the intellectual part of it. Because it is a very emotional thing.”

Michelle clearly highlights the emotional challenges that she experiences to date. Michelle explained the importance of seeking therapy despite feeling that you are well and can manage on your own. She highlighted that the consequences of growing up with a psychotic mother may not even be known to the child. She stated “you may think that you are strong enough to deal with it and psychologically strong enough to deal with it but it does ultimately catch up with you and you do start questioning things about yourself.” She further stated:

“At the time when you are dealing with it, when you don’t understand everything and you become so angry, like you know... You also fear, like what if I become like that. That is why I am saying, that it is very important for a person dealing with that to also go for counselling. Because in the beginning you... When you still have all that strength and energy, and you are just starting out, you think that you can take on the world. But as time goes on, it does drain you emotionally. It does drain you psychologically. Because like I say, it is very difficult and it is very traumatic...”

Praveena, similarly explained that it might be necessary for the child to be in their own therapy:

“I’d say that depending on how you react to it you will either have to seek some kind of, some kind of care or some kind of counselling yourself. Because if this engulfs your entire life and you are unable to function optimally and normally, you know, you are crying all the time, you are angry all the time, you are unable to finish your

studies, keep a job so on and so forth because you feel that this is such a burden, then you are going to have to seek out some kind of counselling yourself.”

Natalie, however, highlighted her concern around ethics and therapists. She stated:

“I mean if you go to a psychologist what are they going to do, they are going to phone your parents, ‘what’s going on at home’. What sort of trust are you building with that child? And that’s why I think, sometimes I don’t know if psychologists just are the right people at a very young age, because they are going to phone your parents because it’s ethical and you are a minor, and you have got to do those things.”

Praveena mentioned support groups, although she believes that there is value in joining a support group she emphasised that your experience of growing up with a psychotic mother is something that you mostly have to process for yourself. She stated:

“You would think that you would like to get involved in a support group, or hear how other people deal with it and so on. I have heard of one, because of my studies and the work that I do now, well, used to do for a while, you hear from other people when you interview the nurses and so on you chat with them and you have an idea... The support group things work to some extent, but honestly it’s something that you have to work out for yourself.”

The use of professional services in relation to the mother as well as to the daughter was highlighted by all participants. This whole sub-theme is a direct and conscious reflection by participants on the fact that they had to manage overwhelming experiences and affects during childhood and that they struggled to do so as this was far beyond their capacities as little children. Both Nadira and Praveena emphasised the necessity of the daughter’s mother being cared for by a psychiatrist. However Praveena also highlighted in particular how despite the

necessity to have psychiatry involved in the care of the mother, psychiatry also complicates the care of the mother; this is with regards to the side effects of the medications prescribed. Michelle, Praveena and Natalie highlighted the role of professional services with regards to the child. Michelle and Praveena highlighted the importance of the child being in her own psychotherapy in order to manage the difficult affect experienced. Natalie however mentioned her concerns around how the psychologist might contact the mother with regards to information that the child shares with the therapist, and although the therapist might think he/she is acting in the best interests of the child; this might not be the case. Furthermore, with regards to psychotherapy, Praveena mentioned some benefit of joining a support group. She did however emphasise her belief that support groups only work to a certain extent.

A synopsis of the findings is provided in the following chapter.

Chapter five – Discussion of the Findings

5.1 Introduction

This chapter includes a synopsis of the findings and thereafter a psychodynamic exploration of the findings. The synopsis of the findings draws the main themes together into a coherent picture from which the discussion of the findings can emerge. The researcher highlights the similarities, nuances and differences in participants reported experiences, reflections and interpretations.

5.2 Synopsis of the findings

All the participants indicated having experienced, and continuing to experience strong affect in relation to their mothers within the context of their mothers psychosis. One participant highlighted the necessity of her enforcing an emotional boundary between herself and her mother so as to protect herself from the being affected by powerful feelings in response to her mother. She seemed to highlight this coping mechanism as being formed as a result of having endured extremely emotionally challenging circumstance within her childhood and thus learned to implement this boundary in her adulthood. She spoke of a need to be numb. However this participant displayed notable anger whilst explaining how inattentive she has experienced her mother to be in her childhood as well as in her adulthood.

Three of the participants expressed a sense of feeling responsible for their mothers' wellbeing and expressed a strong sense of loyalty towards their mothers; these participants care for their mothers currently. This sense of loyalty was however somewhat coloured with other feelings of regret, anger, guilt and resentment. Similarly, previous research has found guilt and loyalty to be common powerful feelings held in adult daughters of psychotic mothers (Dunn,

1993) as is anger (Brown & Roberts, 2000). Two of these participants have their mothers living with them in a cordoned off section of their homes. Both these participants expressed a sense of resignation with regards to their taking care of their mothers. They noted the significant impact it had had on their lives practically and emotionally; sometimes leaving them with significant anger and regret. One of these participants also highlighted a sense of feeling guilty for thinking at times that she perhaps should not have taken on the responsibility for taking care of her mother. The third participant shares the responsibility of taking care of her mother with her siblings. She too expressed strong feelings with regards to the responsibility of taking care of her mother, expressing frustration at the burdensome nature of taking responsibility for her mother. Furthermore she expressed the subsequent guilt she feels when she does experience anger towards her mother and a need to rid herself of her mother. The fourth participant expressed a sense of absolute emotional distance, and reported feeling nothing toward her mother; a finding of two previous studies (Brown & Roberts, 2000; Dunn, 1993). Perhaps this participant's need for complete emotional distance or numbness in relation to her mother serves to protect her from experiencing strong affect that she has previously experienced in relation to her mother.

When recalling childhood memories of their mothers, participants expressed strong feelings (including anger and deep seated sadness). Two participants in particular spoke of emotionally unavailable mothers and described a relationship with their mothers that they needed protection from; corroborated by findings from Williams (1998). They expressed anger whilst recalling the necessity for protection, which they did not receive. These participants had not had been physically separated from their mothers and their mothers were not admitted to hospital until much later, when these participants were adults. Another participant explained how she was separated from her mother and recalled how painful this was for her, which echoes the data provided by one of the participants in Brown and Roberts

(2000). In her current life she resides in a feeling of resignation to her circumstances, desperately trying to accept that whilst she has a need to remain loyal to her mother (and take care of her mother), this loyalty seriously limits and impacts on her freedom within her day to day living.

Participants alluded to a sense of secrecy about their mother's condition even within the family; these themes emerged strongly in research studies by Brown and Robert's (2000), Dunn (1993), and Williams (1998). One participant in particular highlighted how secrecy within the family regarding other family members' mental illnesses was also a result of the stigma of mental illness. These secrets were however uncovered as her mother's condition worsened and she started asking more and more questions. One of the participants explained how her mother's mental illness and the lack of support from family meant the isolation of the family, and the isolation of the family rendered herself and her sister easy victims for sexual assaulting strangers. This participant recalled her traumatic experiences and the associated strong affect, such as anger, guilt, shame and fear. Perhaps some of the strong affect she experienced and still experiences is that of shame and extreme fear of her own vulnerability. Interestingly the theme of neglect emerged through research conducted by Brown and Robert's (2000) and Dunn (1993), however these studies did not report on how neglect of the safety of the child resulted in sexual offences against these children. Williams (1998) however highlights this finding. Another participant expressed significant anger and resentment towards her extended family whilst she explained how her mother's mental illness lead to family members selfishly taking advantage of their situation and used her mother's diagnosis to manipulate the situation so that they could acquire the outcome that they desired – gaining custody of one of the participants younger siblings. Here, this participant recalled her experience of strong affect, possibly including shame and resentment with regards to how her mother were treated by extended family

.

There seems to be an overall sense that each participant felt that being raised by a mother suffering from psychosis had, had a significant impact on her developing sense of self; a finding strongly corroborated by Brown and Roberts (2000). Participants described the many different ways they feel that their mothers' mental health problems have affected their lives, with regards to the roles that they tend to assume in the family, in their lives and in relationships. Two of the participants felt that the lack of support that they received from other family members is what has affected their lives and not their mothers' illness as such. It seems that the common implications highlighted by participants are a strong sense of independence as well as assuming a strong care-taking role in their current lives. These participants seemed to express deep sadness in this regard, perhaps this sadness was fuelled by anger or resentment or even disappointment in light of feeling as though they lacked the experience of being cared for and mothered. Perhaps their sadness is intertwined with a longing for the experience of being nurtured and mothered. Having said this it is important to note that the coping strategies (such as monitoring the environment and adapting in order to meet the needs of the environment and cause minimal disruptions) highlighted by these participants are considered protective factors and contribute to resilience. (Masten & Tellegen, 2012; Fraser & Pakenham, 2009; Pölkki et al., 2005; Mordoch & Hall, 2008). However these coping mechanisms may not serve in their best interests in their current life; further discussed below.

One of the participants highlighted how she felt she had had to mould herself to the environment as well as how she needs to mask her weaknesses. Perhaps the experience of strong feelings such as fear, confusion and anxiety coupled with the lack of support from those around her pushed her to become "psychologically strong". Perhaps this participant experiences vulnerability or dependence as frightening, and thus she may defensively hide

her vulnerability and feelings of dependence in an attempt to avoid the experience of significant fear. Another participant regretfully recalled how she used to take on all the responsibilities within the home. Perhaps in this way was able to manage the environment so as to limit disruptions within the home environment, and thus limit occurrence of overwhelming feelings. She regretfully explained how this is something that she continues to do today, even to the extent of neglecting herself. Another participant highlighted the sense of independence which she feels she has gained as a result of growing up with her psychotic mother; a finding also highlighted by Brown and Roberts (2000). This participant expressed anger whilst explaining how her mother was not present for her in her childhood and thus she had to parent herself, and by implication she had to manage her own affective experiences. Two of the participants spoke of a 'parentified' self; a finding common to Brown and Roberts (2000) and Dunn (1993).

Participants also described the ways in which they feel that their mothers' have impacted their lives with regards to their relationship choices in adolescence and adulthood. One of the participants explained that her mother's mental illness influenced her decision to end a good long term romantic relationship, she regrets this now. It seems that she ended the relationship in fear of the powerful emotional experiences that her mother would cause her to feel through her response to (her inability to accept) this partner; including confusion at her mother's behaviours, guilt at understanding she is causing her mother emotional and psychological distress and anger at her mother for not empathically understanding and supporting Praveena's choice of partner. It appears that this participant's mother has a significant impact on her decisions in light of the strong affective experiences that she experiences in relation to her mother; perhaps she is able to manage or avoid this by the romantic relationship. One of the participants explained that her mother's illness has affected her own behaviour in her own relationships – that she could see herself behaving in ways that resembled her mother. Two

of the participants (Nadira and Michelle) reflected on how their lives could have been potentially different had their mothers not been ill; possibly having made different relationship decisions, as well as having chosen different career paths or studied further after completing matric. This finding is similar to that of Stromwall and Robinson (1998), who found that children who care for their mentally ill parents may be less likely to establish their own vocational or educational goals. Nadira experiences strong conflictual feelings, feelings of loyalty, and feelings of guilt regarding moments of anger and of wanting to be free of her mother. She expressed deep-seated regret and sadness, and perhaps even disbelief, as to how life had turned out with regards to missed opportunities etc. Michelle also expressed a sense of resignation, a deep sense of sadness and burdened acceptance with regards to having to care for her mother.

All participants highlighted different means through which they coped with their mothers' mental illness. Two of the participants highlighted the role of religion as a supportive structure; these participants also expressed the lacking of familial support. The other two participants highlighted the importance of family. One of the participants in particular highlighted the necessity of speaking to someone who has been through a similar experience. This finding pertains particularly to that of Williams (1998), in which participants of the study had found benefit from knowledge of a shared experience. Support structures (or otherwise referred to as social connectedness) are considered crucial for resilience (Fraser & Pakenham, 2009; Garmezy et al., 1984; Masten & Tellegen, 2012), and within the domain of social connectedness, religious/spiritual systems have also been found to contribute to resilience (Masten & Tellegen, 2012; Walsh, 1996). All four of the participants highlighted the importance of knowledge or understanding of the illness in facilitating their coping with their mothers' mental illness; a finding corroborated by Reupert and Mayberry (2010) who investigated the education component of a program for children of parents with a mental

illness and found that knowledge was indeed of benefit. The extent of the protective effect of mental health literacy is not clear (Fraser & Pakenham, 2009; Reupert & Maybery, 2010) however it does play a role in increased life satisfaction (Fraser & Pakenham, 2009), and is generally considered beneficial as it aids the child in having “language” through which to effectively communicate with others regarding their circumstances, facilitating the child’s access to relevant support more efficiently.

The importance of having a place to escape to from time-to-time was highlighted by three of the participants. Two of these participants spoke of escaping to ‘normality’ during their childhoods, and being around ‘normal’ people. One of these participants even explained how she idealised her boyfriend’s mother and wished that she could have rather had her for a mother. The theme of ‘normality’ has come up in previous research (Brown & Roberts, 2000) as it has in the current project. Two participants found comfort by ‘surrounding themselves with normality’ while at the same time comparing their home environment to what is normal. This brought about feelings of shame, embarrassment and even envy. One of these participants explained how in her current life, perhaps in an attempt to avoid the experience of strong affect (including embarrassment, anxiety, confusion and possibly anger at her mother), she limits the contact that her mother has with significant others in her life (such as her boyfriend’s mother). In this way she is able to manage her environment, and thus strong affective experiences.

The concept of enforcing and maintaining some form of psychological, cognitive and/or emotional boundary was highlighted by all of the participants. Two of the participants in particular spoke of mental blocks; possibly as a means of coping with circumstances. Brown and Roberts (2000) also highlight ‘memory blocking’ (p. 118) as a protective measure. This lends insight into the significant emotional challenges that these daughters faced. Three of the participants spoke of putting a boundary within themselves; between past and present and a

block between internal and external worlds. For one participant this seems to be related to 'dissociation' (p. 110) highlighted in Brown and Roberts (2000). Once again this possibly highlights how the extent of her affective experiences warrants the necessity to distance herself from the memories so as to alleviate the potency of the affective experiences recalled. For the other two participants it implementing a boundary between themselves and their mothers served to minimise the impact of their mothers on them. This is telling of possible strong affect experienced previously, thus warranting a boundary for the purpose of protection.

In agreement with Brown and Roberts (2000) and Dunn (1993), the *shadow* of participants' mothers' psychotic mental illness was raised by all the participants. Three of the participants noted their fear of becoming like their mothers. One of these participants expressed sometimes wondering if she is going "mad" like her mother, with possible associated strong affect such as fear and distress. She raised her concerns that if they were to become like her mother then her children would have to endure the difficulty that would come with her illness; her statement is perhaps telling of having experienced significant emotional distress in relation to her mother. Another one of these participants spoke of the same although within the context of the having children in the future; this participant does not have any children at present. She expressed a similar sentiment of needing to protect her children from having to face some of the painful effective experiences she recalls from her own childhood in relation to her mother. One of the participants explained her fear of having children is related to the fear of having a child that is mentally ill like her mother. This is perhaps linked to her need to never experience some of the painful experiences she has had to endure in her life with her mother, again, through her own future child. Two participants highlighted the issue of their children having a psychotic grandmother; they highlighted their need to protect their

children/future children from strong affective experiences, which they had experienced growing up.

When asked what participants might say to another child who is living with a psychotic mother, participants raised the importance of support in some form, the necessity to understand what the condition their mother is suffering from, and the issue of contacting professional services for help. With regards to support, all of the participants highlighted the importance of support, which pertains to literature which emphasises the role that support plays in resilience (Fraser & Pakenham, 2009; Garnezy, Masten & Tellegen, 1984; Masten & Tellegen, 2012). One of the participants emphasised the importance of having the support of family. Two of the participants expressed their feeling that it is too much for one person to take on and that it is necessary for the child to receive guidance and support from a willing other. Two of the participants spoke of just having someone that the child trusts to be a listening ear. Collectively, it can be understood that the emphasis placed on obtaining some form of support possibly refers to the shared feeling between participants that they had to deal with tremendous emotional challenges which may have felt to far exceed their own emotional capacities. One of these participants in particular went a step further than the other three participants and offered herself as a listening ear.

Means through which the child could cope was highlighted by all of the participants. Three participants emphasised the importance of understanding the illness as a means to coping with their mothers' psychosis. Two of the participants emphasised the importance of knowing that the child's mother is not hurting her intentionally. One of the participants highlighted the simple necessity that the child be removed from the environment. The importance of understanding the mother's behaviour within the context of her mental illness or to simply be removed from the home environment possibly indicates that indeed strong affect such as fear, sadness and guilt is a shared experience between participants.

All four participants highlighted the issue of contacting professional services. Two of the participants highlighted the importance of seeking out therapy for themselves, and highlighted the lifelong challenge that making sense of and working through childhood experiences of growing up with a psychotic mother is. Once again there is the implication of have experienced strong affect. One of the participants spoke more generally of speaking to someone who can guide, educate and assist the child on how to manage the situation. One of the participants questioned whether seeking out therapy would be the right thing to do; in particular she questioned whether the therapist would break the child's trust in contacting home.

5.3 Psychodynamic exploration of the findings

As mentioned in the Literature Review, object relations theory refers to intrapsychic processes and the internalisation of the experiences of the infant in early development shapes the way in which the individual at any stage of life relates to others (Klein, 1926; 1935; 1940; 1946; 1956; Bion's, 1959; 1962; 1963; 1967; 1993; Winnicott, 1960a; 1960b; 1963; 1965). As discussed in the Literature Review, object relations theorists propose that it is crucial for the infant's psychological development, that her mother is accurately attuned to her verbal and nonverbal communications. Given that psychosis is defined by a loss of contact with reality and that it prevents the ability to be empathically attuned one can understand that a psychotic mother will be unable to provide her infant with a secure, stable and containing experience of the affect that the child needs to have processed. The infant's experience of holding (Winnicott, 1960a; 1965) and containment (Bion, 1962; 1963) is compromised by the mother's impaired capacity to be attuned to her infant /child. It is possible that the lifelong consequence of this is that the adult child of a psychotic mother may still operate through the

use of excessive and/or unhelpful psychological defences. These defences may have served to facilitate the child's psychological survival in her developmental context in infancy and childhood, but these may later (in their adulthood) impede her psychological, emotional or relational functioning.

For example, the mother's unavailability (emotionally and/or physically) renders the infant helpless in the face of persecutory anxiety related to the uncertainty as to whether her needs will be met by her mother (Klein, 1946). With the presence of strong affect the infant requires containment. Bion (1963) states that if the mother's mind is preoccupied with delusional thoughts then containment is impossible and hence a psychotic mother cannot provide the child with a container to be made use of to help the child deal with her own "stress". Rather through the process of projective identification the infant experiences herself as a 'mad-making' object, and almost responsible for her mother's 'madness'. She may experience her needs and her vulnerability and her dependence, all of which are experiences of herself, as mad-making. This seems to be alluded to via participants urging of other daughters growing up with a psychotic mother not to blame themselves and to understand that their mother has a condition and that her behaviours and words should not be taken seriously. For example Praveena stated "you keep thinking 'why are you doing this to me, what have I done to hurt you, or upset you, why are you being so vicious.'" And Natalie stated "your mom doesn't really understand what is going on so you can't take it all in too seriously." The implication within participants 'advice' to other daughters, is that they have personally experienced a powerful sense of confusion, anger and guilt in relation to their mothers' mental illness.

Indeed, Klein theorised that guilt is a natural part of the process of psychic development. However it is crucial that the mother aid her infant into the depressive position by allowing the infant the experience of successful reparative attempts to assuage guilty feelings (Klein, 1956). The daughter of a psychotic mother may be left feeling that their attempts at reparation

have been unsuccessful as the mother's capacity to be attuned to the communications of her child and respond in an appropriate way is impaired. As a result of this these daughters may present with reparation tendencies, an unending cycle of reparative attempts, which are unlikely to be received in a way that the child is alleviated of her feelings of guilt. Instead the child is likely to be left with and thus leaving the child with an exaggerated idea of her own badness. This can be linked to the tendency to take on caregiving roles and over-extending oneself at the expense of meeting one's own needs. Perhaps the tendency to over extend oneself is linked to feelings of guilt at having caused injury to the mother (Klein, 1946). This guilt may be brought upon by the mother's impaired capacity to relate to the daughter in a way that communicates that her attempt has been successful. For two of the participants in particular (Nadira and Michelle), it is possible that this guilt continues to haunt them in their current day to day living. Perhaps they over extend themselves to the point of self-neglect in a manic attempt to repair the damage they feel to have caused in the past (Klein, 1940). These reparative attempts extend beyond that of simply their mothers but to their children as well. For example, Nadira explained with deep sorrow "sometimes you get so focused on everything else that you forget to look after yourself", "I found in my adulthood that eventually I thought it was my responsibility to do everything. And I started working and taking on all the burdens...", "today, if I look at my life... I see myself as always being the person to support everyone – as a child." And Michelle explained tearfully "I have always had to take the responsibility. There were times where I became extremely angry. And I felt, not only angry, but resentment, because I felt 'why is it always just my burden.'"

Perhaps Klein's concept of projective identification can offer some insight into the tendency to care for others. Klein (1946) explains the defence mechanism of projective identification to entail the identification of a disowned of a part of the self which has been located in another; a part of the self which the daughter experienced as unmanageable. It seems significant to

note here the findings of Mordoch and Hall (2007), the adaptive coping mechanism of finding a rhythm and maintaining the frame. Participants (Natalie, Nadira and Michelle) highlighted their strong sense of independence and the caretaking role which they developed at a very young age. As a result of the demands of the environment and the inability of the environment to meet the infant's needs, the daughter may attempt to adapt herself to the environment, and in the process she may repress her 'true self' (Winnicott, 1960). The possible consequence of this adaptation is that of a false self-structure (Winnicott, 1960). The development of the false self serves as a protective mechanism whereby the developmental context can be survived. For example, Nadira conveyed being the strong one in the family and being the main member of the family who attended to the needs of the rest of the family. Perhaps it is through this process of attending to everyone's needs within the family she was able to manage the environment so as to limit disruptions within the home environment, and thus limit occurrences of being overwhelmed by the emotional experiences provoked by her mother's behaviours in psychosis. Another example is that of the possible overly defensive nature of Michelle's emphasis on self-reliance is highlighted when she explained that she believes strongly in not letting people see her weaknesses as she recalls how her family took advantage of their situation in light of her mother's illness (or weakness, so to speak). Michelle stated:

"You know the world sees you in a certain light and we all portray parts of our persona that we want people to see of us. And for me, what I have always wanted to be perceived as is strength... It is very important to me. I don't like to display weaknesses, because for me, I always perceive weakness as a negative trait. And I think that is a lot to do with, because of my mother."

Thus it seems that finding the rhythm and maintaining the frame (Mordoch & Hall, 2007) were factors that loomed large for these participants' in their home environments and thus

they sought and continue to seek the sanctuary of a secure holding environment where the parts of their true self can be safely expressed. Within these other environments excessive compliance and a predominating false self is/was not needed (Winnicott, 1960b). For example Michelle stated:

“... And I can just be myself with him [her husband] and I can cry, and I can let it out, and I can let the frustration out and the next day I can put on my strong face again and I can feel like I can take on the world again.”

Nadira spoke of the comfort she sought in her relationship with her grandmother:

“I used to always go there [to her grandmother’s house], to try and get away from things. I would spend more time with her. But I suppose that also helped me a bit, getting her guidance, being around her, doing normal things that you should be doing with your mother.”

Natalie spoke of the comfort she found in her boyfriend’s family:

“... I attached myself because I was trying to gain a secure environment, where I can be me and not be judged and not be told I am fat by another woman who is the mother... Because she is such a calm ‘I love my family’, ‘kids come first before anything’, and you know I get so attached to his mom, because she’s a normal, normal mother, the mother that I would have sort of wanted.”

With regards to the current time, participants expressed the need to implement some form of emotional boundary within themselves. Overall, participants spoke of a need to make use of defence mechanisms that prohibit the experience of feeling vulnerable or disown the vulnerability that may possibly be experienced. Perhaps these are attempts to survive the difficult feelings experienced within their relationships with their mothers or to survive the

pain present in their childhood memories. Both Natalie and Praveena highlighted the necessity of firmly refusing to take in anything (internalisation) from their mothers. Natalie and Praveena highlighted the significant emotional pain that they experienced in relation to their mothers verbal attacks and insults which were directed at them (such as in the case of Natalie) and others (such as in the case of Praveena). Refusing to relate to their mothers emotionally, and being emotionally cut off to their mothers, possibly protects them from internalising or experiencing emotional pain.

It may be understood that ‘creating a rock’ (Praveena) and refers to the process of a refusing container, as defined by Joffe (2008). The refusing container is defined as a defensive maneuverer in which the individual (the daughter), who firmly believes that containment is not possible and is unwilling to risk the experience, attacks the link offered by the mother (Joffe, 2008). It is important to note here that the link offered by a psychotic mother is not located in reality and is likely to be delusional or thought disordered in nature. Similarly, it is possible that Natalie also refers to the process of a refusing container. She stated “I don’t let it affect my life now... I have put that boundary there, and I will not let her overstep it and I won’t overstep that boundary, because then it will continue to affect my life.” She added: “Like she has cut me out, she has destroyed me, she can’t destroy me anymore, I won’t allow it to happen.” Michelle possibly also refers to the process of a refusing container. She relayed childhood experiences and drew links to her current inability to display any form of weakness or vulnerability. As she recalled her memories she explained that she felt quite “emotional” and elaborated that “it’s like I feel like its two different people, because I am actually sitting and thinking about that child, and I am actually feeling like, sorry for that child”. It may be understood that here, Michelle makes use of a defence mechanism so as to refuse the link between her recollections of herself a child and her present life due to the difficult affect experienced as a child. The difficult nature of the experiences of “that child”

(Michelle the child) seems to have resulted in the process of splitting (Klein 1946), in which Michelle feels her childhood to not be a part of herself. It seems that in some way Michelle is distancing her childhood experiences so far so as to create the sense that the memories she holds are not even her own, but memories of ‘another’ ‘vulnerable’ child. The implication of this possibly being that the experience of strong affect for Michelle was at times so significant and exceeding of her own ego capacity that she may have employed splitting as a defence mechanism.

Participants have highlighted a fear of being “mad” like their mothers’ as they possibly fear having internalised their external mother – a psychotic mother (Klein, 1946). When they behave in ways that resembles their mothers then concern regarding having psychotic parts within themselves surfaces. Natalie alludes to a notion that whatever is not like her mother is right and not terrifying. She stated: “You know I think in my own way of living, I try not to be like her. So everything she would do, I do the opposite to try and better, because I am trying to teach myself, after all those years of seeing what she does”. It may be understood that Natalie is in some ways attempting to deny the existence of, or attempting to fix the psychotic mother she feels to have internalised. Praveena highlighted a fear of having a psychotic child. This could be understood to be linked to the phantasy of having made her own mother mad, and thus having ‘madness’ within herself which she could transmit to her own child and thus have a ‘mad’ child. It is understood that both Praveena’s and Natalie’s fear of having children, although different in manifestation, stem from a similar notion – that of having internalised their external psychotic mother (Klein, 1946).

The role of support structures such as family and religion emerged quite strongly in the data. Interestingly, the two of the participants who seemed to indicate less familial support emphasised the importance of religion in helping them cope, while the other two participants emphasised the importance of family or significant others offering support. Perhaps it can be

understood that both Michelle and Nadira had little good to introject from their external environments, and both felt alone in their experiences of their mothers. Thus they held on strongly to religion as a source of strength and ego support.

All participants emphasised the importance of having someone with whom the daughter could speak to in order to facilitate her coping with the emotional challenges inherent in growing up with a psychotic mother. This seems to call upon Bion's (1962) notion of internalising a meaningful experience through the process of containment. Through the process of talking to someone who is able to offer an empathic listening ear and process the feelings of distress present in the daughter is able to introject a meaningful experience, and not an experience that is devoid of meaning – such as nameless dread (Bion, 1962). Through this the person's capacity for thought may be restored and maturation is possible. It seems plausible to think that both Nadira and Michelle emphasise the importance of a support system and their non-specification of family as a support system is linked to their experience of lacking familial support. The emphasis of a supportive structure can be linked to the necessity of having containing figure in the child's life – having an alpha function present which the child can internalise and be contained (Bion, 1962).

Natalie and Praveena specifically emphasised the importance of knowledge pertaining to mental illness that gives them a better understanding of their mothers' illness. Perhaps knowledge gained through reading and research can too act as a containing function. Having a clear understanding of the mother's mental illness perhaps facilitates the daughter's capacity for thought; this may especially be in times when experiencing strong affect. Participants cautioned daughters of psychotic mothers to be mindful of the fact that they are not responsible for the bizarre behaviour that the mother is displaying. It seems useful here to call upon Bion's (1962; 1963) theory in understanding the sentiment conveyed by these participants. Bion lends the understanding that if the infant is left uncontained and

experiences the intensification of her difficult affects there is the possibility that the daughter experiences severe anxiety regarding her own badness (Bion, 1962). Perhaps education regarding the mother's mental illness is an important part of coping with the adverse developmental conditions that the daughters of psychotic mothers face and can serve as a form of containment for the daughter.

Chapter six – Conclusions

6.1 Research report conclusions

The aim of the research was to investigate adult daughters' reflections about being raised by a mother who suffered from psychosis, including the powerful affective experiences they remember having. These experiences were understood by participants to be at least partly the result of the longer term impact of having a life-long relationship with a psychotic mother.

Crucial to the emotional and psychological development of the infant is affect regulation and the reciprocity between mother and infant. Furthermore it has been documented that mothers suffering from mental illness are likely unable to provide their infant with an ego building relationship. Literature widely documents the increased risk of poorer developmental (Aldridge & Becker, 1999; Berg-Nielsen et al., 2002; Cogan et al., 2008; Polkki et al., 2008; Reupert & Mayberry, 2010) and adjustment outcomes (Farrell et al., 1999; Goodman & Brumley, 1990; Jacob & Windle, 2000; Oyserman, et al., 2000; Thomas et al., 1995) of children raised by a mentally ill parent. However resilience plays a crucial role in developmental outcomes, this is further elaborated on below.

Resilience is understood to entail the interaction of the child's personal characteristics (such as temperament) and the clinical characteristics of maternal psychopathology (Berg Nielsen et al., 2002). Furthermore literature indicates that gender plays a role in resilience, and that women are at less risk for the development of behavioural problems (Mowbray et al., 2004). Beyond this, some of the protective factors include social connectedness, (Fraser & Pakenham, 2009; Garmezy et al., 1984; Masten & Tellegen, 2012), and within the domain of social connectedness, religious/spiritual systems have also been found to contribute to resilience (Masten & Tellegen, 2012; Walsh, 1996). Other protective factors include the

child's intelligence (Garmezy et al., 1984) and ability to problem solve (Masten & Tellegen, 2012), the child's ability to adopt good practical coping skills (Fraser & Pakenham, 2009), such as doing household chores (Pölkki et al., 2005), or paying close attention to the environment and adapting one's behaviour accordingly so as to minimise disturbances in the environment ('finding a rhythm' and 'maintaining the frame') (Mordoch & Hall, 2008).

In light of the above, the research sought to explore the experiences of daughters in relation to their psychotic mothers. Four adult daughters of psychotic mothers were interviewed. The research made use of a semi structured interview which allowed for the researcher to probe participants where necessary, which ultimately facilitated the discussion of the results. Participation was voluntary and informed consent was provided. Interviews were audio recorded and transcribed. Thereafter the data was analysed through Interpretive Phenomenological Analysis, through which six main themes were identified, and nine subthemes. The results were analysed using an appropriate selection of psychoanalytic concepts from the Object relations perspective, to provide a deeper interpretation of the data.

The psychodynamic theoretical framework that underpins the research project includes Melanie Klein's (1926; 1935; 1940; 1946; 1956) theory of object relations, Wilfred Bion's (1959; 1962; 1963; 1967; 1993) concept of 'containment' and Donald Winnicott's (1960a; 1960b; 1963; 1965) concept of the 'holding environment' and the development of the true and false self. Crucial to the emotional and psychological development of the infant is affect regulation and the reciprocity between mother and infant. Failure in this reciprocity and attunement may relegate the child to experiencing overwhelming affective states (guilt, pain, hatred and anger) (Klein, 1926; 1935; 1940; 1946; 1956), compromise containment (Bion, 1959; 1962; 1963; 1967; 1993) and complicate the development of the self (Winnicott, 1960a; 1960b; 1963; 1965).

It may be broadly understood that the research participants did indeed have some protective factors within their childhood development. Firstly, all participants are female, being female has been found to be a protective factor (Mowbray et al., 2004). Participants indirectly highlighted some of the protective factors present within their lives. For example, two participants reported the immense social and familial support that they received through their childhood. One of these participants in particular referred to social support. However the other two participants clearly indicated the lack of support they received from others and instead emphasised the value of religion as a supportive structure; religion has been found to act as a powerful support structure within previous research (Masten & Tellegen, 2012; Walsh, 1996). Furthermore, these two participants highlighted the value of managing the environment through adapting themselves; ‘finding a rhythm’ and ‘maintaining the frame’ (Mordoch & Hall, 2008).

Furthermore, participants highlighted the value of having some form of psychological knowledge in order to understand or manage powerful feelings (particularly feelings of rejection, anger, guilt and shame) within the context of growing up with a psychotic mother (themes (4.3) *Childhood reflections: adapting and coping*, and (4.7) *What to say to another daughter*). Previous research has found knowledge regarding parental mental illness is associated with greater life satisfaction, and is greatly valued by children of mentally ill parents (Fraser & Pakenham, 2009; Reupert & Mayberry, 2010). Furthermore, three of the participants emphasised the value of having a physical location to which they could escape, if only for a short while (theme (4.3.2) *Escaping*). For two of these participants, escaping allowed these daughters the opportunity to be around ‘normality’ and be around a nurturing and caring mother figure and, at least for a short while, to not be experiencing strong feelings such as confusion, anxiety and fear. While these two participants highlighted the value of escaping in the context of childhood, the other participant highlighted the value of escaping

within the context of her adulthood. She explained how she found refuge in her husband's presence, where she could escape to a place in which she could express her powerful feelings (such as anger and disappointment, which often come as a result of reflecting on her life and the lack of support from extended family). All participants emphasised the importance of enforcing some form of psychological boundary either between themselves and their mothers or within themselves. These boundaries served to limit the impact of strong feelings on themselves (theme (4.3.3) *Psychological boundaries*). The use of psychological boundaries is something that participants find themselves implementing as a result of having experienced powerful feelings (including anger, confusion, anxiety and disappointment) that arise from interactions with their mothers.

Strong feelings (such as shame, guilt, confusion, anxiety and fear) experienced within the context of childhood seem to have had a significant impact on these daughters. Some of the consequences of these powerful emotions (further elaborated on below) within childhood even impact these daughters in varied ways within their current lives (theme (4.4) *Perceived impact of the past*). All participants highlighted how their mothers' mental illness does in some way impact upon their lives (theme (4.4.1) *Perceived impact on life path/choices/opportunities*). For example, one of the participants explained how her mother's mental illness and the powerful emotions that were elicited in her in relation to her mother (such as guilt and fear) influenced her choice of partner. And in an attempt to avoid experiencing these powerful emotions she regretfully terminated a meaningful long term relationship with her partner. Another participant explained how the lack of guidance from her mother compromised her studying further after matric. Two participants explained how their taking care of her mothers' makes it difficult for them to take holidays or to immigrate as they have to consider either passing the responsibility onto another sibling or how their mother will cope with a holiday.

Furthermore, participants highlighted how their experiences of strong emotions (such as guilt, anxiety, confusion, fear and shame) and the means through which they managed these affects continue to function within their current day to day living (themes (4.4.2) *Perceived impact on sense of self* and (4.4.3) *Taking responsibility*). Having experienced and continuing to experience powerful feelings (such as confusion, anxiety, guilt and fear), and mostly having to deal with and manage these strong feelings on their own, participants made use of coping mechanisms such as implementing psychological blocks and/or adapting themselves in order to meet the demands of the environment so as to minimise disruptions within the environment. Some of the powerful affects rife within participants lives at present include that of disappointment, resentment, deep seated sadness, anger, loyalty, guilt and fear. Two of the participants highlighted how they continue to take responsibility for everyone around them, these two participants in particular care for the mothers currently (the have their mothers living on the same premises as them). For these participants, as well as the other two participants, it became clear that the powerful emotions experienced throughout childhood reside powerfully in the back of participants minds. All participants (possibly as a result of these memories) verbalised experiencing fear of psychosis; fear of becoming psychotic themselves, fear of subjecting their children to the experiences that they endured, or fear of having a psychotic child (theme (4.5) *Fear*).

The findings of the research indicate that these daughters continue to experience powerful emotions related to that of their experienced strong feelings within childhood memories pertaining to that of growing up with a psychotic mother. Daughters felt that their mothers' psychosis indeed has had and continues to have a profound impact on their lives. Powerful feelings that participants highlighted having had in relation to maternal psychosis within their childhoods include that of fear, anxiety, confusion, guilt and shame. Similar findings are documented in the few research projects that pertain to research focusing on daughters

(and/or sons) of psychotic mothers (Brown & Roberts, 2000; Dunn, 1993; Kadish, 2003). As a result of having experienced these strong feelings and having to make sense of and manage these feelings they adopted coping mechanisms which have acted as protective factors in their development. However the means through which these children managed their powerful feelings, has indeed left a prevailing impact and has influenced the people they identify as and their choices. Some of the powerful feelings that daughters raised as currently experiencing in relation to their psychotic mothers include anger, disappointment, sadness, guilt, shame, loyalty and resignation.

6.2 Limitations of the research

Some of the limitations of the research project are mentioned below:

One of the limitations of this research is the characteristics of the sample with regards to race and sample size. The current project sought to explore individual experiences of participants rather than obtain generalizable results and thus the characteristics of the sample (with regards to race and circumstances) were not criteria included in the sampling process. It is possible that the data yielded from the research would have more depth and breadth if participants had come from backgrounds that were diverse. There may have been additional aspects and interesting nuances found if the sample included participants from other racial groups.

Given that Interpretive Phenomenological Analysis typically requires a small sample (Smith & Osborn, 2003), the research made use of a small sample size. However, this could be considered to be a limitation of the current research as the repertoire of possible experiences of being raised by a psychotic mother and the nature of the impact of this relationship is considered to be strongly influenced by the interaction of risk factors and protective factors

(Berg Nielsen et al., 2002). A larger sample size could have furthered the depth and breadth of data obtained; this is considered in the following section on recommendations for future research projects.

6.3 Recommendations for future research projects

Based on the results of the research as well as the strengths and limitation of the research, the following recommendations for future research projects are mentioned below:

The current research project focused on daughters of psychotic mothers and the affective experiences within this relationship, and not on gender identity as such. In light of the findings of the research project at hand, there seems to be some value implicated in focusing on sons of psychotic mothers and of psychotic fathers and daughters of psychotic fathers, with the intention being to explore and gain a deeper understanding of how parental psychosis impacts on gender identity.

Previous research indeed documents that protective factors such as support (Fraser & Pakenham, 2009; Garnezy et al., 1984; Masten & Tellegen, 2012; Walsh, 1996) and psychological knowledge and understanding of their mothers conditions (Fraser & Pakenham, 2009; Reupert & Maybery, 2010) are invaluable in the resilience of daughters of psychotic mothers. The current research corroborates these finding, as highlighted previously in *Conclusions of the research*. However it is not clear as to how these factors operate, thus offering a possible avenue of investigation for future research projects.

Given the limitations highlighted regarding the sample size and characteristics of the current research project, it may be useful to extend the sample size and incorporate more racial groups into the sample as different races and cultures may further contribute to the richness to

the data yielded. Richer findings could possibly be obtained through recruiting a more racially diverse and larger sample size given that the repertoire of possible experiences of being raised by a psychotic mother and the nature of the impact of this relationship is considered to be strongly influenced by the interaction of risk factors and protective factors (Berg Nielsen et al., 2002). Perhaps future qualitative research within this area could employ an analytic methodology that is suitable for a larger sample size or future research projects could be undertaken within a quantitative methodology, and herewith make use of a larger sample. In these ways future research projects could build upon the findings of the current research.

Reference List

- Aldridge, J., & Becker, S. (1999). Children as carers: the impact of parental illness and disability on children's caring roles. *Journal of Family Therapy*, 21(3), 303-320.
- American Psychiatric Association. (2013). *The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM 5)*. American Psychiatric Publications Incorporated.
- Beardslee, W. R., & Podorefsky, D. (1988). Resilient adolescents whose parents have serious affective and other psychiatric disorders: Importance of self-understanding and relationships. *American Journal of Psychiatry* 145(1), 63– 69.
- Beardslee, W.R., Versage, E.M., & Gladstone, T.R.G. (1998). Children of affectively ill parents: A review of the past 10 years. *Journal of the American Academy of Child and Adolescent Psychiatry*, 37(11), 1134-1142.
- Berg-Nielsen, T. S., Vikan, A., & Dahl, A. A. (2002). Parenting related to child and parental psychopathology: A descriptive review of the literature. *Clinical Child Psychology and Psychiatry*, 7(4), 529-552.
- Bernstein, P. P. (2004). Mothers and Daughters from Today's Psychoanalytic Perspective, *Psychoanalytic Inquiry. A Topical Journal for Mental Health Professionals*, 24(5), 601-628.

Biggerstaff, D., & Thompson, A. R. (2008). Interpretative phenomenological analysis (IPA):

A qualitative methodology of choice in healthcare research. *Qualitative Research in Psychology*, 5(3), 214-224.

Bion, W. R. (1959). Attacks on linking. In E. B. Spillius, *Melanie Klein today: Developments in theory and practice* (Vols. I, Mainly Theory. 1988). London: Routledge.

Bion, W. R. (1962). Learning from experience. In *Seven servents*. New York: Aronson.

Bion, W.R. (1963). *Elements of Psychoanalysis*. London: Heinemann

Bion, W. R. (1967) *Second Thoughts: Selected Papers on Psycho-Analysis*. Heinemann Medical; reprinted Maresfield, 1984.

Bion, W. R. (1993). *Second thoughts: Selected papers on psycho-analysis*. Northvale: Jason Aronson.

Bowlby, J. (1953). *Child Care and the Growth of Love*. London: Penguin Books.

Bowlby, J. (1969). *Attachment and Loss, Vol. 1: Attachment*. New York: Basic Books.

Bowlby, J. (1973). *Attachment and loss: Vol. 2. Separation anxiety and anger*. New York: Basic Books.

Bowlby, J. (1979). *The Making and Breaking of Affectional Bonds*. London: Tavistock.

Bowlby, J. (1988). *A secure base: Parent-child attachment and healthy human development*. New York: Basic Books.

Bronstein, C. (Ed.). (2001). *Kleinian theory: A contemporary perspective*. London: Whurr.

Brown, M. J., & Roberts, D. P. (2000). *Growing up with a schizophrenic mother*. McFarland Publishing.

Cartwright, D. (2004). The psychoanalytic research interview: Preliminary suggestions. *Journal of the American Psychoanalytic Association*, 52(1), 209-242.

Cleaver, H., Unell, J., & Aldgate, J. (1999). *Children's needs-parenting capacity*. Stationery Office.

Cogan, N., Riddell, S., & Mayes, G. (2005). The understanding and experiences of children affected by parental mental health problems: a qualitative study. *Qualitative Research in Psychology*, 2(1), 47-66.

Davies, P. T., & Windle, M. (1997). Gender-specific pathways between maternal depressive symptoms, family discord, and adolescent adjustment. *Developmental psychology*, 33(4), 657.

Denzin, N. K., & Lincoln, Y. S. (Eds.). (2007). *Strategies of qualitative inquiry*. Sage Publications, Incorporated.

Donatelli, J. A. L., Seidman, L. J., Goldstein, J. M., Tsuang, M. T., & Buka, S. L. (2010).

Children of parents with affective and nonaffective psychoses: a longitudinal study of behavior problems. *American Journal of Psychiatry*, 167(11), 1331-1338.

Douglas, H. (2007). *Containment and reciprocity: Integrating Concepts for Work with Children*. Routledge.

Dunn, B. (1993). Growing up with a psychotic mother: A retrospective study. *American Journal of Orthopsychiatry*, 63(2), 177-189.

Evans, M. (2008) Tuning into the psychotic wavelength: Psychoanalytic supervision for mental health professionals. *Psychoanalytic Psychotherapy*, 22(4), 248-261.

Farrell, G., Handley, C., Hanke, A., Hazelton, M., & Josephs, A. (1999). *The Tasmanian Children's Project Report: The needs of children and adolescents with a parent/carer with a mental illness*. Launceston: University of Tasmania.

Flanagan, L. M. (2008). Object relations theory. *Inside out and outside in: Psychodynamic clinical theory and psychopathology in contemporary multicultural contexts*, 121.

Flaskas, C. (2005). Psychoanalytic ideas and systemic family therapy: Revisiting the question 'why bother?'. *Australian and New Zealand Journal of Family Therapy*, 26(3), 125-134.

- Forbes, L. M., Evans, E. M., Moran, G., & Pederson, D. R. (2007). Change in Atypical Maternal Behavior Predicts Change in Attachment Disorganization From 12 to 24 Months in a High-Risk Sample. *Child Development, 78*(3), 955-971.
- Foster, K., O'Brien, L., & McAllister, M. (2005). Addressing the needs of children of parents with a mental illness: current approaches. *Contemporary Nurse, 18*(1-2), 67-80.
- Fossey, E., Harvey, C., McDermott, F., & Davidson, L. (2002). Understanding and evaluating qualitative research. *Australian and New Zealand Journal of Psychiatry, 36*(6), 717-732.
- Fraser, E., & Pakenham, K. I. (2009). Resilience in children of parents with mental illness: Relations between mental health literacy, social connectedness and coping, and both adjustment and caregiving. *Psychology, Health and Medicine, 14*(5), 573-584.
- Freyd, J. J. (1994). Betrayal trauma: Traumatic amnesia as an adaptive response to childhood abuse. *Ethics and Behavior, 4*(4), 307-329.
- Gammon, G. D. (1983). Blue parent: Disturbed child. *Journal of the American Medical Association, 249*, 11-12.
- Garber, J., & Little, S. (1999). Predictors of competence among offspring of depressed mothers. *Journal of Adolescent Research, 14*(1), 44-71.

- Garnezy, N., Masten, A. S., & Tellegen, A. (1984). The study of stress and competence in children: A building block for developmental psychopathology. *Child development*, 97-111.
- Gladstone, B. M., Boydell, K. M., & McKeever, P. (2006). Recasting research into children's experiences of parental mental illness: Beyond risk and resilience. *Social Science & Medicine*, 62(10), 2540-2550.
- Glover, N. (2009). *Psychoanalytic aesthetics: An introduction to the British School*. London: Harris Meltzer Trust.
- Gomez, L. (1997). *An introduction to object relations*. New York: New York University Press.
- Goodman, S. H. & Brumley, H. E. (1990) Schizophrenic and depressed mothers: relational deficits in parenting. *Developmental Psychology* 26, 31–39
- Hall, A. (2004). Parental psychiatric disorder and the developing child. In M. Gopfert, J. Webster, & M. Seeman (Eds.), *Parental psychiatric disorder: Distressed parents and their families* (pp. 22–49). Cambridge: Cambridge University Press.
- Heimann, P., Isaacs, S., Klein, M., & Riviere, J. (Eds.). (1989). *Developments in psychoanalysis*. Karnac Books.

- Hipwell, A. E., Goossens, F. A., Melhuish, E. C., & Kumar, R. (2000). Severe maternal psychopathology and infant-mother attachment. *Development and Psychopathology*, 12, 157-175.
- Hopkins, S. (1992) Countertransference and containment in a patient with a psychotic mother. *Psychoanalytic Psychotherapy*, 6(2), 89-106.
- Holmes, P. (1992). *The inner world outside: Object relations theory and psychodrama*. Tavistock/Routledge.
- Jacobs, A. (2007). The potential of theory: Melanie Klein, Luce Irigaray, and the mother daughter relationship. *Journal of Feminist Philosophy*, 22(3), 175-193
- Jacob, T., & Windle, M. (2000). Young adult children of alcoholic, depressed and non-distressed parents. *Journal of Studies on Alcohol and Drugs*, 61(6), 836.
- Joffe, A. (2008). Three forms of container pathology: towards a classification. In Ivey, G. (ed.) *Psychoanalytic psychotherapy in South Africa*, 16(2), pp. 1-30.
- Johnson, J. G., Cohen, P., Chen, H., Kasen, S., & Brook, J. S. (2006). Parenting behaviors associated with risk for offspring personality disorder during adulthood. *Archives of General Psychiatry*, 63(5), 579-587.

Jonsson, C. O., & Clinton, D. (2006). What do mothers attune to during interactions with their infants?. *Infant and Child Development*, 15(4), 387-402.

Kadish, Y. (2003). *Shattered mirror, fragmented reflection: A psychoanalytic exploration of the perceived effects of serious maternal psychopathology on the development of the girl child*. Unpublished master's dissertation, University of the Witwatersrand, Johannesburg, South Africa.

Klein, M. (1926). Infant analysis. *International Journal of Psycho-Analysis*, 7:31-63.

Klein, M. (1935). A Contribution to the Psychogenesis of Manic-Depressive States. *International Journal of Psycho-Analysis*, 16, 145-174

Klein, M. (1940). Mourning and its Relation to Manic-Depressive States. *International Journal of Psycho-Analysis*, 21, 125-153.

Klein, M. (1946). Notes on Some Schizoid Mechanisms. *International Journal of Psycho-Analysis*, 27, 99-110.

Klein, M. (1965). *Contributions to Psycho-Analysis 1921 – 1945*. London, UK: Hogarth Press Ltd.

Kristeva, J. (2013). *Melanie Klein* (Vol. 2). Columbia: University Press.

Legard, R., Keegan, J. & Ward, K. (2003) In-depth Interviews. In L. Lewis, & J. Ritchie

(eds.), *Qualitative research practice: A guide for social science students and researchers*. London, UK: Sage.

Lucas, D. R. (1993). The psychotic wavelength. *Psychoanalytic psychotherapy*, 7(1), 15-24.

Magliano, L., Fiorillo, A., Malangone, C., De Rosa, C., & Maj, M. (2006). Social network in long-term diseases: a comparative study in relatives of persons with schizophrenia and physical illnesses versus a sample from the general population. *Social Science and Medicine*, 62(6), 1392-1402.

Manning, C. & Gregoire, A. (2006). Effects of parental mental illness on children. *Psychiatry*, 5(1), 10-12.

Masten, A. S., Best, K. M., & Garmezy, N. (1990). Resilience and development: Contributions from the study of children who overcome adversity. *Development and Psychopathology*, 2(4), 425-444.

Masten, A. S., & Tellegen, A. (2012). Resilience in developmental psychopathology: contributions of the Project Competence Longitudinal Study. *Development and Psychopathology*, 24(02), 345-361.

McNeil, T., Naeslund, B., Persson-Blennow, I., & Kaij, L. (1985). Offspring of women with nonorganic psychosis: Mother-infant interaction at three-and-a-half and six months of age. *Acta Psychiatrica Scandinavica*, 71, 551-558.

Merriam, S. B. (2009). *Qualitative research: A guide to design and implementation*. San Francisco, CA: Jossey-Bass.

Mills, J. (2010). Object Relations Theory. *Corsini Encyclopedia of Psychology*.

Mohit, D. L. (1996). Management and care of mentally ill mothers of young children: an innovative program. *Archives of psychiatric nursing*, 10(1), 49-54.

Mordoch, E., & Hall, W. A. (2008). Children's perceptions of living with a parent with a mental illness: Finding the rhythm and maintaining the frame. *Qualitative Health Research*, 18(8), 1127-1144.

Mowbray, C. T., Bybee, D., Oyserman, D., MacFarlane, P., & Bowersox, N. (2006). Psychosocial outcomes for adult children of parents with severe mental illness: Demographic and clinical history predictors. *National Association of Social Workers*, 31(2), 99-108.

Newman, K. M. (2013). A More Usable Winnicott, Psychoanalytic Inquiry. *A Topical Journal for Mental Health Professionals*, 33(1), 59-68.

- O'Shaughnessy, E. (1981). W.R. Bion's theory of thinking and new techniques in child analysis. In E. Bott-Spillius (ed.) *Melanie Klein Today: Developments in theory and practice. Volume 2: Mainly practice*. 1988. London: Routledge (Chapter 3).
- Ogden, T. (1979). On projective identification. In E. Spillius & E. O'Shaughnessy (Eds.), *Projective Identification: The fate of a concept*, pp. 275-300. London & New York: Routledge, 2012.
- Oyserman, D., Mowbray, C. T., Meares, P. A., & Firminger, K. B. (2000). Parenting among mothers with a serious mental illness. *American Journal of Orthopsychiatry*, 70(3), 296-315.
- Oyserman, D., Bybee, D., Mowbray, C., & Kahng, S. K. (2004). Parenting Self-Concepts of Mothers With a Serious Mental Illness: Efficacy, Burden, and Personal Growth¹. *Journal of Applied Social Psychology*, 34(12), 2503-2523.
- Pölkki, P., Ervast, S., & Huupponen, M. (2005). Coping and resilience of children of a mentally ill parent. *Social Work in Health Care*, 39(1-2), 151-163.
- Renault, S. N. (1987). An especially dangerous situation: The nursing infant and its psychotic mother. *Psychiatrie Française March-April*, 18(2), 217-227.
- Reupert, A. E., & Mayberry, D. (2010). "Knowledge is power": Educating children about their parent's mental illness. *Social Work in Health Care*, 49(7), 630-646.

- Riordan, D., Appleby, L., & Faragher, B. (1999). Mother–infant interaction in post-partum women with schizophrenia and affective disorders. *Psychological Medicine*, 29, 991–995.
- Rosenbaum, B., & Harder, S. (2007). Psychosis and the dynamics of the psychotherapy process. *International Review of Psychiatry*, 19(1), 13-23.
- Rutter, M. (1989). Psychiatric disorder in parents as a risk factor for children. In V. Anthony, N. B. Enzer, I. Philips, D. Shaffer, & M. M. Silverman (Eds.), *Prevention of mental disorders, alcohol and other drug use in children and adolescents. OSAP Prevention Monograph-2* (pp. 157–189). Rockville, MD: Office for Substance Abuse Prevention.
- Rutter, M. (1990). Psychosocial resilience and protective mechanisms. In J. Rolf, A. S. Masten, D. Cicchetti, K. H. Nuechterlein, & S. Weintraub (Eds.), *Risk and protective factors in the development of psychopathology* (pp. 181–214). New York: Cambridge University Press.
- Segal, H. (1978). In *Introduction to the Work of Melanie Klein*. London: Hogarth Press.
- Smith, J. A. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology*, 1(1), 39-54.
- Smith, J. A., & Osborn, M. (2003). Interpretative phenomenological analysis. *Qualitative psychology: A practical guide to research methods*, 51-80.

Stallard, P., Norman, P., Huline-Dickens, S., Salter, E., & Cribb, J. (2004). The effects of parental mental illness upon children: A descriptive study of the views of parents and children. *Clinical Child Psychology and Psychiatry*, 9(1), 39-52.

Stangor, C. (2011). *Research methods for the behavioural sciences*. Belmont CA: Wadsworth.

Stromwall, L. K., & Robinson, E. A. (1998). When a family member has a schizophrenic disorder: Practice issues across the family life cycle. *American Journal of Orthopsychiatry*.

Tebes, J. K., Kaufman, J. S., Adnopoz, J., & Racusin, G. (2001). Resilience and family psychosocial processes among children of parents with serious mental disorders. *Journal of Child and Family Studies*, 10(1), 115-136.

Thomas, A. M., Forehand, R., & Neighbors, B. (1995). Change in maternal depressive mood: Unique contributions to adolescent functioning over time. *Adolescence*.

Van Buren, J. (2005). Discovery of the Mother's Body and the Creation of the Daughter's Subjectivity. *Psychoanalytic review*, 92(1), 117-135.

van der Kolk, B. A., & Kadish, W. (1987). Amnesia, dissociation, and the return of the repressed. *Psychological trauma*, 173-190.

- Waddell, M. (1998). Infancy: Containment and reverie. *Inside Lives: Psychoanalysis and the growth of the personality* (Chapter 3). London & New York: Karnac.
- Walsh, F. (1996). The concept of family resilience: Crisis and challenge. *Family process*, 35(3), 261-281.
- Wan, M. W. & Green, J. (2009). The impact of maternal psychopathology on child–mother attachment. *Archives of Women's Mental Health* 12, 123–134.
- Warner, V., Weissman, M., Fendrich, M., Wickramaratne, P., & Moreau, D. (1992). The course of major depression in the offspring of depressed parents: Incidence, recurrence, and recovery. *Archives of General Psychiatry*, 49(10), 795-801.
- Watts, J., Cockcroft, K. & Duncan, N. (2009). *Developmental Psychology* (Second Edition). UCT Press.
- Weissman, M. M., Warner, V., Wickramaratne, P., Moreau, D., & Olfson, M. (1997). Offspring of depressed parents—10 years later. *Archives of General Psychiatry*, 54, 932–940.
- Werner, E. E. (1984). Resilient children. *Young children*, 40(1), 68-72.
- Williams, O. B., & Corrigan, P. W. (1992). The differential effects of parental alcoholism and mental illness on their adult children. *Journal of clinical psychology*, 48(3), 406-414.

Winnicott, D. W. (1960a). The theory of the parent-infant relationship. In *The Maturational Processes and the Facilitating Environment* (Chapter 3). London & New York: Karnac

Winnicott, D. W. (1960b). Ego distortion in terms of true and false self. *The maturational processes and the facilitating environment*, (Chapter 7). London & New York: Karnac.

Winnicott, D. W. (1963). From dependence towards independence in the development of the individual. *The maturational processes and the facilitating environment*, (Chapter 7). London & New York: Karnac.

Winnicott, D. W. (1965). *The family and individual development*. London: Tavistock.

Williams, A. S. (1998). A group for the adult daughters of mentally ill mothers: Looking backwards and forwards. *British Journal of Medical Psychology*, 71, 73-83.

Willig, C. (2008). *Introducing qualitative research in psychology*. (2nd, Ed.) Berkshire, UK: Open University Press

Zeitz, M. A. (1995). The mothers' project: a clinical case management system. *Psychiatric Rehabilitation Journal*, 19, 55-62.



Psychology
School of Human & Community Development
University of the Witwatersrand
Private Bag 3, WITS, 2050
Tel: (011) 717 4500 Fax: (011) 717 4559



Appendix A: Participation Information Sheet

Good day.

My name is Nishara Govinda, I am currently a Masters in Clinical Psychology student at The University of the Witwatersrand. I am currently endeavouring to complete a research report as part of obtaining my Master of Arts Degree in Clinical Psychology. The aim of the research is to gain an understanding of daughter's childhood experiences of being raised by a mentally ill mother then and now. The research hopes to contribute to understandings of the experiences of daughters of mothers with psychosis, hoping to inform therapeutic interventions aimed at families or individuals who have a mentally ill (psychotic) parent.

I would like you to consider participating in this study. If you agree to participate, you will be requested to sign a consent form indicating your willingness to participate. We will arrange a suitable time for when you can participate in this study. During this arranged time I will interview you at an agreed upon place with the purpose of gaining an understanding of your experiences relevant to the research focus.

If you agree to take part in the study I will also check whether you are willing to allow me to record the interview. You are not expected to share any information that you do not wish to share. There are no benefits for agreeing to participate in this study. However, it is possible that talking about your recollections of your mother's disturbance and its impact on you may be difficult at points, possible leading to feelings of emotional distress. If feeling overwhelmed during the interview you may ask for the interview to be paused until you are ready to continue. Furthermore, you are free to withdraw from the research at any point without any consequence to yourself.

After the interview the audio recordings will be transcribed, and both the recordings and transcriptions will be kept in a password protected folder. Audio recordings will be stored for

a period of five years by the researcher, and the transcribed interviews kept for an indefinite time period. This material will be kept in a password protected computer file. The information obtained during the interview process will remain confidential and pseudonyms will be used in the final research report. The transcripts will remain confidential and only myself as the researcher and my supervisor will have access to the original recordings and transcripts. Direct quotations may be used in the final report but will not be presented in a way that gives away your identity. A summary of the findings will be made available to you upon request. The written report of the findings of the research will be published in a research report and may be presented/published in an academic setting. The final research report will be available in the Cullen library at the University of the Witwatersrand.

I have obtained ethical clearance for this study (ethics clearance reference number H130508) from the University of the Witwatersrand Human Research Ethics Committee.

If you have any concerns about the research you are welcome to speak to me or my supervisor

Researcher

Nishara Govinda

e-mail address: nishara@govinda.co.za

Supervisor

Dr Yael Kadish

e-mail address: Yael.Kadish@wits.ac.za

If you become distressed during or after the research interview the following are free counselling resources, that it may be useful to contact if you need support beyond your usual support system.

Free Counselling Services:

Life-line Johannesburg	0861 322 322
Emthonjeni Community Counselling Centre at The University of the Witwatersrand	011 717 4513
South African Depression and Anxiety Group (SADAG)	011 262-6396



Psychology
School of Human & Community Development
University of the Witwatersrand
Private Bag 3, WITS, 2050
Tel: (011) 717 4500 Fax: (011) 717 4559



Appendix B: Consent Form for Participation

Nishara Govinda has asked me to participate in an interview for her research. She has explained to me that the interview will take about one hour. The nature of the study has been fully explained to me, and I have been informed about the details of my involvement in the research. I understand that:

- My participation is voluntary;
- I may withdraw from the research at any time with no negative consequences for me;
- I have the right not to answer a question if I so wish;
- My interview will be transcribed verbatim and quotes from my interview may be used in a manuscript/article;
- My answers will be kept confidential, ensuring that no information is traced back to the participant;
- Transcripts are safely stored and password protected;
- The audio recordings and the transcripts will be kept confidential;
- Only the researcher and her supervisor will have access to the transcripts;
- The audio recordings will be destroyed after 5 years;

- I may choose to have portions (or all) of the interview excluded from analysis by communicating this to the researcher;
- I understand that there are no benefits to participating in this research, but that talking about the topic may bring up some difficult memories;
- I can contact Nishara Govinda if I have any concerns or if I want access to a summary of the results. I have received the contact details of Nishara Govinda on the participant information sheet.

All my questions about the research have been answered and I agree that my responses to the interview questions can be used for the research.

Name: _____

Signature: _____

Date: _____



Psychology
School of Human & Community Development
University of the Witwatersrand
Private Bag 3, WITS, 2050
Tel: (011) 717 4500 Fax: (011) 717 4559



Appendix C: Consent form for Audio-Recording

I hereby give my consent to the researcher, Nishara Govinda, to audio-record my interview. I understand that the audio recordings will be transcribed. Both audio recordings and transcriptions will be stored in a password protected folder which only the researcher and her supervisor will access to for 5 years and then the audio recordings will be destroyed. I understand that the transcripts will be kept by the university indefinitely. All the information will be treated as highly confidential and my identity will be protected.

Date: _____

Signature: _____



Psychology
School of Human & Community Development
University of the Witwatersrand
Private Bag 3, WITS, 2050
Tel: (011) 717 4500 Fax: (011) 717 4559



Appendix D: Interview Schedule

1. Could you tell me about your childhood in general?
2. Please tell me as much as you are comfortable with about your mother's periods of mental illness in your childhood?
3. What experiences/memories stand out for you?
4. What feelings come up for you when you think about your childhood and your mother's mental illness?
5. Could you describe anything currently in your life that takes you back to your childhood experiences and feelings?
6. As a child, how did you make sense of your mother's psychosis?
7. As an adult how do you feel about your mother and your mother's psychosis?
8. As a child, do you remember what sort of feelings you had in response to your mother's psychosis and psychotic behaviour?
9. Was there anyone in your life that helped you cope with your mother's psychosis? Who? How did this person/these people help you cope?
10. Thinking back on your childhood experiences today, have any thoughts or feelings come up for you?

11. Is there anything else you would like to share today about any aspect of your experience growing up with a psychotic mother?
12. What would you want to say (if anything) to a young daughter of a psychotic mother?