

**An exploration of the recollections of adult daughters on being raised by a mother with  
a psychotic disorder**

**Research Report**

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**Declaration**

I, Sarah Kathrine Day, declare that this is my own unaided work. Where other peoples' work has been used, it has been duly cited and referenced. It is being submitted for the degree of Master in Psychology by Coursework and Research Report at the University of the Witwatersrand.



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16 February 2015

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## **Chapter one: Introduction, aims and rationale**

### **Introduction**

Mordoch and Hall (2002) state there is a dearth of research focusing on the subjective experiences of children raised by parents with a severe mental illness. Research that has been done on children raised by parents diagnosed with a mental illness has focused on the risk of genetic transmission (Apfel & Handel, 1993; Beardslee, Versage & Gladstone, 1998; Rutter & Plomin, 1997). Compared to the greater population, offspring of parents diagnosed with a schizophrenia spectrum disorder have a 10% chance of being diagnosed with a mental illness themselves, compared to 1% for the general population (Riley, Asherson & McGuffin, 2003 cited in Duncan & Browning, 2009).

Despite this, most children of parents with schizophrenia do not have this outcome (Duncan & Browning, 2009). Research focusing on the risk factors of these children neglects to examine the more subtle effects on children who go on to lead “successful” lives and do not develop pathology themselves (Bleuler, 1974; Duncan & Browning, 2009; Wan, Abel & Green, 2008); and when difficulties do arise, they may be transient (Wan, Abel & Green, 2008).

Only a handful of studies (Duncan & Browning, 2009; Dunn, 1993; Mander, Norton & Hoare, 1987; O’Connell, 2008; Williams, 1998) have examined the subjective experience of children growing up with a mother with a severe mental disorder. A review by Murphy, Peters, Jackson and Wilkes (2011) done on studies similar to this one found that predominant themes yielded by these studies were difficulty with emotional parental bonding, parental absence, parentification, childhood feelings of isolation and lack of support by external familial relationships, difficulty establishing and maintaining interpersonal trust throughout their life, devaluing of self, grief, worry, seeking escape and blocking emotions, healing,

hope and growth and the impact of stigma associated with mental illness. Some of these studies are elaborated upon in the next chapter.

This study examined the retrospective recollections of women who were raised by a mother with a severe mental illness with a psychotic component. These accounts were gathered using a semi-structured interview (see Appendix A) and analysed using interpretive phenomenological analysis (IPA).

### **Research aims**

The aims of this study are to examine how an adult daughter who grew up with mother with a severe mental illness with a psychotic component reflects on her experience in the context of an interview. Utilising a semi-structured, open-ended interview, the research aims to gain information from participants regarding their perceptions and recollections of their early childhood experiences, their relationship with their mothers during childhood and adulthood, and the presence and role of the mental health services. The data focuses both on the phenomenological (the participant's perceived experiences) and the interpretative (placing the interviews within a psychologically theoretical background) (Larkin, Watts & Clifton, 2006; Smith et al., 2009 cited in Van Parys, Smith & Rober, 2014).

### **Research questions**

1. How do adult daughters make sense of the experience of having had a mother with a psychotic disorder while growing up?
2. How do participants view their own coping skills and adaptive psychological mechanisms, in relation to their experiences of being raised by a mother with a severe mental illness with a psychotic component?

## **Research rationale**

This study explored the recollections of five women on their experiences of growing up with a mother who had a severe mental illness with a psychotic component, such as bipolar affective disorder with psychotic features, schizophrenia spectrum disorders and in one participant's case, borderline personality disorder with a distinct psychotic component. Women were selected for this study as it falls into a bigger study examining daughters' retrospective recollections of being raised by a mother with a psychotic disorder conducted by Dr Yael Kadish of the University of the Witwatersrand (the student's supervisor). This study will be taking an overarching psychoanalytic perspective, looking at psychic structures and psychological defence mechanisms across all the interviews collected by several students over the last five years. This study slots into the aforementioned larger study in that it provides data for the research to be conducted.

Only a handful of studies (Duncan & Browning, 2009; Dunn, 1993; Mander, Norton & Hoare, 1987; O'Connell, 2008; Williams, 1998) have examined the subjective experience of children growing up with a mother with a severe mental disorder. The subject of subjective experience has largely been neglected in favour of the examination of genetic risk of transmission (Apfel & Handel, 1993; Beardslee, Versage & Gladstone, 1998; Rutter & Plomin, 1997). This study is valuable as it attempts to add to the limited body of knowledge on the subjective experiences of these children.

There is heterogeneity in the manifestation, duration and severity of psychopathology, and in each person's ability to cope, personality characteristics and social circumstances (Brockington et al., 2011). The presence of psychopathology does not necessarily detract from a parent's ability to be an exemplary caregiver. However, the possible ways in which mental disorders affect parenting, which include parental preoccupation, emotional unavailability of the parent, anger and hostility towards the children

and demonstrating disturbed behaviour in front of their children, which may prove frightening. While not present in all cases, children raised by parents with severe mental illness may be exposed to neglect, emotional neglect and abuse and physical abuse (Brockington et al., 2011). Considering these possible consequences of maternal mental illness and the complicated nature of the heterogeneity of experience, it is important to examine the perceived impact of these experiences on the children of these mothers. Severe mental disorders with psychotic components were selected for this study because IPA requires a homogenous sample (Smith et al., 2009 cited in Van Parys, Smith & Rober, 2014).

Research that focuses on parental mental illness and psychopathology as an adult outcome of these children frames children as passive receivers of their environments (Mayall, 2002; Qvortrup, 1985; Van Parys, Smith & Rober, 2014). The use of IPA gives the participant an active voice. Qualitative methodology, utilising IPA, provides a more appropriate forum for addressing such a research concern as it aims to tap into and explore these heterogeneous experiences (as reported by participants) rather than limiting them through quantification. Qualitative methodology acknowledges that experiences often cannot be clustered into neat framework and that it is inherent messy and overlapping (Miles, Huberman & Saldaña, 2014).

## Chapter two: Literature review

### Introduction

Living with severe mental illness in the mother presents a variety of challenges (Montgomery, 2005). A mother's ability to respond to and address the challenges presented by severe mental illness is limited by a lack of resources, choices and invisibility as a mother by others, including those who work in the mental health sector (Montgomery, 2005). The impact of a parent's diagnosis of mental illness has far-reaching implications for the child. The nature of mental illness is episodic and recurrent. This means that a mother may experience an episode of acute symptoms across more than one of the child's developmental stages and this may result in an accumulation of risk for behavioural and psychological problems for the child (Hammen, 1997). The majority of research that has been done on children with a parent diagnosed with a mental illness has been concerned with how the children are at risk of behavioural and psychological problems themselves because of genetic transmission (Apfel & Handel, 1993; Beardslee et al., 1998; Hall, 2004; Rutter, 1989, 1990; Smith, 2004) and environmental factors (Beardslee et al., 1998; Nicholson, Sweeney & Geller, 1998a, b; Rutter, 1989; Rutter & Plomin, 1997).

Children of parents with a mental disorder are not just vulnerable to developing a mental disorder themselves, due to genetic transmission of risk, but are vulnerable to exposure to deprivation, an absence of social support, exposure to marital conflict and disorganised family lives (Brockington et al., 2011). Children of parents with mental disorders may be exposed to child maltreatment, such as physical abuse and emotional neglect and abuse (Brockington et al., 2011).

Some infant disturbances can be related to parenting (Brockington et al., 2011). A study by Wan, Warren, Salmon and Abel (2008) examined the responsiveness of mothers

diagnosed with a psychotic disorder in comparison to mothers diagnosed with affective disorders. The mothers' interactions with their infants were observed in a laboratory setting. Psychotic mothers reported a low rate of responsiveness, which was similar to mothers with affective disorders. Mothers with affective disorders were distracted visually, which made them unresponsive to their infant's behaviour (Wan et al., 2008). In contrast, psychotic mothers became psychologically withdrawn. This suggests that the reasons for low responsiveness differ. Psychotic mothers tend to become unresponsive when their infants stop self-initiating behaviour. Psychotic mothers differ in three important ways: they may display negative response to positive infant behaviours, psychological unresponsiveness and abnormal behaviour in front of their infant (Wan et al., 2008). This could be because of the presence of positive symptoms and social-cognitive deficits. Despite this, no infant inertness, low inhibition or negativeness was found. This contrasts with mothers with affective disorders, as they only respond negatively to negative infant behaviour (Wan et al., 2008).

Parental mental illness may also influence parenting style. Depression in mothers may result in them seeing the maternal role as negative, which in turn may result in them resorting to more use of punishment (McLoyd, Jayaratne, Ceballo & Borquez, 1994) and an inability to set standards without using too harsh a punishment due to feeling uncertain as a mother (Mowbray, Oyserman & Ross, 1995). Robinson, Mandelco, Olsen and Hart (1995) state that mothers with mental illness may use permissive parenting, which means that children have very little structure, low discipline and are subject to low parental demands. Both these parenting styles are related to negative outcomes for the children (Coleman & Karraker, 1997). The child may also display over-compliant behaviour in order to deal with the parent's unpredictability. In addition, ambiguous communication given by the parent is prevalent. One parent may contradict the demands or expectations of the other parent. Of more concern is

that the child's life is intruded upon by the delusions and hallucinations of the parent (Cooklin, 2006).

Bleuler's (1974) classic work examined 184 children whose parents were diagnosed with schizophrenia. He found that the children faced many adversities and a developmentally inappropriate level of responsibility. They had to look after both themselves and their parents and lived in environments that were considered to be deprived. This has been theorised to have both long- and short-term effects on the child, and would likely result in negative mental health outcomes in adulthood. Bleuler (1978) noted that his patients' children were well adjusted socially, despite having difficult childhoods. However, Bleuler (1974) notes that even if they appear to be successful later in life, the effects of being raised by a parent with schizophrenia may translate into more subtle difficulties.

### **Risk and resilience**

Research that emphasises risk does not necessarily offer an explanation about the resilience of children who have been raised by a parent with a severe mental illness (Duncan & Browning, 2009), and frames these children as passive receivers of their parents' adverse behaviour (Van Parys et al., 2014). The risk/resilience discourse in research is powerful and is based in the larger discourses of contemporary childhood and risk. An overreaching theme in the literature is that children who are living with parents who have been diagnosed as being mentally ill are at risk of being diagnosed with a psychiatric disorder themselves; those who are not diagnosed with a mental illness are viewed as extraordinarily resilient (Gopfert, Webster & Seeman, 1996; Nicholson et al., 1998a, b; Smith, 2004). These discourses claim that childhood is a critical development stage where children need protection due to their physical and psychological vulnerability (Beck, 1992; Douglas, 1990; Lupton, 1995; Scott, Jackson & Beckett-Milburn, 1998; Valentine, 1996). Childhood is seen by some theorists as a preparatory stage rather than a participatory stage (Mayall, 2002; Qvortrup, 1985). Events in

childhood are emphasised as having a link to adult outcomes instead of considering the significance for the child at that current stage of development. Considering future implications is important; however, consideration of the present well-being of the child is also of great importance (Prout, 2001).

Gladstone, Boydell & McKeever (2006) argue that new lines of enquiry should be opened in terms of the subjective experience of children being raised by a mentally ill parent. The dominance of the risk/resilience discourse should be critiqued, especially the view of the child as passive, developing and unfinished. Recasting of children opens up new lines of enquiry in terms of their experiences of having a parent diagnosed with mental illness (Hutchby & Moran-Ellis, 1998; Mayall, 2002). The danger of casting children into the “at-risk” category is that it is a status that follows them into adulthood, especially with regard to the formation of social relationships (Gladstone et al., 2006).

### **Qualitative studies**

Mordoch and Hall (2002) argue that the child’s experience of growing up with a mother diagnosed with a mental illness has been neglected. Little is known of the effect of this on children, due to a lack of literature that seeks a subjective response from the children themselves (Nicholson, Biebel, Hinden, Henry & Stier, 2001).

Mander, Norton and Hoare (1987) did a case study on an 11-year-old girl, called G, whose mother had grandiose delusions and visual hallucinations. During the time the mother was in hospital, the impact on G was not considered. If G had been assessed upon this admission, many of the problems she encountered may have been averted. G engaged in shoplifting and her school attendance was irregular as she stayed home to look after her mother. G was very protective of her mother and often interrupted her to prevent her talking about her experiences. G’s case study supports that the child may be concerned with the parent’s safety

and attempt to fulfil the role of caregiver (Cooklin, 2006). However, some theorists argue that the caregiver role of children in families that have a parent diagnosed with mental illness is a protective factor, because it gives the child a constructive family role. Little research has been done on finding out how children experience the premature caregiving role (Gladstone et al., 2006).

When interviewed, G claimed that she experienced the same hallucinations and delusions as her mother when interviewed in the presence of her mother. This could be because wanted to comply with her mother's request for confirmation of her experiences. Cooklin (2006) states that some children may imitate the symptoms the parents present with for defensive purposes. However, when interviewed alone, she showed no sign of any symptoms of psychosis. There were detrimental effects on her cognitive abilities due to her irregular school attendance and she showed a childlike immaturity. G is an example of how the children of mothers diagnosed with mental illness can often be invisible to the mental health care workers who are treating their mother, unless any abuse or neglect is clearly visible (Gladstone et al., 2006).

Williams (1998) did a study examining a group therapy situation with four women who were raised by a mentally ill mother. Two of the mothers had bipolar affective disorder, one had a diagnosis of schizophrenia, and the other had suspected schizophrenia and alcoholism. The fathers of the women whose mothers had schizophrenia sexually abused them, and the fathers of the women whose mothers had bipolar affective disorder were distant (Williams, 1998). Three of the women were mothers themselves and often spoke about parenting issues. In the follow-up study, the women reported ongoing burdens with regard to childcare. Themes that emerged from this study were hatred of self and mother, current lack of support from extended family, current parenting difficulties, ongoing stigma and isolation.

The group therapy process allowed for strong identification between the participants, which resulted in a willingness to self-disclose (Williams, 1998).

Although the participants in this study were viewed as resilient by others, they had difficulty attributing this quality to themselves (Williams, 1998). The participants all appeared to be functioning well and they were all well-dressed, well-groomed and had acquired good jobs. However, while the participants displayed a competent image, they spoke of internal distress in the context of group therapy. Williams (1998) theorised that the women had created false selves as a coping strategy. This strategy had both negative and positive outcomes. While they supported the others in group therapy, they felt unsupported themselves. However, the reason for the participants' resilience is unclear. They had no alternative main adult to provide a protective factor. This development of appearing to be well-adjusted may be an early adaption in order to take control of their self-care (Williams, 1998).

Dunn (1993) did a study on the experience of growing up with a psychotic mother. There were nine participants in the study, four men and five women. One of the participants had a diagnosis of schizophrenia themselves. Similar to the study by Williams (1998), the participants' fathers were emotionally or physically distant. Dunn (1993) found themes of abuse and neglect, isolation, guilt and loyalty, and grievances with mental-health services and support (Dunn, 1993). In terms of abuse and neglect, some participants described maternal withdrawal. Some mothers' ability to provide basic care was compromised. In some cases there was physical abuse and in one case, sexual abuse. Interestingly, one statement by a participant noted that the people who should have noticed what was happening did not (Dunn, 1993). This links back to the proposed invisibility of children of a mentally ill parent (Gladstone et al., 2006).

Participants felt isolated from their peers, their community and their family (Dunn, 1993). In addition, no explanation was offered of what was happening with their mother's illness. This resulted in confusion, and psychotic episodes were found to be frightening. The theme of guilt and loyalty is linked to isolation. The participants described the need to be loyal to their mother, despite it being difficult to live with her (Dunn, 1993). Loyalty to the parent is common in such situations, despite their experiences (Cooklin, 2006). Some participants felt as though they had somehow contributed to their mother's illness. In addition, some felt guilty for being healthier than their mother or guilty for moving away. Most participants found contact with the mental health services negative. Mental health professionals blamed the children or gave them too much responsibility to "blow the whistle" on their mother (Dunn, 1993).

Living in a family where one of the parents has been diagnosed with a mental illness is complex and challenging. Family members are often blamed for the member's illness. Family members must deal with the care of the family member who is ill as well as combating feelings of guilt and partial responsibility (Boyd & Nihart, 1998; Canadian Mental Health Association, 1991; Dunn, 1993). Self-blame and taking responsibility for the family's problems may occur in result of this (Cooklin, 2006).

Eight out of nine of the participants entered into therapy during their adult life. Most found it helpful (Dunn, 1993). However, the study did not ask what motivated them to do so. Interestingly, the participants who engaged in therapy gave rich data sets and were better able to verbalise their feelings. Therapy allowed participants to overcome feelings of shyness, feelings of being different, and fear of reprisal from their mothers. Dunn (1993) asks for future research to orientate around such questions as it could add to our understanding of resilience and coping. In terms of resilience, most participants had an adult that they found to

be supportive and with whom they felt safe. This person provided a protective factor for the participants (Dunn, 1993).

The study by Duncan and Browning (2009) examined the attachment problems of now-adult children of parents with schizophrenia, using qualitative methods. The study consisted of 23 participants, of whom four were men and 19 were women. Four of the participants' fathers had schizophrenia. The study used a semi-structured, in-depth interview; it did not directly assess attachment style but used the narratives produced by the participants to extrapolate. The participants' accounts were heterogeneous but a number of commonalities emerged (Duncan & Browning, 2009). The accounts produced by the participants centred on mistrust of others and difficulties achieving the vulnerability needed for intimate relationships. Their retrospective accounts described their parent as being psychologically absent and reported a lack of closeness, love and bonding between them and their mother. The participants recall detaching from their parent with schizophrenia and they speak of their feelings of caution as to their parent's unpredictable behaviour. These experiences may have left a lasting legacy of relationship difficulties that affects the participants' adulthood (Duncan & Browning, 2009).

The issue of children with parents diagnosed as mentally ill is complex. Gladstone et al. (2006) call for research that examines children's subjective experiences through direct contact with them. It is for this reason that the present study explores this question. Through accounts given by an adult who grew up with a mentally ill parent, access can be gained to the way in which the experience is reflected upon in an interaction.

## **Chapter three: Methodology**

### **Methods**

This study utilised qualitative research, using the specific method of interpretive phenomenological analysis (IPA). According to Larkin et al. (2006) IPA has two primary objectives. The first requirement is phenomenological and is committed to providing a “voice” for the preoccupations of the participant, and the second is the interpretive requirement that seeks to place the narratives of the participant into a psychological context. By using IPA, it is possible to explore how the participants make sense and meaning of growing up with a mother diagnosed with a mental illness. IPA involves both an empathetic and a questioning hermeneutic (Smith & Osborne, 2008).

As well as documenting the participants’ reflections on their experiences, the researcher examines the entire research process from a more critical stance, as per IPA guidelines (Larkin et al., 2006; Smith & Osborne, 2008). This involves examining the participant’s narratives in more nuanced ways. In addition, it is important to consider how the interview process influences the data (Smith & Osborne, 2008). The aim of IPA is not to gain objective knowledge about the experience; rather it emphasises the participant’s perception (Smith & Eatough, 2008). The experience the participant is reflecting on cannot be accessed during an interview, and the interview remains an account constructed by both the participant and the interviewer (Larkin et al., 2006; Silverman, 2004). Through the interview process, only the way in which the participant reflects on the event can be captured and analysed.

### **Sampling**

The sampling method that was used is purposive sampling. The sample consisted of five women whose mothers suffered from a psychotic mental illness. A condition of participation in this study was that participants’ mothers must have experienced at least one

episode of psychosis, preferably diagnosed by a psychiatrist, during the period in which the participant was growing up. The study requires participants to be over the age of 18, as that is the age at which a person is legally considered to be an adult according to South African law. Due to the possibility of distress, participants should not have had an episode of diagnosed mental illness themselves within a two-year period prior to participating in the study. Before the interview, the participants were asked if they had suffered from an episode of severe mental illness within the last two years.

Three of the five participants were known to the researcher (the ethical ramifications of this are discussed in the ethical guidelines section) and were approached and invited to participate in the study. Two of the participants found out about the study via word of mouth and approached the researcher as they wished to participate. The diagnoses of the mothers were heterogeneous. *Pseudonym* Anna is 23 years old. Her mother was diagnosed with schizo-affective disorder during her childhood. The affective disorder that accompanied the schizophrenia is bipolar affective disorder. Donna is 23 years old and her mother was diagnosed with bipolar affective disorder and alcoholism.

Chrissie's mother was diagnosed with bipolar affective disorder during her childhood. Chrissie is also in her early twenties. She did not fulfil the criterion of not being diagnosed with type II bipolar affective disorder within the last two years, but because of her ongoing psychotherapy and her compliance with her medication it was deemed that she had enough external formal support to deal with any distress that might arise from the interview. This was discussed prior to the interview taking place.

Belinda was the oldest participant and the only one whose mother is deceased. Her mother was only diagnosed with borderline personality disorder when she was 70. Although Belinda's mother does not satisfy the criterion of being diagnosed with a disorder that falls

within the schizophrenia spectrum and delusional disorders, her interview was included because she reported that her mother had paranoid features.

Ginny is 41 years old. Her mother was not formally diagnosed by a psychiatrist; however, Ginny believes that she has experienced being raised by a mother with a severe mental illness and her interview provided valuable data, so it was included.

The study was conducted at a location and time of the participant's choice. The researcher had two available venues should the participant prefer to use those. All others with access to these venues were notified timeously that the room was unavailable when an interview was scheduled. Some of the participants preferred to stipulate their own venues.

### **Data gathering**

The instrument that was used is a semi-structured interview. Semi-structured, open-ended interviews allow for participants to be active agents in the research process (Smith & Eatouge, 2008). An open-ended interview is usually so called because although the questions are predetermined by the interviewer, the interviewer is not aware of what content the interviewees' answers will hold (Thibodeaux, n.d.). Interviews allow the researcher to access people's reflections on their experiences, memories and perceptions (Zhang & Wildemuth, 2009).

The interview took place at the time and location of the participant's choice. Each participant was interviewed for approximately one hour; due to the nature of the semi-structured interview, interview times varied for each participant. Before the interview took place, the first step was to gain informed consent. The participants were given a participant information sheet (see Appendix B). The aims of the study were discussed and made as clear and transparent as possible (Burman, 1994). The research form addressed issues of anonymity and gave a promise to the participant that she could terminate the interview at any

stage for any reason without any consequences. Accessibility to the data was also addressed (Burman, 1994).

The use of an audio-tape recorder was discussed with the participant. Consent for the use of the audio-tape was gained by the participant signing the permission form (see Appendices B and C). The reasons why the recording is used, how it is used and how it helps the researcher were included in the discussion (Burman, 1994). As IPA seeks to give voice to the participants, it is important to use the participant's own words during the analysis, which is why audio-recording is imperative. Audio-recording is an important part of the interview process, as it is impossible to write down everything verbatim that is said in the interview. Audio-recording enables the researcher to concentrate on what the respondent is saying, including non-verbal expressions. Recording by hand only captures the gist of what is being said (Smith & Osborne, 2008).

A list of 15 questions was compiled (see Appendix A for the interview schedule). Preparing a set of questions beforehand helps conceptualise which areas the researcher wishes to access. It also helps the researcher to predict any difficulties the interview may encounter (Smith & Eatouge, 2008). By acknowledging these issues, questions can be structured in a way that is sensitive. Having a set of prepared questions allows the researcher to be confident and relaxed (Smith & Eatouge, 2008). The interview began with general questions in order to gain rapport, and more sensitive questions were asked later in the interview (Smith & Osborne, 2008).

The research questions were conceptualised after reading through past research and aiming to target certain experiences: childhood experiences of growing up with a mother with a severe mental illness, current and past relationship with the mother, coping strategies, experiences of the mental health services, and experiences of therapy (see Appendix A for

interview schedule). In order to reduce bias, the questions constructed by the interviewer aimed to be neutral, which means they did not lead the interviewee in a specific direction (Smith & Osborne, 2008); the way in which a question is asked can influence the way in which the respondent responds. Some of the questions could make use of a more specific prompt when the participant is struggling to answer the question (Smith & Osborne, 2008). Although the interviewer's role is to guide and facilitate the interview process, it is impossible for him or her not to influence the respondent's answers in some way. This is because the interview process is an interactional one and the researcher cannot escape being a participant (Larkin et al., 2006; Smith & Osborne, 2008). However, as much as possible, the researcher will ask questions in a way that does not steer the conversation in a specific direction (Smith & Eatouge, 2008).

The emphasis in semi-structured, open-ended interviewing is not on the prepared questions. It is important that the researcher is able to negotiate between the interview schedule and following up novel lines of enquiry that the participant offers (Eatouge & Smith, 2008). This allows the researcher to follow the participants' concerns and interests. The sequence the questions follow is not important (Smith & Osborne, 2008). All the interviewees were given the same basic interview. However, the follow-up questions in some cases were different. While the study required all participants to have experienced having a mother diagnosed with a mental illness growing up, their experiences were not homogenous and some things were more influential in one participant's life than another's (Burman, 1994).

An interview is an interactive process that forms a meaning-making conversation. The interactive process means that it is a constructive process (Holstein & Gubrium, 1995); meaning is constructed between the interviewer and the interviewee. It is important to remember that participants are not reporters on reality; instead, they construct it during the

interview process (Speer, 2002b). The use of a semi-structured interview allows the participant to take greater control and ownership of the research process. The benefits of this are that greater rapport is established, the data produced is richer and more lines of enquiry are explored. Disadvantages of the semi-structured interview are that it is more time-consuming to analyse such data sets and it is harder to analyse the transcript (Smith & Osborne, 2008).

## **Data analysis**

### **Step one**

The aim of the analytical process is not to measure the frequency of the themes that emerge, but rather their content and complexity (Smith & Osborne, 2008). After the interviews were completed, the transcription phase was undertaken. The audio tape-recording was converted to a written transcript where significant pauses, laughs, tears, inflections and deflections and false starts were noted. There were left and right margins for the later stages of analysis (Smith & Osborne, 2008). Burman (1994) notes that in the process of converting an audio transcript to a written transcript, a lot of content is lost, with a resulting loss of objectivity. Therefore it is important to note in the transcript the tone of voice, significant body language and emotion displayed by the participant.

### **Step two**

The transcript was read through a number of times so that the researcher could become familiar with the text (Smith & Osborne, 2008). The interview material was read in relation to the research question (Burman, 1994). The left-hand margin was used to note anything interesting the participant may have said. These initial notes were not clustered or grouped in any way (Smith & Osborne, 2008) but were unfocused (Willig, 2008).

### **Step three**

Once this process of reading and notation was finished, the right-hand margin was used to list emerging themes. The themes generated aimed to answer the researcher's questions as well as to give voice to the participant's primary concerns, as per IPA (Larkin et al., 2006). Once this was complete, the themes were listed on a separate piece of paper. Connections between themes were clustered together. Some of these themes consisted of subordinate concepts (Smith & Osborne, 2008). Phrases from the transcript were used to support the emerging themes (Smith & Osborne, 2008). This process is important because the analysis should do justice to both the research concerns and the participants' preoccupations (Burman, 1994).

### **Step four**

Once this process was complete, a table was produced that ordered the themes coherently and placed subordinate themes under a main theme (Smith & Osborne, 2008). The analysis paid attention to analytic reflexivity. The analysis should be placed within an account of its production and acknowledge constraints, limits and possibilities created by the researcher's position as an analyst (Burman, 1994). Analysis requires interpretation, and inherent in this is incompleteness and partiality; a transcript can be vulnerable to over-interpretation and misinterpretation. A text can always be read in multiple ways; it is important to acknowledge that any analysis done on the transcripts is only one way of reading them (Burman, 1994).

The analysis of a transcript is inexhaustive and partial. While it is important to acknowledge this, the researcher must also accept that an analysis remains unfinished (Burman, 1994). As this study is designed to fulfil the requirements of a Master's degree, there are limitations on space and time and this limited the analysis of the transcripts.

Especially in this study, it is important to examine the effect of the researcher's prior relationships with the research participants (Burman, 1994). Three out of the five participants were known to the researcher. While it was initially anticipated that the pre-existing relationship would make the participant more comfortable and open to disclose, the experiences of the interviews proved to be the opposite. The participants known to the researchers tended to offer less information and the researcher had to use more follow-up questions to get information. The participants unknown to the researcher seemed to speak more freely and offer information more spontaneously. The researcher was careful not to force the participants to say more than they were willing to by noticing hesitance and noting it down.

#### **Step five**

Once the analysis was complete, it was written up. The analysis was expanded during the write-up and themes were translated into a narrative account. Once this was completed, an analytic comment was made (Smith & Osborne, 2008). In the write-up, when passages are selected to elaborate a point, limitations on length dictate that the whole transcript cannot be used. What is chosen and what is ignored has an effect on the content of the research. The selection of the content of the transcript for the research report reflects the researcher's questions, ideas about the participants, ideas about the topic at hand and many other unintentional things. While it is impossible to remove this effect, it is important for the researcher to remain reflexive about it (Bucholtz, 2000).

#### **Quality**

Plausibility of the conclusions drawn from the data is an important consideration of quality criteria with qualitative research (Miles et al., 2014). It is important that the conclusions drawn from the data are directly related to the data and make sense. In order to do this, the researcher has provided the quote from which the conclusions are drawn in order

to demonstrate that the conclusions are based within the data and readers of the report are able to consider whether the conclusions are appropriate. By doing this, this also links to Tracy's (2010) call for qualitative research to engage in sincerity, which involves demonstrating transparency. Plausibility of the conclusions needs to extend beyond the used of intuition and requires commitment to verification (Miles et al., 2014). This involves basing the conclusions within previous research, stating how they align and disalign with the current state of knowledge on the topic.

In addition to examining the transparency of the plausibility of the conclusions of the study it is important to outline the procedural process with as much transparency as possible (Miles et al., 2014; Tracy, 2010). These processes need to be clear enough to be evaluated by an outsider (Miles et al., 2014; Tracy, 2010). In the case of the research report, the conclusions and procedures will be evaluated by two examiners: an internal and an external examiner. This aspect also correlates with reliability, in that a peer review aspect is available to evaluate the piece of research (Miles et al., 2014).

Miles et al., (2014) makes an important differentiation between plausibility and confirmability. While this research reports seeks to make the analysis of the participants accounts logical and locating it within the current body of knowledge surrounding experiences of daughters who have grown up with a mother with a psychotic disorder, it cannot seek to make any generalisations about the topic.

While phenomenology does not adhere to the notion that there is a single reality, this does not mean that there is no 'wrong' way to analyses the data (Miles et al., 2014). The analysis needs to be based in reasonable conclusions. According to Miles et al., (2014) this means that the researcher needs to acknowledge that qualitative research cannot be grouped

into neat clusters or themes and that it is inherently messy and difficult to classify neatly.

This is called the holistic fallacy (Miles et al., 2014).

Other aspects of reliability that needs to be considered in the research process are that the participants need to be placed within their context, the process acquiring the participants needs to be accurately described, specifications on the limits of participation is specified (see sampling for exclusion criteria for participating in the study), and acknowledgement of the generalisability of the study (Miles et al., 2014).

### **Reflexivity**

The researcher acts as both a participant and an observer (Speer, 2002a). The researcher should not appropriate data to suit his or her own theoretical agenda or subjectivity. By examining the interview process as an interactional product, the contours of the agendas of both the researcher and the respondent should be made transparent. Even when the researcher attempts to minimise his or her impact on the data collection and analysis process, the interview remains a product of interaction (Speer, 2002a). However, the researcher must not try to steer the interview or analyse the data in such a way that it suits the researcher's theoretical or political ideology. The researcher must try not to examine the data through a subjective lens, but rather as it presents itself.

Respondents should take an active rather than a passive role in the interview process. The researcher's involvement should also be analysed (Holstein & Gubrium, 1995; Larkin et al., 2006; Speer, 2002a, b). Stances that require the researcher to be neutral and separate from the respondent imply that the researcher is somehow ontologically distinct from the respondent (Speer, 2002b). Instead, this research focused on the interview as a social interaction where both the researcher and the respondent engaged in meaning-making, instead of looking at it as a neutral instrument or something particularly vulnerable to distortion. The

researcher engaged reflexively with how the interactional process unfolds and how meaning is constructively made (Holstein & Gubrium, 1995). Both these standpoints move away from the respondent being a passive knowledge holder (Speer, 2002a, b; Holstein & Gubrium, 1995).

After the interview, the researcher noted her own feelings and impressions surrounding the interview. While transcribing the interviews, the researcher noted any bias or leading questions. Further subjective impressions and feelings were noted on the interview transcripts before analysis began.

### **Ethical considerations**

The participants in this study may be considered a potentially a vulnerable population. In order to address this concern, the proposal was sent to an external ethics review board to be approved before any research commenced. Because the participants were potentially vulnerable, it is possible that they may have felt psychological distress during or after the research process. Because of the strong likelihood of secondary trauma, all participants were strongly recommended to attend a free counselling service at the Emthonjeni Centre at the University of the Witwatersrand. Details of how to make an appointment were made available on the participant information sheet (see Appendix A). However, some of the participants were already in therapy and they reported that they would return to their current therapist. This was discussed with the participant before commencing the interview. If the participant feel distressed during the interview, the interview was stopped and the researcher engaged in containment. Afterwards, the participant was asked if she wished to stop the interview process. If she did, then the data collected in that interview was discarded. Some of the participants felt quite emotional when talking about various aspects of their experiences, but emphasised that they wished to continue speaking about them.

In addition, a participant was not included if she had experienced an episode of diagnosed mental illness within two years of participating in this study. However, a concession was made for one participant who had been diagnosed two years previously, as she was in weekly therapy, compliant with medication and the diagnosis fell just within the two-year limit. This was stated upfront on the posters advertising participation in the study. In addition, before the interview began, the participants were asked whether they had suffered an episode of serious mental illness within the last two years. If it became apparent in the process of the interview that the participant had been experiencing symptoms of severe mental illness that had been undiagnosed, or the participant had concealed that they had experienced an episode of mental illness in the last two years, the interview was stopped and the data discarded. A debriefing session followed and the reasons why the interview was stopped were discussed with the participant, and any concerns or emotions expressed by the participant were addressed.

This study opened with a very short briefing session, where informed consent was gained in order to conduct the interviews. The aims and the overall purpose of the study were openly discussed (Burman, 1994; Brinkman & Kvale, 2008). At this point, any risks and benefits, as well as issues of confidentiality, were discussed with the participant. It was stated that any data that could identify the participant would be removed and each participant would be given a pseudonym (Brinkman & Kvale, 2008). There was no direct benefit to taking part in the study; however, the participants may have found that telling their story could be an empowering process. The risk of the study was that the participants may have felt psychological distress during or after the interview, which may uncover experiences and memories that the participant had not dealt with or may not be ready to deal with, and these may have caused discomfort or distress. It may have been necessary for the participant to seek therapy after the interview in order to deal with these emotions, which is why free

counselling at the Emthonjeni Centre at the University of the Witwatersrand was provided. Feelings of guilt may occur, due to divulging this information. In the consent form, participants were informed that they could withdraw from the study at any time during the research process with no consequences. In addition, participants could refuse to answer specific questions and choose the level of detail with which they wished to answer. It is vital that the participants knew that participating in this study was voluntary (Brinkman & Kvale, 2008).

The use of a tape recorder also required a consent form to be signed by the participant (Burman, 1994). The consent form stated that the researcher and the supervisor alone have access to the transcripts and informed the participants about the researcher's right to publish the interview or some of it, subject to issues of confidentiality (Brinkman & Kvale, 2008). The recordings of the interviews and the transcripts were kept in a password-protected file on the researcher's and supervisor's computers. A written agreement between the researcher and the participant was signed and the consent forms were filed in a locked cabinet (Brinkman & Kvale, 2008). Debriefing occurred at the end of the interview. The research participants were given an opportunity to voice any feelings or concerns that they wished to discuss and were advised that they could have access to the transcript and the analysis if they so wished (Brinkman & Kvale, 2008).

The sample was difficult to obtain as only two people who were not known to the researcher responded to the research call, which meant that the researcher had to resort to a sample of people known to her. It is perhaps not advisable to interview friends or colleagues on sensitive topics, as this might change the pre-existing relationship once the researcher comes to know the details of participant's traumatic experiences. Additionally, participants may feel emotionally exposed in later interactions, which they could not have foreseen prior

to consenting to participate. Lastly, participants may feel that their ability to exert their right to refuse participation or to withdraw from the study may be influenced by their existing relationship with the researcher. However, due to the difficult nature of acquiring the sample needed for the study, it was not possible to exclude participants known to the researcher; extra care was taken with these participants.

Where a potential participant is known to the researcher before the study, the dynamics of the friendship will influence the way the data is produced. This aspect of possible bias was dealt with by the researcher assuring the potential participant in the strongest possible terms that she was absolutely free to participate or not and should not feel pressured by knowing the researcher. Should the participant agree to participate, before beginning the interview the researcher strongly adhered to the ethical principles of confidentiality and anonymity of the data. The researcher stipulated that this implied that she will never to divulge any of the material outside the research context and that the participant's identity would be disguised in the research write-up. It was clearly stated that the level of detail that participants wished to divulge was completely up to them. Participants were informed that they did not have to answer all the questions. If the researcher saw that a participant seemed to be experiencing difficulty or distress during the interview, she asked if the participant wished to take a break, or stop the interview entirely.

Recruiting participants known to the researcher may allow for possible bias in the research results. In order to deal with this, all analysis was grounded in the data that stemmed from the interview. No other information that was gained prior to the interview, such as knowledge the researcher may have about a participant, was used. Interestingly in this study, the researcher's previous relationship with the participant made her less open to discussing her experiences and the interviews were significantly shorter and details were less spontaneously offered. The interviews with strangers had richer data and a lot more content.



## Chapter four: Discussion of findings

### Introduction

This research report identified six main themes: 1. Relationship with mother: then and now; 1.1 Child and adolescent recollections; 1.2 Adult recollections; 2. Abuse and neglect; 2.1 Neglect; 2.2 Physical abuse; Emotional abuse and neglect; 3. Isolation, secrets and facades; 4. Emotional responses and adult relationships; 4.1 Self-concept and relationship with others; 4.2 Anger, guilt, ambivalence and sorrow; 5. Protective relationships; 5.1 The role of therapy; 5.2 Protective family members; and 6. Mental health services and the role of the diagnosis; 6.1 The absent mental health system and resistance to psychiatric treatment and 6.2 The importance of the diagnosis.

As found in this study, outcomes for adult children of mother's with a severe mental illness are heterogeneous (Brockington et al., 2011; Duncan & Browning, 2009). Most of the participants reported good grades, except Donna, and four went on to pursue tertiary education. Of these four, two completed their tertiary-level education and the other two were currently studying. The participant who did not manage to achieve at school and dropped out of tertiary education does have a job and is thinking about continuing her education later in her life. The richest dataset came from the oldest of the participants, Belinda, who provided a picture of her childhood all the way up to having to care for her mother in her old age. She provided insight into how she has adapted over the years and has had more time to deal with her experiences during her upbringing.

All the participants reported that while they may appear to be well-adjusted, the effects of their upbringing have had pervasive effects into their adult life. Three of the five participants reported having suffered a mental illness themselves sometime in their lives;

however, all believed they had adjusted better than their mothers did. All were compliant with their medication and sought treatment.

When speaking about their experiences, many of the participants chose to focus on their positive outcomes and progress with aspects of their difficulties with relationships and personal perception. Their recollections emphasised hope and their achievements to date rather than focusing on the negative experiences.

Only one of the five participants' mothers was in active psychiatric care. The rest had rejected psychiatric treatment and denied there was problem. Many of these daughters were not aware of the nature of their experiences and spoke about a concerning lack of strategies to identify parents with severe mental illness who are in need of support.

## **1. Theme one: Relationship with mother: Then and now**

### **1.1 Childhood and adolescent recollections**

As in the meta-analysis done by Murphy et al. (2011), the participants found their mothers' behaviour "difficult and confusing" (p. 3433) and reported tumultuous relationships with their mothers during their childhood, characterised by hatred, resentment, guilt and personal distance. Recollections of their mothers were characterised by ambivalent and avoidant reactions and the participants reported a lack of closeness, nurturance and love, similar to the participants in Duncan and Browning's (2009) study. However, it is important to note that this study did not assess the attachment styles of the participants.

All the participants can remember instances of unusual behaviour exhibited by their mothers. Anna recalled her mother's paranoia:

"My mom's quite a character but um - when she doesn't - not when she gets her own way. [...] My mom used to shout, "Call the police, call the police!" Run around. She stopped taking her medications. She

started seeing things ... [she] starts thinking that the FBI's out to get her, she starts seeing ghosts, she starts thinking her daughter's planning to kill her with her father. It's just ridiculous. You know, it really becomes - it becomes a joke the way they act sometimes ..."

The episodes of paranoia occurred after her mother stopped taking her medication. During this time Anna was viewed as the "enemy". Anna did not describe her experiences as frightening, but viewed her mother's behaviour as absurd.

Belinda spoke about how her mother had superstitions that she and her sister had to participate in.

"She also had a lot of superstitions which I found very, very strange. I mean, for instance, when we cut our nails or had our hair cut, we had to collect all our hair and burn it. So you could imagine this was quite an exercise, having to make a fire and then burn this because if somebody got hold of this - it was like our body parts. If somebody got hold of this they would put on bad spells etc. And we just had to do it."

Like G, in the case study described by Mander et al., (1987) some of the participants (Belinda and Donna) participated in their mother's unusual behaviour. Each participant reports a different motive for and appraisal of their participation in their mother's mental illness. Belinda reported participating in these behaviours to avoid confrontation with her mother, not because she thought the behaviour was valid. She reports being aware that the behaviour was unusual. She further recalled:

"I often felt that I had been hit between the eyes, you know, because I would come out with things and people would shake their heads and say, "Where did you get that crazy idea?" And I realise then that it had become part of my thinking, in a way, some of it."

She did also report that when she was immersed in the working world, interacting more with people other than her mother, she realised that some of her mother's unusual thinking patterns and behaviours had infiltrated her own way of thinking and behaviour. She only became aware of this through her interactions with others.

Donna stated:

"And what scares me the most is, when I drink, I understand her and like I can get along with her and the crazy shit she says and does, I can laugh at now but I understand it, which scares the crap out of me. Obviously I don't want to say I'm going to end up like her cause that's horrible to say but I really don't want to."

Donna participated in her mother's behaviour differently and mimicked her mother's treatment of her. She continued to do this this in her interactions with her mother by drinking with her. She elaborated:

"I'm scared because she started drinking at about my age and - I think she started drinking at about 22 or 23. So it's been a long time and I feel like I enjoy drinking quite a bit but I don't - I really don't like that effect of being really drunk and sick so it kind of doesn't push me to drinking every day and sometimes I test myself and say, "Listen, I'm not going to drink for a week or two. I'm going to see what's in control and what's not.""

This caused anxiety that she would one day become like her mother and she continually tested how long she could go without drinking. When recalling specific incidences of unusual behaviour during her childhood, Donna recollected:

"It's just - she's the most irrational woman on this planet. And like the smallest things would trigger her. Like it was crazy. My dad would boil the kettle and she would go fucking ballistic and then she

would throw hot water and mugs at him and I remember like, she - I think she locked me - ja she locked me outside a few times and I got so crazy and mad at her ...”

From the above quote, it can be seen that Donna employs humour to relay her accounts. She also reported responding to her mother’s unusual behaviour with anger. She further recalled reacting in a manner that mirrored her mother’s lack of reality testing. These behaviours included setting off firecrackers and locking her mother out of the house.

“I locked her in the garage. And then I went back after an hour and she had fallen asleep in the car, drunk [...] And we used to do crazy shit like set firecrackers outside her room because we were angry with her ...”

Ginny also reported her mother’s lack of expression of love:

“I don’t actually remember her saying, “Ginny, I love you.” Her love was incredibly conditional. We had to be good. We had to do things her way and then she would be nice to us, sort of thing.”

Ginny spoke about her mother’s oscillation between regarding her as “the favourite daughter” and as “her juvenile delinquent” and her desperation to win her mother’s love. It seems from her recollections that her mother’s love was not freely available and that she needed to work for it and comply with her mother’s demands. Despite being viewed as the “favourite daughter” she stated that she felt that she “could never do anything right.”

Chrissie reported:

“... if I honestly had to believe she was evil then I would be in a situation where I would have to question why two people who didn’t love me would have me and you know, a part of me has to believe that somehow she does love me. Somehow, not showing me affection but

buying me everything that she can afford to buy me is her way of telling me that she loves me. [...] I feel that some part of me loves her and I feel some part of me respects the fact that she had me and raised me the best way she could. She didn't send me to live with my biological father. You know, she has taken over the role as mother but not very well. You know, I feel my basic needs were always met. I had everything I wanted – and I always say this: I had everything I wanted but nothing I needed. I got the latest phone. I got a car, like I said nice clothes. If I wanted to do something, I probably could.”

Just before the above extract, Chrissie talked about how she assigns blame regarding her mother's behaviour to her illness (see theme five for further discussion). The alternative to believing that her mother's lack of affection and lack of ability to take up the maternal role were due to her illness was that these things were intrinsic to her nature and that her mother did not love her, a state of affairs that would be terrible for her. Chrissie reported that she never lacked basic care and material goods. She rationalised that this was the way her mother demonstrated her affection. When Chrissie spoke about how her mother provided for her financially, her primary concern did not focus on the provision of her basic needs but on the “luxury” material provisions as a way for her mother to demonstrate her underlying love. Chrissie rationalised this behaviour by saying that although her mother could not provide the nurturing role that she longed for, she was able to provide for her basic needs and encourage her learning. While it did not seem to be of primary concern to Chrissie, her mother fulfilled some of her learning needs by providing private schooling and opportunities to follow her career path.

She reported that even though her mother had not taken up the maternal role as well as Chrissie would have liked (fulfilling the nurturing role), she had done the best she could.

She focused on the possibility that her mother could have done worse and justified her statement by saying that she could have been forced to live with her biological father, which she framed as a worse alternative. She acknowledged that her mother's illness has impaired her ability to take up the maternal role. As a result of this, Chrissie conceded that she must have some respect and love for her mother. However, her use of the words "some part of me" suggested that it is not an overt love and respect.

Communication was also impaired by the mother denying or forgetting the conflict that arose between her and the participant, which resulted in an inability to engage in conflict resolution. Chrissie reported that this denial resulted in a lack of self-trust when recalling her appraisal of the event. Therapy has been an important aspect of Chrissie's coming to terms with the denial of events.

"And the next day she denied everything. It was like it never even happened. You know, learning a bit about it in therapy, is whenever you go through what is basically an abusive relationship that I had with her and she denies it, it takes away a little bit of my reality. So you start questioning it. Maybe I imagined it. Maybe it didn't really happen like that."

Ginny reported that when she spoke to her mother about all the things that had happened during her childhood, her mother had denied them and said that they had a happy childhood. Ginny addressed this by speaking to her sister to validate her experiences because her mother denied them.

"- But she's denying that all of this stuff happened when I was younger. She's saying, 'I'm not sure what you're on about. We had a loving childhood' [...] I remember because I was sharing the emails with Lauren at the time and saying, 'This is what mom was saying. Am I imagining things or did these things happen or didn't they?' Cause

I started, kind of, doubting myself. And they both [Lauren and Sharon] emailed me back and said, 'No, these things did happen. Mom's in denial. She's delusional'."

Donna also recalled a lack of resolution and stated that because her mother forgot much of their conflict, she felt that holding onto anger was futile.

"... and then the next morning, just to top it off, she forgets fucking everything so bring anything, you can't hold grudges, you can't do anything. You just gotta learn to get over it and carry on."

## **1.2 Adult recollections**

Unlike in the study by O'Connell (2008), all of the participants, except Ginny, reported that they had been able to repair their relationship and forgive their mothers. Many participants used strategies such as limiting time spent with their mother to improve their relationship. Some reported that moving out allowed them to begin repairing their relationships. Many of the participants utilised distancing, emotionally and physically leaving the situation, as a coping mechanism, such as was found in other research (Duncan & Browning, 2009; Mordoch & Hall, 2008 cited in Murphy et al., 2011). Each of the participants in this study used various tactics to physically and/or emotionally distance herself from her mother, both in childhood and adulthood. This coping mechanism seemed to still play a prolific role for each of them in maintaining their relationship with their mother.

During their childhood two of the participants, Donna and Chrissie, reported staying late at school and university in order to delay returning home. Donna reported:

"I liked to stay at school longer than what you should. You obviously go to school until 14:00 or 15:00, so I just fit in a lot of sport so I could come home a lot later."

Chrissie said, providing a lot more detail and reasoning:

"Coming home was just horrible. I used to, in first year, I didn't want to go home so I used to sit at this bar in the square and then I used to do my homework there, study there, just avoid her. Luckily my step-dad, being kind and understanding, was willing to pick me up at, you know, 20:00, 21:00 or 22:00 at night and that helped me escape a lot. On holiday, I would be on campus studying in the library, even if I had nothing to study for I would make up some kind of excuse to just be removed from the household and her crazy tangents."

Many of the participants, especially Chrissie, reported that moving out of the house and/or starting work was important for their own mental health. Chrissie stated:

"If you get to know me you'll also realise I speak of my step-father very highly because in my mind he saved my life. He was the one, knowing that he couldn't afford it, finally told me that I was allowed to move out of the house. And I believe that's when I started living."

Anna was the only participant who had been removed from her mother during periods of her childhood and she believed that this is what stopped her becoming like her mother. Anna acknowledged that removal from her situation by her grandparents and the physical distance that granted her were probably what helped her to cope with her experiences.

"I know that if you're in a family too long you start to model their behaviour. I think it's pseudo - you know like they say that you mustn't be around mentally ill people because you start modelling and you become mentally ill unless you're removed and my grandparents helped me a lot."

Donna and Anna all talked about needing to limit physical contact with their mothers. Distancing played an important role in maintaining their current relationship. Donna reported that she could love her mother "from a distance", suggesting that personal space is an

important coping mechanism. When speaking about how she managed to improve her relationship with her mother, Anna reported that she did it by “limiting her time” and that she “can’t be around her too much.”

All of the participants reported utilising emotional distancing in order to cope with their experiences. The ways in which this manifested ranged from refusing to talk about personal topics with the mother, refusing to get drawn into conflict, wishing to be removed from the situation during childhood and feelings of indifference towards the mother. Most poignantly, when examining the participants’ reported indifference towards their mothers, Donna stated:

“If I get a phone call saying, “Hey, you know your mom’s stuck here or she doesn’t have money or she doesn’t have a place to stay or she doesn’t have a job”, I’m just numb to it. I don’t care. I mean for a long time, I used to kind of wait for that call to say, “Hey, could you please identify your mother’s body”’ and I’d be like, “Yus, relief!””

However, there is a tension in what she is saying when she later states:

“I understand her a lot more now where before I used to get so frustrated and angry because she made no fucking sense at all. And I was just, irritated. I was like, “Why’s this crazy woman doing these things?” And she’s explained a few more things to me now, why all these things happen and this and this and that. She has apologised but it does just feel empty and I don’t want apologies. I just, to be honest, I just want her to be happy and live her life. If I only see her once a year, it’s fine by me. As long as I know she’s safe, she’s got money, she’s got a job, she’s got a partner and she’s living. That’s it. It’s cool by me.”

It seems that, although Donna reported feeling indifferent to her mother, she did still care and wanted her mother to live a self-fulfilling life. She maintained that she still wanted the distance but wanted not to have to worry about her mother, which is currently not the case. She reported that apologies given by her mother seemed empty.

Ginny has cut her mother out of her life not only physically but emotionally. The statement below demonstrates her feelings of indifference towards her mother. However, there seems to be some uncertainty surrounding how she would feel in this situation.

"I don't know how I will feel if I got news that she had passed away. Will I cry? Will I go to the funeral even? At the moment, my answer is no."

**Belinda reported using emotional distancing to cope with her mother:**

"I remember my husband saying he will never - "We will always be together. You will never leave." And I said to him - One day we were at my mom's place and he could see how I distanced myself. She was having another tantrum and my sister was - you know, she would hook you in. She knew just what hurt. She would throw out these things and she would immediately start defending herself and then it would end up in a screaming match. And she tried - she said something to me and I said, "Okay, if that's how you feel. And I carried on - I remember we were having supper, I carried on dishing up for the rest of the family. And my husband always watched this and I think he'd quite enjoy this interaction, seeing me get upset, and he said, "I can't believe how you're handling your mother." And I said, "Yes, it's taken time but I realised that it's not impossible." And I said, "The same goes for you." I said, "I can't say that the divorce won't hurt but I can say that I can now see that I can do the same with you and

I can unhook myself emotionally from you and I will do it." And that's exactly what I did."

This mechanism allowed her to refuse to be drawn into conflict, take control over her interactions with her mother and speak her mind about her mother's behaviour. It also allowed her to claim back her life from her mother's control.

Belinda, Anna and Chrissie found that realising that their mother had an illness allowed them to gain insight into her behaviour. Chrissie recalled: "The understanding also came when I was diagnosed with it." Chrissie had been diagnosed with type II bipolar affective disorder two years before and this was pivotal to her understanding her mother's behaviour (see the final theme for further discussion). Anna remembered:

"As soon as I entered in psychology, I became educated. I started realising, geez, there's a real big problem. And ah - and through therapy and actually through the campus psychology, there I actually formed a good relationship with my mom. As soon as I understood her and I actually felt sad for her. I felt sad for her because - I forgave her obviously for everything. I also tried to forgive myself because there are two sides to a story. I wasn't an angel either. I was - I was difficult because I was feeling this way and I was a difficult person as well."

Anna realised this when she started study psychology at tertiary level and recalled that this allowed her to forgive both her mother and herself. Interesting to note is that Anna still frames her mother's illness in such a way that she (Anna) is partially accountable.

Belinda stated:

"I think once we realised it was a mental illness - [the understanding came] [...] Had it been explained that this was actually a mental illness, there isn't really a cure. We can treat symptoms.

That's how it is. They're very difficult to live with but that's just how it is. I think we would have understood early on ..."

Belinda reported that her mother was only diagnosed during her seventies. When speaking about how her understanding of her mother's illness had changed over time, she stated that the understanding came when she was diagnosed (this is discussed further in the final theme).

Chrissie, however, reported when asked about her current relationship with her mother that "It's better?" The question suggests that it is moderately better but still lacking in some aspects. It being better, however, does not suggest that the relationship is good. Her primary concern about her relationship with her mother remains a lack of communication. However, as with both Anna and Donna, moving out and gaining space was an important coping mechanism. Chrissie emphasised that moving out was the most beneficial thing for both her relationship with her mother and her ability to live a normal life. However, despite this Chrissie remained quite protective of her mother and stated that she did not allow other people to speak badly of her.

"I don't allow too many people to use the phrase, "Your mother is a bitch" in front of me. I do take offense to that. I do believe that if you understand the situation fully - the only person I wouldn't tell to stop is my best friend because he almost entirely understands the situation as well as I do. Other people, don't say that. It's kind of offensive. I'm allowed to say that. You can't say that."

Both Anna and Donna reported feelings of sympathy towards their mother. Donna reported that she "just started feeling sorry for her". Anna's accounts are quite similar and she stated that she "actually feel[s] sad for her". However, the participants who managed to

forgive their mothers reflected that this did not negate the effects of their experiences and that they still struggled with a lack of self-worth.

Ginny was the only participant to cut off contact with her mother, and did so when she was 36. She stated:

"You know it was in 2010 that I finally - I was 36. Mom was having a go at me for what decisions I'd made in my life and I eventually decided so far and no further and kicked her out and I was angry for a long time afterwards because she actually cost me a job."

This is interesting to note, as the other participants are much younger than Ginny and their relationship with their mother still appeared to be fluid. So, although at the time the research was conducted they were able to forgive their mothers and establish what they reported to be a better relationship, this may change over time.

Ginny reported utilising a colleague's narrative about cutting contact with his family to gain "courage" to have no further contact with her own mother. This was important for dealing with her feelings of guilt.

"It was actually one of my colleagues who told me that when he married his wife, he took on her surname and he cut his family out because he wanted nothing to do with his family, they were that bad. That gave me the courage to say eventually, so far and no further and kick mom out of my life and not feel guilty about it."

Belinda was the only participant to speak about her grief and sorrow at the loss of opportunity that her mother's illness brought.

"I would say another emotion was sorrow in a way that we didn't know. Or sorrow that that some of the relationship had been damaged by the illness and looking back on her good times we could have had a lot

more good times. I get emotional thinking about it. [...] I think this is the heartbreak I think with mental illness. It's just so, because it's in the head, it involves everything: emotion, thinking, all the rest of it, whereas somebody who is in a wheelchair you can still relate to and have a relationship with. [...] You could just look at it and think, "This person has a problem and this is how we handle it." And then get on with it. You can't do that with borderline. There's no way - there are helpings with this book, there're coping strategies, there are ways of making the person realise what they are doing and working - if they really feel strongly enough about the relationship, mainly couples and that who want to stay together, but one has borderline personality, but it's difficult. It's not cut and dried. [...] You have to look for different strategies all the time. You're constantly thinking of ways to try to cope."

Belinda felt sorrow for the loss of the relationship and "good times" with her mother. She elaborated by saying that dealing with physical disability was easier than dealing with a mental disorder, and that while it is possible to come up with a consistent method of coping with a physical disorder, with a mental disorder a person has to constantly develop new strategies.

All the participants reported feeling anger towards their mothers. The reasons ranged from anger because the mother did not seek treatment, anger because of her lack of reality testing, and anger because of various actions by their mothers. These feelings persisted into adulthood and many of the participants still felt anger.

## **2. Theme two: Abuse and neglect**

According to Brockington et al., (2011) the needs of children that parents must address are basic needs, safety and emotional warmth. The potential harmful effect of

parental mental pathology is child maltreatment, which includes physical abuse, neglect and emotional abuse and neglect. Each of the participants reported that she had experienced either physical abuse, neglect or/and emotional abuse and neglect.

## **2.1 Neglect**

Neglect is defined as “the persistent failure to meet a child’s basic needs and rights, resulting in serious impairment of health and development” (Dubowitz, Newton & Litrownik, 2005 cited in Brockington et al., 2011: 97). It includes the parent failing to feed their children, leaving them unattended for an extended period of time, failing to teach or look after basic hygiene, failing to provide timely health care and parentification (Smith, 2003). In this study, the participants reported that their basic needs were often fulfilled. While none of the participants reported experiencing homelessness and poverty, this could be attributed to the sample being primarily middle-class. In addition to this, all the participants had had a protective caregiver who was able to step in and fulfil their basic needs. However the participants in this study did experience parentification and were often tasked with cooking, cleaning and looking after younger siblings.

Belinda recollects:

“I think she had periods of depression which immobilised her but when she didn’t, she looked after us very well, in fact, over-protectively. She definitely was a helicopter mom. But we were clean most times. She would be really worried about our cleanliness and food and that sort of thing. Then looking back, the depression would set in and then it would be the case where she was just so immobilised she wouldn’t care and that’s when we would take over. Sometimes she would go to bed for three weeks and we would just have to take over. We would do the washing, the ironing, and my dad would help. In the evening, he would fill in and feed and shopping. She would sort of

run everything from bed and say, 'Go run down and buy X, Y and Z for supper tonight' and then we would often - sometimes she would - often she would get up and cook but some of the time we would just have to. She would just leave it in the middle. Just put the stove off and say, 'I just can't do this anymore' and go to bed and we would have to continue."

Belinda recounts that the only time her basic needs were neglected was when her mother suffered episodes of debilitating depression. During these episodes, Belinda, her sister and her father took over the household duties. However, when her mother was well, she tended to be over-protective and always concerned with their basic needs. Belinda framed her mother's over-protectiveness positively. This may be because she compares it to her mother's episodes of depression, when there seems to have been an absence of care, and over-protectiveness is preferable to a complete absence of care. These are two extreme parenting styles and neither is optimal. When her mother suffered debilitating depressive episodes, her father and sister played a protective role in being able to spread the responsibility of cooking and cleaning between them.

Many of the participants were required to fill a parental role in the family before they were emotionally or developmentally prepared for it. However, as Gladstone et al. (2006) warn, there has been little exploration of what the child's caring duties entail or how they experience their role as a caregiver. This study had mixed results regarding the experiences of their caregiver role. For the majority of participants, the caregiver role entailed cooking, cleaning and looking after younger siblings. These responsibilities were experienced by many participants as being beyond their abilities and maturity; the effect of this seems to have been that participants felt they had missed out on a normal carefree childhood.

One of the participants, Donna, reported that in addition to this she had had to look after her mother.

"... my role was to like take care of her, all of us. Like when my dad left, I had to do everything. I had to help cook, clean, all of that, so - and then make sure she would wake up, not get too drunk, fall asleep in some strange area and die or - basically the role was to look after, especially when my dad left, like I couldn't leave her home alone because I felt too guilty ..."

She reported that having to look after her mother caused her feelings of guilt and isolation. She was unable to leave her mother unattended because of the possible consequences, and she assigned responsibility to herself to manage these. This role came about because of the removal of her father, who was the protective adult.

When speaking about her caregiver role, Belinda stated:

"... we'd start making beds. One would clean floors, one would do dishes and by the time my mother arrived, the house would be sparkling and we would have a tray of tea waiting for and sandwiches and everything and we would say that we've been working so hard. Never occurred to us that we had actually been at school and we'd clean the house in the afternoon that we had been working hard. We had the energy so we just did it. That's - we were always counter balancing, seeing what we could do to de-stress her. So we took over a lot of things that probably we shouldn't have at that stage."

In contrast to this, Belinda did not find that the caregiver role she played, cooking and cleaning for her mother and looking after her younger brother, was damaging for her. As with the research done by Smith (2004), it seems as though taking on the caregiver role provided

Belinda with a survival role that gave her the tools to manage her mother's emotional outbursts.

Ginny reported on the caring role she had to play for her siblings and being placed in a position of being an "informant" for her mother.

"I kind of unknowingly became a bit of an informant with regards to the rest of the family, Lauren and Sharon and Dan. You know, if mom wanted to know anything about them, how they were feeling and that she came to me because they all spoke - they all came to me. They all came and chatted to me about stuff and ja - So I kind of ended up in a very awkward position and it didn't make me feel very good. And all the time I just blocked off what I needed to do cause Lauren needed to talk, Sharon needed to talk, Dan needed to talk, so I was there for them and I felt so bad about being the favourite daughter and even though I could never seem to do anything right."

Ginny had ambivalent feelings about her role as a caregiver for her younger siblings. She reflected that her mother used her to gain information about her siblings and she had to play a "double-agent" role, as her siblings used to speak to her about how they were feeling. Because of the difficulty of the situation, she denied her own needs and placed the needs of her siblings above her own. In this case, the role of caregiver for her siblings placed an increased strain on Ginny, as her own needs were neglected.

Both Chrissie and Donna reported that having to take on responsibility early resulted in premature psychological maturation and they felt that they had missed out on the childhood experience. Chrissie reported:

"But I don't feel that I lived as vitally as other people did because a part of me was always, "So I've skipped a step. I'm now an adult. I need to take hold of my life." [...] I'm the kind of person that can

live with people about the same ages, say ranging from 19 to 22. I'm 21. So when they go out at nine or ten at night, I came out in my dressing gown and I say, 'Be safe kids. Call me if you need a ride home. Don't drive drunk.' Lock the gate behind them. You know, I was always sort of mothering them. It's very hard for me to find friendships ..."

Chrissie found that her experience of being forced into early maturity now makes it difficult for her to relate to her peers, and she often plays a "caregiver" role for them. Donna said something similar:

"I just want to be a reckless kid one day. I just want to go wild, run around naked, and if somebody asks me why, 'Cause I'm a kid! So shut up.' And then they go, 'Okay.'"

## **2.2 Physical abuse**

Parenting styles characterised by clarity and consistency are deemed to be the most beneficial for children's development (Louw & Louw, 2007; Seeman, 2010). Many of the participants experienced their mothers as lacking consistency and clarity because of their unpredictable moods and behaviour and the lack of logic that governed this, which exposed the participants to an unsafe home environment characterised by what they experienced as inappropriate expressions of anger. This inconsistency made it very difficult for participants to develop a sense of appropriate social boundaries and to discriminate between acceptable and unacceptable behaviour. In addition, the maternal volatility and inconsistency meant that they were unable to modify their behaviour in order to avoid punitive responses. Many of the participants reported that they withdrew from their mothers in order to avoid punishment. In addition to a lack of consistent and clear boundaries, this irrationality hampered open communication, causing conflict that often resulted in violence, verbal and/or physical abuse.

One of the participants, Ginny, reported that her mother's unpredictable behaviour exposed her to unsafe situations, such as walking around the neighbourhood at two in the morning to look for her mother's husband, who was their adoptive father.

"Gone wondering the streets at night at 2 o'clock in the morning looking for Chris because he's run out the house and mom's then collapsed into a crying heap on the floor begging him to come back and, 'Please you must go and find him!' She can't be without him."

Anna recounted that when she made a request to her mother in a public sphere, her mother hit her. However, the primary concern of Anna's account is not the physical abuse but her feelings of humiliation.

"I was at the movies with my friend, meeting my friend, and I went to go ask my mom for extra money, I don't have enough for the movie and when I asked her she slapped me in the face and it wasn't so much the slapping me in the face, it was the embarrassment that everyone was looking around me and that was a one of the few instances in my life where I was embarrassed by her ..."

**Chrissie stated:**

"So walking to the kitchen and all of a sudden, you know this loving mother that I had five minutes ago turns around and she was like, 'Why are you chatting to people about me?' But it was really aggressive and she started calling me names. I don't remember her exact words. And then she grabbed me by the arms and I said, 'Don't do this to me.' She was like, 'You're such a skank. You're such a whore.' And then she started hitting me and punching me and she actually gave me a blue eye."

Chrissie remembered an instance where her mother's paranoia caused her to misconstrue that a conversation Chrissie was having on the phone with her friend was about her (the mother). Her mother responded with physical and verbal aggression. Her account described her experiences of her mother's reactions as unpredictable.

### **2.3 Emotional abuse and neglect**

Although participants' mothers did not suffer from the same psychotic disorder and their experiences of unusual maternal behaviours were different, they all described their mother's behaviour when ill as unpredictable and out of touch with reality. These experiences caused them to feel very frightened and unsafe. This concurs with the findings of Duncan and Browning (2009).

Most of the participants' experiences revolved around a lack of maternal emotional attunement and responsivity to their needs (Seeman, 2010). Responsivity to children's needs is characterised by open communication, low levels of criticism, high levels of emotional warmth and praise, consistency and reasonable limits (Seeman, 2010). Brockington et al. (2011) define emotional neglect to be when parents are unable to respond to their children's needs for affection and assistance because they are emotionally distant. Emotional abuse is characterised by hostility towards the child that is belittling, humiliating, conveys worthlessness, ignores them and isolates them. The participants in this study reported both emotional abuse and a lack of emotional attunement.

Ginny recalled:

"She would always goad Chris into having an argument with her and then she would be yelling and screaming at him from about ten o'clock at night until god knows what time in the morning. Very often in the week as well and she had a habit of after a couple of hours of yelling and screaming at Chris, then coming into Lauren and my room,

waking us up and bringing us into the lounge wherever it was that they were arguing and basically then just saying, 'Your father this. Your father that. This is what the argument is all about.' And just basically involving us in the argument, which had nothing to do with us in the first place. So yeah, a lot of the time we were woken-well, apart from the fact that we were awake anyway when they started arguing, we were hauled out of bed and involved in the argument and, you know, Chris was our step-father so we automatically took my mom's side for the most of the time and until Lauren and I were about 13, 14, then we started realising that Chris isn't the problem and we started trying to be nice to him, I suppose, in the argument, not always taking my mom's side and basically just taking my mom's side to keep her happy and quiet, to quieten her down and calm her down. But yeah, I've taken a knife out of my mom's hand during an argument. We've taken her fingers out of Chris' hair."

Involvement and exposure to domestic violence is also considered to be emotional abuse (Brockington et al., 2011). Ginny recollected often having to join in the domestic disputes between her mother and her adoptive father. This also exposed them to violence, such as needing to take a knife out of her mother's hand.

Many of the participants experienced a lack of attunement by the mothers. As experienced by the participants in Duncan and Browning's (2009) study, their mother's reactions were nonsensical to the participants and resulted in feelings of mistrust, instability and insecurity. Anna stated:

"... it was all of the instability over the years. It's fine, everyone has problems but it's the leftovers of the all the insecurities I have. It's the big problem with me now. The insecurity of having - feeling like a burden to my grandparents feeling so dependent on them

the whole time, since I was young and I'm still dependent on them financially so that is quite a big thing."

Anna particularly reported that because of the lack of stability in her home life, a search for stability in her life has become a prominent concern. She reported that the most difficult thing to come to terms with as an adult was the instability and feelings of insecurity. It was not just her mother's mental illness that she reported finding damaging, but the circumstances surrounding it. Being sent between her mother and her grandparents seemed to create a lack of stability and a feeling that she did not have anywhere that she belonged.

As with the study by Duncan and Browning (2009), many of the participants reported that their mother was "psychologically 'absent'" (Duncan & Browning 2009: 84) as opposed to physically absent. Most of the participants reported a lack of warmth and instances where their emotional needs were not met. Despite giving examples of physical and verbal abuse, Chrissie described the worst instance of her mother's behaviour as her mother's unresponsiveness with regards to her needs, which resulted in reduced affection and lack of support.

"Growing up I did ice-skating. I skated for Gauteng North and then I did a lot of competitions but I remember one in particular. Between the ages of six and eight, I'm not sure what the time from exactly was, when I fell twice while doing my, you know, piece on the ice. And there's the tradition in ice-skating where the parents and everyone throws teddy bears and roses on the ice rink for you. So, you bend down to pick it up then you get off the ice. I remember that day in particular she didn't throw anything on the ice for me and when I got to her, she completely ignored me. She didn't look at me. She was like, 'Your stuff is in the bag.' So it was this complete feeling of, you know, you're young, you're trying to get your parents' approval yet nothing I ever did was good enough because it

was always surrounded by how she was feeling and how her outbursts were making me feel.”

**Ginny reports:**

“... we [Ginny, Sharon and Lauren] kind of realised that what we’ve been through was kind of emotional abuse and those scars are really hard to see.”

This hostility to her displayed by her mother made her feel as though she could never do anything right, and her low self-esteem has persisted into adulthood. Ginny as an adult regards what she experienced with her mother to be emotional abuse and stated that the effects are long-lasting and persistent.

Many of the other participants reported high levels of hostility and criticism from their mothers. While at times the participants experienced their mother as absent, interactions with her were also characterised by intrusiveness. The primary concern shown in Ginny’s account is that her mother violated the boundaries between mother and daughter and did not fulfil the appropriate maternal role. Inappropriate disclosure by a mother to a daughter is a form of emotional abuse.

“... the level of friendship and discussions that she had with me about, you know, especially about sexual problems she was having with Chris, which a mother should not really be sharing with her daughter.”

Donna spoke about how her mother’s persistent belittling and criticism had influenced her perception of self and how she still struggled with how she views herself. Particularly, a concern raised by Donna is that she was unsure of her mother’s current perceptions of her and if they are positive or not.

"... she knows how to get to your weak spots. She would tell me I was stupid, was fat, I was ugly. So many things and I believed it for a long time. I thought I pretty incapable, pretty fat and ugly, pretty useless. Still do sometimes. But I guess you get over it after a while. [...] Being called stupid all the time [was the hardest to get over] and being told I was incapable and being told, basically, I was too ugly for anyone to love, all the normal things you actually want in life: Someone to accept you, someone to have a normal conversation with you, to find you attractive, to want to be with you. I didn't think I would have any of that because I was too incapable and ugly. So I don't know why she did it. She still does. She went through a stage where she was like, 'Oh my god, Donna, you're so fat and huge and blah, blah, blah.' And now she's like, 'Why you so skinny? Blah, blah, blah, blah, blah!' It is one extreme to the next. I never know if she actually, genuinely thinks I'm her pretty daughter. I don't know what she tells people. Sometimes she doesn't even tell them I exist. So honestly I don't even know what she says to them."

### **3. Theme three: Isolation, secrets and facades**

Many previous studies (Brockington et al., 2011; Dunn, 1993; Foreman, 1998; Gladstone, Boydell, Seeman & McKeever., 2011; Seeman, 2010; Williams; 1998) found that social isolation, among other factors, is more common in families where a parent has a mental illness and this is more likely to result in negative outcomes for the children. There are two types of isolation that the participants brought up during the interview. The first is social isolation due to fear of stigma. The second is that their mothers also dissuaded them from engaging in peer relationships. According to Brockington et al. (2011), isolating of children by mothers is considered to fall under emotional neglect and abuse and is called social deprivation. The participants in this study who were isolated from their peers and

extended family members reflected that this resulted in a lack of input of ideas from external sources, a lack of support structure and an inability to seek out help.

Many of the participants reported that during their younger years they did not speak about their experiences with their mother to other people due to their fear of stigma. Anna stated:

"I felt a lot of people, firstly, were not educated enough, were ignorant, and I think a lot of friends also judged me for a mental illness. I think people looked down at me having a mother like that."

Anna recalled that she did not speak to people because she felt they would not understand her because of their ignorance of mental illness, and this resulted in stigma. Earlier in the interview she stated that she believed that no one understood her, including both her parents and her grandparents. While Anna desired someone to speak to regarding her experiences, she nevertheless did not initiate conversations with her peers due to fear of stigma and a belief that they did not possess enough knowledge about mental disorders to be able to provide adequate support. This, did, however, result in isolation from her peers.

Donna also did not speak about her home situation. However, her motivation was not a fear of stigma due to her mother's mental illness, but a desire to not be viewed negatively by others in terms of being "needy and weak". From the extract below, it seems that Donna desires to be seen as self-sufficient and is reluctant to display vulnerability. At this point in her life she does talk about her mother's mental illness but tells it as a joke as she is afraid others might pity her.

"In the beginning I obviously didn't want to talk about it because I didn't want to come across as like needy and weak and complaining and this and that so in my mind that's how I thought I was going to come across. And I still do. That's why I hate talking about it sometimes

but it is better. The way I tell them is like a big fat joke so they laugh and I don't tell them about the seriousness. I guess to me it's still not serious and if I do, like I'm talking to you now, I guess you can see that it's somewhat serious. But they don't take it seriously. They just think it's one fat joke, which I like because I don't want them to treat me differently. I don't want them to go, 'Oh shame. Your mother did this to you and you had to go through that.'"

When offered an opportunity to speak about her home situation by the principal of the school, Belinda did not take up the offer because she believed that others would not understand her situation. She concluded that she had taken up the role of maintaining the image of the family that her mother was adamant to preserve, instead of speaking about her situation. Her silence about her family situation can also be seen as protective of her parents, and taking a caregiver role in protecting the image cultivated by the family, as can be seen in the following excerpt.

"“You better get home. Your mother's really worried about you.” So I went off and the next day the headmistress called me in and said, ‘I've always seen you as a very sort of ...’ She used another word but I think one could say ‘mousy sort of person’. I was always in the corner apologising and trying to stay out the way and do everything right and that all that sort of thing. And she said, ‘After your mother phoned yesterday and the way she screamed at me, I began to understand.’ And she said, ‘Is there anything you want to discuss? Can we have a talk?’ And I - I mean I was in, second last year or matric year of school and that was the first time - of course, and again you can't explain to people but for so many years you have brought up - I suppose it's a way, it's called enabling really, you have surrounded this person of projecting this view that we are this perfect family and everything's fine and this type of thing and of

course we were. There wasn't time to step out of line or rebel or anything because we were so busy looking after my mother so we had taken over as carers. And I think it was the first time that somebody had asked this sort of question but I couldn't talk to her. I said, 'No, no.' She said, 'Do you want to talk to me about your home life?' And I said, 'No. No there's nothing wrong. It's all fine. Sorry she shouted at you. I'm sorry about that.'"

Pertaining to the second type of isolation, Belinda spoke about how her isolation from peers allowed her mother's unusual ideas and behaviours to become her own. Exposure to external people during her time working was of paramount importance in identifying the areas in which her mother's thinking had become her own. Although she was an adult, she was still able to identify and adapt her maladaptive ways of thinking.

"I often felt that I had been hit between the eyes, you know, because I would come out with things and people would shake their heads and say, "Where did you get that crazy idea?" And I realise then that it had become part of my thinking, in a way, some of it. Some of it, the very bizarre thoughts, I still shook my head about but many ideas that she had brought us up with, I didn't realise had become part of my thinking so it was only when I - because of course we weren't allowed to have friends, we weren't allowed to go to friends, etc. So I had no sort of peer - very little peer interaction. I mean I can remember my whole teenage years I went to a movie once with friends and that was just such a big occasion. We went into town by bus and we saw a movie one afternoon and that was just a highlight that really never happened again. It wasn't really before 16 where I was allowed to go out without her. So I had no peer relationships to, sort of, bounce ideas off. So the only people I got ideas off really were my teachers and they didn't go into those sorts of things. You know we obviously just did school work, and my mother. So a lot of

ideas about life I got from her so it was only when I started working that I actually realised that there was another way of looking at things.”

Two of the participants experienced being isolated from their peers by their mother. For one of the participants, this was a central issue when discussing her childhood. Ginny recalled that her mother controlled who she could interact with and when she could go out with friends. Invariably, she found that she could not go out and eventually stopped asking. She recollected:

“Friends at school - I was allowed to have friends but as soon as I started, you know, acting in a way that my mom didn’t like so if I stepped out of line or back chatted her or something like that, it was all my friend’s fault and then I had to then - I wasn’t allowed to be friends with them anymore and I was the one that had to go tell them the next day at school, “Sorry, my mom doesn’t want us to be friends anymore. We’re not allowed to be friends.” Which was quite-quite hard.[...] Every time we had friends invite us out for stuff, you know, we first had to get mom’s permission obviously. And she would, after a mirage of questions about, “When is it going to happen? How long is it going to happen? Who’s going to be there? Who’s not going to be there? What you going to do?” She wanted a blow by blow account of everything we were going to do before she would eventually say no, we couldn’t go. So, I mean by the time we were teenagers when friends invited us out we would just no straight away because we knew we’d never be allowed.”

In addition to isolating Ginny from her peers, her mother isolated her from her father and her grandmother. Once her mother had cut her father out of their lives, Ginny was never encouraged to speak about him or contact him. Her mother isolated her from her grandmother

by telling her that Ginny needed to be treated strictly (as can be seen below). This resulted in her removing two possible support structures for Ginny that may have acted as protective figures. Her isolation from her grandmother was an emotional isolation and resulted in feelings of anger and hurt.

“When I was younger I thought my Ouma hated me because she always treated me at arms-length and she always seemed to be very stern with me and I always thought I was doing something wrong whenever I was in her presence and she told me recently that that was because mom had told her that from day one I was going to be a teenage delinquent and I had to be treated very strictly and all that sort of stuff, which I feel pretty offended about.”

#### **4. Theme four: Emotional responses and adult relationships**

##### **4.1 Anger, guilt, ambivalence and sorrow**

As described in previous literature (Dunn, 1993; Gladstone et al., 2011; NaMetris, 2013), guilt and self-blame emerge from many of the participants' accounts. Some of them appeared to have experienced feelings of guilt, although their reasons differed. However, this was not true for all of the participants: two, Chrissie and Belinda, said that they did not feel guilt. Anna was the only participant to experience feelings of self-blame.

Ginny's account revolved around feeling guilty about her hatred for her mother and her feeling that it is a daughter's duty to love her mother.

“I think we were in our teenage years that we really, that I really started hating - started hating what was happening but feeling guilty for hating my mom because she's my mom and I must love her.”

Donna is the only participant to perceive that she was abandoning her mother, as described by the participants in the research by Dunn (1993). This could be because the rest

of the participants' mothers were reported to be relatively financially secure or have a financial support system in place. Donna's mother was the only one experiencing poverty and homelessness. Donna also felt the responsibility to provide for her mother, which she does not have the financial and emotional resources to do. Donna's guilt also seems to revolve around feeling as though she is moving on with her life and is generally having good experiences, while her mother is not.

"... when I'm feeling like I'm having a really good time, I just - I start getting guilty 'cause I know my mom is staying somewhere where she really doesn't want to be. She's staying with people she really doesn't want to be with. She's in a situation - she's stuck in a hole and she can't find the top. And then here I am, having so much fun with the food I wanna eat, with the people I wanna be around, with the drinks I wanna drink, with whatever I wanna do and she's stuck. So I do feel guilty ..."

Belinda maintained that she did not have strong feelings of guilt in relation to her mother. She said that whatever harm (her word) she may have caused in relation to her mother was offset by a multitude of positive actions that she and her sister had put into the relationship with their mother. In an interesting quote (below) she allowed herself a sort of margin for error by acknowledging her flaws and that her relationship with her mother could not always be conflict-free. This quote seems to show her internal wrestling. She stated later that she often had to curb her feelings and stop herself from engaging in conflict with her mother because she was not always able to resolve the conflict effectively.

"Not so much guilt in that I think it was balanced in that I know what we put into the relationship, my sister and I, was over and above whatever harm, and I mean it maybe verbally or something like that, when I shout at her or get angry with her, I think we had a lot

of plus on our side. There obviously minuses. We weren't perfect individuals ..."

Interestingly, while Belinda never openly stated that she blamed herself for her mother's behaviour, she reported that she often felt apologetic for being present as it put her mother in a bad mood.

"I think because I remember early on just, you know, thinking, 'Well I didn't really do anything.' Or, it wasn't so much things I hadn't done. That I just felt apologetic anyway, thinking just by here I'm putting her in a bad mood."

Although her rationalisation of her lack of guilt is different to Belinda's, Chrissie, by assigning responsibility for her mother's actions to her mother, was able to avoid feelings of guilt and self-blame.

"I never quite thought it was my fault. It's not my fault that she reacted that way."

Anna's feelings were different from Belinda's and Chrissie's. She reported that before she fully understood what a mental disorder was, a revelation she had when she began studying psychology, she blamed her mother's behaviour on herself.

"I knew there was a big problem. I blamed it on myself."

#### **4.2 Self-concept and relationships with others**

Many of the participants struggled and are still struggling with a somewhat negative sense of themselves, as found in other research (Gladstone et al., 2006; O'Connell, 2002 cited in Murphy et al., 2011; O'Connell, 2008) which includes feelings such as: a sense of incompetence, low self-esteem, self-blame, and feeling unworthy of love to a greater or lesser extent. They reported that these negative perceptions impacted their current and past

relationships with others. For example, Donna spoke about how her mother's constant belittling had resulted in a persistent lack of self-worth.

"I believed it for a long time. I thought I pretty incapable, pretty fat and ugly, pretty useless. Still do sometimes."

Anna also feels she lacks self-worth and is incapable:

"... the best thing for me to do was actually to get married and have kids. That was the only function for me to do. I wasn't smart enough to do anything else and aim for stability."

Ginny reflected an over-concern about her self-worth in relation to others. She doubted whether she would ever get to the point where she had dealt with all the difficulties.

"Trying not to be so worried about what other people think. Am I good enough? Getting that feeling of total incompetence and humiliation as soon as I make a mistake. I'm getting there slowly but I don't know if I'll ever get there fully."

Some of the participants, such as Anna and Donna, were in stable, long-term relationships. Anna reported that her boyfriend had been a source of stability:

"... what has helped me a lot was my boyfriend. It was the first time in my life where I felt stability."

Chrissie and Belinda reported difficulties with the selection of an appropriate intimate partner and inability to leave the relationship. These are discussed in more detail below.

Ginny was the only participant not to be in a relationship at the time of the study. She reported:

"41. I'm still single. I'm not good at relationships. I don't want to meet someone and have to introduce them to her and to have her

destroy his life as well. I don't want to have kids. Part of that reason is that I don't want to pass on any genes that I've inherited from her. 'Cause I know there's something not right. I don't want to become her as a mother."

The reason she provided is that she does not wish to have to introduce her husband to her mother and she is afraid of having children because she believes that there is a genetic component to her mother's behaviour that may be passed on. This motivation has little to do with a mistrust of others, but involves fear of becoming her mother and passing those genes on. She reported that her fear of becoming like her mother had motivated her choice not to have children of her own and not to enter into a serious relationship.

One of the participants, Chrissie, reported that she still found it difficult to make friends because she viewed herself as more mature than and as having different interests to her peer groups. During her childhood, her friends formed important lifelines for coping. Donna, too, found that her best friend was an important coping mechanism as she used to be able to confide in the friend and express her feelings and experiences. None of the participants reported having difficulty making friends because they were different.

Chrissie reported:

"It's the same with friendships and people I work with, constantly seeking acceptance. When people are mean to me I don't go, 'Hey, that person's mean.' I go, "What did I do wrong to make them react that way?"

Some of the participants reported difficulties with conflict and assigned blame to themselves. Chrissie did report that she constantly sought acceptance from others and assigned responsibility for others' reactions to herself. This quote demonstrated Chrissie's lack of self-confidence and a seeming inability to stand up for herself. The risk of

acknowledging that the other person may be in the wrong means a loss of acceptance from that person. She seems to modify her behaviour and reactions to remain accepted by others. This is perhaps indicative of a negative view of self. It also seems to show that she engages in a lot of self-criticism.

A few of the participants reported a hyper-sensitivity to the emotional states of others, which they directly linked to having to monitor and manage their mother's emotional states. Anna reported that she needed to constantly win her mother's trust, because her mother thought that she was a threat during the periods where she was off her medication and her positive symptoms were very prevalent. She reflected that she only knew that she did this when she realised she was doing it in other relationships. She reported that she did this because she believed that if she were to be herself, she would be rejected by others. Her lack of self-esteem governs her interactions with others and she believes that if she were to be herself she would not be worthy of love by others.

"... as soon as I express who I am, then people don't like me so just the people pleasing. I think it's influenced the always being kind and sweet and I think that is a part of my nature but I think a lot of the time I don't do it because of that, I do it because I feel like worthless."

While Donna was in a long-term, intimate relationship, she also struggled with feelings of self-blame when any conflict arose in the relationship.

"... for a long time where I would just blame myself for everything. It affects my relationship with my boyfriend. I blame myself for everything. Even if - it could be something so ridiculous and I'll apologise."

In other studies (Duncan & Browning, 2009; Williams, 1998), long-standing relationship issues among adult offspring of mentally ill mothers are characterised by a lack of trust and a hyper-vigilance of others' emotional states. However, the participants in this study did not report a lack of trust towards other people. More prevalent were reports of selection of a destructive intimate partner and an inability to leave a damaging relationship.

There was variability in the participants' relationships. Difficulties with intimate relationships and friendships were reported by some of the participants. Belinda reported that two months after marrying her first husband, she knew that she had married a man who wasn't right for her and if she had waited a bit longer before getting married she would have realised this. Interestingly, Belinda selected a husband who has the same disorder as her mother. She says that the periods when he regarded her as a wonderful woman were what kept her in the relationship for so long, but eventually she was able to emotionally detach herself and leave the relationship. However, her second marriage, she reported, is a functional one. Her selection of an inappropriate partner did not persist throughout her life.

"And probably if I had somebody I could have gone to and a different upbringing - I'm doing a Freudian blame on upbringing - I'm not blaming it at all. It just happened to be there and of course it causes different things to happen. But I think if I had been brought up in a different family I would have maybe - If I had somebody who said, 'Look, just take it easy and don't get married immediately', I might have seen this or like today, living with somebody, you could actually - I mean once we were married it took me two months to realise, boy, I've done the wrong thing. Then again the splitting would take over and then I was marvellous and I would think maybe not. It was a total roller-coaster all the time."

Chrissie reported:

“And I was in a relationship two years ago, well, I’m still in this relationship and things have improved, with a drug addict. And because I was so afraid of being alone, so afraid of not being loved, I chose to compromise my varsity marks, fail the entire year – I think I passed two modules out of say ten. I compromised everything. My whole and entire life was revolved around trying to seek acceptance from one person and even though he is clean now and things are a lot better I still think had I been raised a little bit differently, had I had the comfort I need, I would have had the courage to walk away from something like that.”

In the above excerpt Chrissie discussed being in a relationship she believes she should have left but could not. Her fears of leaving the relationship revolve around a fear of being alone and being unworthy of love and she struggles with feelings of co-dependence. She reported that the consequences of this were that she had to compromise her university career and her independence to live a life separate from her intimate partner.

## **5. Theme five: Protective relationships**

### **5.1 The role of therapy**

All but one of the participants in this study entered therapy at some stage before the interviews were conducted. Following the research by Dunn (1993) this study set out to explore the participants’ reasons for entering therapy and what role therapy played in their making sense of their experiences. While Dunn (1993) called for research that examined differences between the participants who entered therapy and those who did not, this study could not examine these differences because of the small sample size and because only one participant did not enter therapy. It was impossible to make inferences. However, most of the participants who had entered therapy were able to give insightful, rich accounts of their experiences, while the account of the one who did not was less rich in detail (Dunn, 1993).

However, one participant who did enter therapy was hesitant to provide a detailed and rich account. This could be because the participant knew the researcher before the interview and was therefore reluctant to give greater detail. However, this cannot be measured and there is no definitive way of saying that entering therapy gave the participants the ability to provide richer data sets than those who did not.

The participants entered therapy for a variety of reasons. Belinda entered marriage counselling and subsequently was asked to book private sessions. Although the initial reason was not to deal with her experiences with her mother, it became a vital process in becoming emotionally detached from her and dealing with her experiences. She stated:

“But I did go to counselling and I worked through it and it was really very painful in the beginning and my sister did the same thing and she said to me, “I can’t believe how I’m crying – every time I talk about mama I’m crying.” But it was very painful but that was actually a saving grace. That actually working through it because afterwards I could detach myself.”

Chrissie reports:

“I knew I needed the help. I knew that the knowledge they had was what I needed. [...] So I realised that I needed the help. I needed to be diagnosed. I needed to be put on my meds. So for me, having all of this is a very clinical process. I go there, I spill my guts as honestly as I can. There’s nothing that I hide. It is what it is. They have the tools and can recognise from an outside perspective which I cannot do myself. So I cannot read my psychology textbook and say, ‘Oh, let me cure myself’ because I don’t see it from that outside perspective where if I tell you about a story, you can analyse it. You weren’t immediately involved. [...] You know, it’s like instead of working through my issues like I know I’m not crazy, I

know I'm sick, but giving me pills isn't going to take away things that I still need to talk about."

After an incident of excessive anger, fear of becoming like her mother prompted Chrissie to enter therapy. Therapy gave her insight into her current issues and tools to resolve them and it gave her the chance to address current relationship issues so that they did not persist in later relationships. In addition to this, Chrissie said that with medication and therapy she was able to manage her bipolar affective disorder and "live a relatively normal life". However, Chrissie emphasised that medication alone would not help her address her experiences and that therapy was necessary.

Anna spoke about therapy being quite common in her life:

"I can't remember a time I wasn't in therapy, that's the problem. I've been in therapy as long as I remember. Obviously, when I went to school there was like psychologists and when I went to university there were psychologists. So I always continually saw - whether it was paid or whether it was just free service, but I just felt it was good to talk to someone because I felt a lot of people, firstly, were not educated enough, were ignorant, and I think a lot of friends also judged me for a mental illness. I think people looked down at me having a mother like that. Secondly, um, it was good to discuss things with someone, like, a caregiver. I felt like I never had someone to really talk to so it was almost nice to have a mother figure in therapy. It sounds silly. But it was good in that sense. The older I get, the more I realise that a therapist is just another person who can't help with everything. You have to help yourself. I think when I was younger I was more dependent, but now I'm becoming less dependent.

Um. (2.0) I don't trust psychologists anymore ... It was just like, um, I just started realising that they don't have the answers to everything. I just started realising - the older I'm getting, just realising that people don't have the answers to everything."

Psychologists initially played the role of a caregiver in her life, acting as her mother figure, and she described being dependent on them. She also used therapy as a way to replace sharing her experiences at peer level. At the end of the extract she talked about disillusionment with the therapeutic process when she realised that therapists are people too. This later statement suggests that she used to elevate the position of the psychologist.

Ginny went through two sets of counselling and went on anti-depressants for a period of time. She found that it was only the second experience of counselling that made a difference in her life. She used counselling in a similar way to Chrissie: to gain insight into her current reactions.

"... the cognitive behavioural therapy helped me kind of make sense of my reactions to everyday things: why I was getting so angry, why I was reacting the way I was to just normal everyday things that most people would shrug off. So it just helped me look at how I can change how I react, which I think has helped."

## **5.2 Protective family members**

As in many other studies (Cooklin, 2006; Duncan & Browning, 2009; Dunn, 1993; Robinson et al., 2008, cited in Murphy et al., 2011), all of the participants had one specific close relationship with a parent that provided a protective factor and allowed for development of resilience. Many of the adults who fulfilled these roles were fathers and step-fathers, and they helped with both practical and emotional coping. They took on aspects of care that included household chores and financial support, and provided an emotionally safe space.

However, many of the participants reported that their father-figure was caught between defending the participant and avoiding conflict himself.

Both Anna and Donna had protective adults who compensated for the neglect by their mothers. Donna's mother spent most of her money on alcohol and lost the house. Donna, when talking about her father, said:

"... my dad, obviously, he got divorced from my mom, like he - I give him a fucking gold medal because he stayed with her for sixteen years and then he decided, okay, that's enough. I can't do this anymore. Okay, so obviously in the beginning, my dad's role was to be a dad and take care of us, and then he spent a lot of time with us 'cause he wanted to avoid my mom as much as possible. He was always around and he helped with everything and then, very kind and caring. [...] Only years after [they had been divorced], when shit hit the fan, did we move in with my dad."

Donna's father played a protective role when Donna was able to go and live with him and avoid joining her mother in poverty and homelessness. However, before that Donna's father had been the primary caregiver and provided both for both the basic and emotional needs of his children.

Anna, speaking about the role of her grandparents, stated:

"I just felt pushed around a lot. I just felt like I never really had a home and I was really unstable because I don't know where I'm moving next, you know? Cause my parents fight for me and they wanna fight for me, bring in a lawyer to take me away from my grandparents then my grandparents want me back - No! They didn't want me back 'cause they had their own problems. So, then I wanted to go back, so it was confusing."

Anna spoke about how her grandparents played an important role financially and were able to support her learning and basic needs. They provided financially for both her and her mother. When speaking about the caregiver role her grandparents provided, Anna's primary concern was their vital, supportive role in her life. They represented a protective factor and, by providing her mother with the financial means, her mother was able to provide for her basic needs. Anna reported that her grandparents provided a caregiver role for both her and her mother. Seeman (2010) reports that when the mother retains legal custody it is often other family members such as fathers and grandparents who take over the caregiver role, and this creates a risk of inconsistent rearing. This was especially true for Anna, who was often moved between her grandparent's care and her mother's care. The result was that Anna had feelings of instability and of being a burden. She spoke about her desperate need for acceptance by her grandparents.

Siblings played a role in some of the participants' experiences. Donna stated that although her brother did not play an active role in the caregiving duties, he still played a vital role in allowing her to talk about her experiences. Ginny experienced the same and still uses her sister to talk about her experiences and try to make sense of everything that happened.

"... her and I had a very close relationship. We'd find comfort in each other, spend time with each other."

Chrissie recalls:

"I adopted people I felt close to me as my siblings. I adopted my best friend's mom as my mom. When she passed away, that became my loss because my mother died. You know, she was the one I could talk to. She would cry with you when you did badly on a test. You could tell her about it and she would comfort you."

Chrissie, an only child, found that she deeply desired siblings and so she adopted her close friends as family. These “siblings” provided the same protective role as Ginny and Donna’s siblings. In addition to this, Chrissie used her friends’ mothers as confidants to talk about her experiences and, as with O’Connell’s (2008) study, she found that time spent with one friend’s mother provided a valuable mother figure for her. As with Dunn’s (1993) research, Chrissie aggressively sought out support structures in other people. However, she was the only participant to do so.

## **6. Theme six: Mental health services and the role of the diagnosis**

### **6.1 The absent mental health system and resistance to psychiatric treatment**

A review by Gladstone et al. (2006) focuses on the invisible children of mentally ill parents. However, in this study, the participants recall that even their seriously mentally ill mothers were invisible to the mental health system, which was either absent or not considered helpful by the family. Very few of the participants’ mothers underwent psychiatric treatment for their disorder. It was not a lack of availability of support that prevented the mothers from seeking treatment and support but a lack of willingness, because of their own sense of the stigma of being labelled mentally ill and general misperceptions of the treatment of mental illness. The other family members, in the case of Anna and Ginny, were complicit in this lack of help-seeking behaviour. As a result the participants experienced minimal intervention by formal institutions or organisations such as the mental health services; two of the participants did, however, receive some support from social workers. Anna stated:

“Everyone in my family still denies it. She doesn’t have a problem. [...] They just think a lot of the time she’s lazy or she’s stupid. I don’t think they – maybe they think it’s all in the head. That’s the thing. Especially with Italian families, they don’t really believe in

mental disorders. You don't have depression. You're just feeling sorry for yourself."

This denial of the illness may have led to a lack of sufficient support by the family members. Ginny also reported that her mother refused any treatment, remembering "Mom didn't think she needed counselling. She always knew better than the doctors." In addition to this her adoptive father did not want anyone from outside seeing what was happening in the family.

"And that was something Chris didn't want either. He almost got angry when you said you were going to call the police or something. He didn't want anyone outside the family to know what was going on."

Anna spoke about how, even though her mother had contact with psychiatric institutes and psychiatrists, no intervention was ever provided for Anna. When asked if she had received any intervention from formal institutions, she recalled:

"No. Not at all. And that's why I think South Africa's - South Africa doesn't have those services available to people who need it. [...] There was a social worker when I was younger. She was actually like a nun. So Sister - I forgot her name. Sister Something. She was actually a nun but she was also a social worker. She intervened for a very little while. But she didn't intervene with me. She intervened with my mother. So it wasn't really an intervention in terms of me."

She assigned responsibility for this lack of support for children of mentally ill parents to her context, being the South African mental health system. When she mentioned the social worker previously, she said she had an integral role to play in assisting with removing her from her mother; later in the interview she downplayed the role of the social services in terms

of emphasising that the intervention was directed at her mother and was not for her. She further recalled her mother's lack of compliance with her medication:

"No one [got her back on her medication]. Except when she was forced. She had to go to Denmar Clinic sometimes. It didn't really work. Because they can't take psychotic patients. She had to go to Weskoppies."

Previous to this extract, Anna described her mother's behaviour as "ridiculous" when she was off her medication and recalled how during these times she was often viewed as the enemy by her mother. She recalls that the only way that her mother went back on her medication was for her to be admitted to a psychiatric hospital.

**Belinda recalled:**

"... we were indoctrinated in a way that social services, well then they called it the welfare, you don't go there and if they do, they'll take you away and that. Because I think - and my dad years later, I realised about it, little things she told me (I was an adult, I could read between the lines). My dad had also been at this meeting - they had called this meeting and said, 'Look, we will take this child away because you are physically abusing her and you've got to work at this' sort of thing so we were brought up with this idea, if you complain, the welfare will take you away."

Belinda's mother's fear of being labelled "mad" prevented her from seeking treatment and support for her episodes of depression and delayed her diagnosis with borderline personality disorder. Belinda reported that there was a social worker present; however, she was too young to remember the instance. She recalled that she was told that neighbours reported her parents for physical abuse because they had physically beaten Belinda. The

social worker threatened to take her away should the abuse continue. However, the intervention by the social services was ineffective. Her mother used the possibility of being taken away by the social services as a threat should any of her children speak to other people about what was happening at home. This isolated her from potential formal support structures, because when given the opportunity to speak to an outside support system, she refused.

Speaking about her own struggle with bipolar affective disorder, Chrissie talked about her own mother's refusal to seek treatment and take her medication:

"If I take my medicine I have a relatively normal life. So the resentment towards her is, 'Why didn't you go get help? Why did you raise me the way you did? You know, basically drive your marriage into the ground.' She has such little friends. She was basically declared medically unfit to work because of it. Why would you let it get to the point where everybody that you know doesn't really love you? It's just like, why would you let it get to that point? So when I experienced that I understood and I told her this as well and I get it but it can be treated. There is help for it."

Her position – being diagnosed with the same mental disorder as her mother – is the basis of her resentment and anger towards her mother. While experiencing the same problem as her mother made it possible to empathise with her, it also became a source of contention because Chrissie sought help and her mother did not. Chrissie reported believing that by seeking treatment, it is possible to live a "normal" life. Her mother could have done the same. Chrissie seemed to attribute her mother's loss of job and friends and the breakdown of her marriage to her mental illness. By emphasising that there had been help available for her mother's illness, she was perhaps saying that staying "ill" is a choice and that her mother

would have fulfilled the nurturing role she longed for if she had sought treatment much earlier. If she had done this, Chrissie may not have experienced what she did.

## **6.2 The importance of diagnosis**

The diagnosis of each participant's mother played an important role in most of the participants' understanding and "forgiveness" of their mother. From these accounts, it is possible to see the diagnosis of the disorder as providing some sort of protective factor for the children. In some cases, the participant was able to assign blame for her mother's behaviour to the mental illness instead of to her mother. Four of the five participants' mothers were diagnosed formally by a psychiatrist or doctor. Especially pertinent is Ginny, whose mother has never been diagnosed with a mental disorder.

"So we've kind of just been chatting about it every now and again trying to figure it out and we've come to the conclusion that there must be something mentally wrong with mom but we just don't know what. We don't know. I've done a bit of a read of what schizophrenia and Bipolar, what all these mental illnesses are and none of them really quite fit with what we remember so we're not sure what is there but - I don't know if it makes it easier to think that mom's got a mental illness and that's why she was the way she was or - I suppose it would be because if she was quite sane and normal and she still treated us like that then she's quite a horrible person and I think that would be harder to accept."

The lack of a diagnosis means the participant experiences a lack of resolution. The alternative to her mother having a mental illness was worse, which is that her mother was inherently unloving.

The same can be seen with Chrissie:

“But having suffered from depression myself, I understood that there were grey areas [...] I tried to handle it the best I could and I tried and made sense of what she was going through, which is why when people ask me if I hate my mother, I would say but I hate what she did and I hate what her disease has done to her. She is not inherently an evil person. She is just a ... (3.0) She was acting out on her disease ... It is the only way I can truly make peace because if I honestly had to believe she was evil then I would be in a situation where I would have to question why two people who didn't love me would have me and you know, a part of me has to believe that somehow she does love me.”

The diagnosis provides a “scapegoat” for her feelings of resentment and anger towards her mother. She can rationalise that it was the mental illness that prevented her mother from displaying affection and providing the nurturing role she perceives that a mother should play. Assigning the blame for her mother's actions to the diagnosis is a protective factor for Chrissie. She also uses her own experiences of having a mental illness, depression, to explain her position of empathy for her mother. As with Ginny, the alternative to believing her mother's behaviour stemmed from her mental illness is far worse for her to cope with.

Anna spoke about how the diagnosis provided her with a sense that she was not alone in her experiences and made it possible to improve her relationship with her mother.

“Yes, I think I was ignorant a lot of the time. I didn't think there was a mental disorder. Now I understand what Schizophrenia is. Now I'm much more patient with her. And I'm accepting and giving [...] I think after I understood my mom, we had a good relationship and I think that understanding grew through awareness, through therapy, to understand why she does what she does because a lot of the time I thought it was her. To actually realise that, hey, this is a

disorder. Here are the symptoms. The person has paranoia. A person (3.0) if it's really like a textbook explanation of my mom. I was like 'Wow, there's other people going through this as well.'"

**Belinda stated:**

"But I don't think it actually benefits anybody by trying to pull the wool over their eyes or downplaying it. It's a very difficult illness to live with."

Belinda's mother was only diagnosed in her seventies, and the diagnosis provided Belinda with some understanding of her experiences during her childhood and her mother's reactions. However, she queried the way in which family members of the mentally ill person are told the diagnosis. Using her position as the leader of a support group for people with schizophrenia and bipolar affective disorder, and her experiences dealing with family members, she stated that it is better to tell the family clearly and in detail the diagnosis of their family member and explain what to expect and how to deal with it, and validate their feelings of anger and guilt. The diagnosis should be given in a way that provides tools for every member of the family to deal with it.

## **Chapter five: Conclusion, limitations and recommendations for future research**

### **Conclusion**

The aim of this research project was to examine how participants – now adult daughters who grew up with a mother with a severe mental illness – reflected on their experiences in the context of an interview. It is important to note that this study represents just one possible reading of many of the accounts provided by the participants. The second aim of the study was to examine how resilient the participants thought themselves to be. The use of IPA allowed for analysis of the participants' lived experiences. The study achieved both aims.

Five participants took part in the study. Each of the participants' mothers experienced severe mental illness with a psychotic component. Four of the five mothers were diagnosed by a psychiatrist. The one participant whose mother was not diagnosed by a psychiatrist was included because she believed she had the experience of growing up with a mother who had a severe mental illness with a psychotic component. Her interview also proved valuable, so was included. The participants' age range was between 21 and 60 years old, with a majority of the participants in their twenties.

The data was collected using a semi-structured, open-ended interview. The interviews were audio-recorded, with participants' consent, and later transcribed. The data was then coded and themed using IPA. Six themes emerged, with a number of sub-themes. The main themes were the relationship with mother: then and now; abuse and neglect; isolation, secrets and facades; emotional responses and adult relationships; protective relationships; and mental health services and the role of the diagnosis.

Each of the participants believed that having a mother with a severe mental illness had an effect on their development and these effects have persisted into their adult life. The participants' accounts of their experiences revolved around their difficult childhood

relationship with their mother, characterised by a lack of maternal responsiveness, inappropriate expressions of anger and feelings of never being able to do anything right. As found in the study by Duncan and Browning (2009), the participants reported that they lacked closeness with their mother. Despite this, some of the participants remain incredibly loyal to their mothers. The participants recall always needing to manage their mother's emotions and developed various strategies for avoiding conflict. The participants found that they had to continually assess how to cope with the situation to avoid conflict.

All but one of the participants reported that they were able to repair their relationship with their mother. Many of the participants found that they were able to "forgive" their mother when they understood that she had a mental illness. The strategies the participants used were emotional and physical distancing. They found that if they managed to limit the time spent with their mother they were able to cope. For some of the participants, detaching emotionally was essential for dealing with their experiences and managing their mother.

The participants felt a variety of types of guilt. One felt guilt for hating her mother, another felt guilt for her perceived abandonment of her mother by living her life independently and another felt self-blame, assigning responsibility for her mother's illness to herself. Two of the participants reported feeling no guilt at all. One said that she provided enough counter-balances (kindness to her mother) to outweigh any "harm" (her word) she may have done in the relationship.

The participants faced two distinct types of isolation. Some of the participants self-isolated because they felt that their peers could not understand and would judge them. The other type was that their mother dissuaded them from entering peer relationships. This social deprivation, as outlined by Brockington et al. (2011), resulted in a lack of input from external

sources, removed potential support structures and dissuaded participants from seeking external assistance.

Their childhood reflections often focused on physical and emotional abuse and neglect and they spoke about how these things had had a pervasive negative effect in their lives, resulting in a lack of self-esteem and continued relationship difficulties. These relationship difficulties consist of selecting destructive intimate partners, continual searching for acceptance at the expense of self, co-dependence and self-blame. However, many of the participants emphasised their attempts to overcome these difficulties, as opposed to focusing on the difficulties themselves.

Important coping mechanisms for each of the participants were: having a protective adult who often took over the household responsibilities; emotional and physical distancing; and therapy later in life. The aspect of therapy that proved most helpful for all the participants who underwent it was focusing on why they react and behave the way they do and how this influences their relationships. An important coping mechanism for most of the participants was being told their mother's diagnosis. This allowed for forgiveness of the mother and acceptance of their situation. For some of the participants, this provided the tools necessary to improve their relationship with their mother. For the one participant who did not have a diagnosis of mental illness, there was some lack of resolution and she considered that the alternative to her mother having a severe mental illness – that her mother was inherently unloving – was worse. The diagnosis provided a protective factor for the daughter. For all the participants, mental health services were absent; for those who were exposed to social services, they found them ineffective and their role was minimal.

### **Limitations and recommendations for future research**

The sample of the study consisted of predominantly white, middle-class participants. Due to the difficulty of gathering a sample, the researcher was only approached by this sample. For future research it would be interesting to have a sample that contained different cultures and income groups to this study. In addition, the nature of qualitative research means that generalisations cannot be made due to the small sample size. The sample was also self-selected, which prevents generalisability. Due to the nature of this sample, there is an elite bias (Miles et al., 2014) as the study could not examine the voices of people who have experiences growing up with a mother with a psychotic disorder but have a substantially less privileged socio-economic position within society.

The accounts given by the participants are retrospective, which means that the narratives generated in this study must be treated as personal accounts. Due to the time and spatial constraints of doing this study for a Master's degree, the analysis of the transcripts is partial. Further analysis can be done on the current transcripts for future studies done by the researcher.

Although this research delineated the data into six themes and a number of subthemes, it is important to consider that while the act of clustering themes acts to organise the data into neat boxes of knowledge, because of the nature of these accounts, there is overlap within the themes. Miles et al., (2014) state that while we seek to categorise data into small, meaningful and carefully delineated meaning, it is important to remember that the process is not always straight forward and there is much overlap.

While Miles et al., (2014) state that utilising numbers to count the number of times an instance occurs across the study in order to delineate themes, this was not strictly adhered to in this study. Qualitative research has often been criticised for being largely based on

intuition (Miles et al., 2014). While this study did not strictly adhere to numbers, it examined each instance according to which participants describe it happening to them and which participants do not describe such an instance. This was also commented on.

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**Appendix A: Interview schedule**

1. This research is about daughters who were raised by mothers who suffered from psychotic mental illness. Do you believe you had this experience? If so can you please describe your experiences of your mother's mental illness in your childhood?
2. Do you have specific memories of any unusual behaviour of your mother when she was mentally ill?
3. Do you remember how you made sense of her behaviour? Do you recall how you felt at the time?
4. Did anyone explain to you what was happening with your mother when she was mentally ill in your childhood?
5. What was the role of the other family members during your childhood?
6. Overall, what was your childhood relationship with your mother like?
7. If you feel that your mother's mental illness had an effect on your development and/or on the way you are today, can you tell me about this?
8. Growing up, do you think your mother's mental illness affected your relationship with her, either positively or negatively?
9. Has your understanding of these experiences change over time? If so, how?
10. How do you think you have dealt with these experiences?
11. What is your relationship with your mother like currently?
12. Did you have any contact with the mental health services while growing up?
13. Do you talk to anyone about your experiences? If so, how have people reacted?
14. Have you had therapy at any time in your life to process your childhood experiences? If so has this been helpful? If not, why not?
15. Is there something else you would like to add about your experience that I haven't yet asked about?

**Appendix B: Participant information sheet****Psychology****School of Human & Community Development**

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Private Bag 3, Wits 2050, South Africa. Telephone: +27 11-717-4500/2/3/4. Fax: +27-11-717-4559

**Participant information sheet****An exploration of the recollections of adult daughters on being raised by a mother with a psychotic disorder**

My name is Sarah Day. I am currently pursuing my MA in Psychology by Coursework and Research Report at the University of the Witwatersrand, Johannesburg, working under my supervisor, Dr Yael Kadish, in the School of Human and Community Development. In order to fulfil the requirements of my degree, I am required to do a research report. I would like to invite you to take part in my research study, which concerns the exploration of recollections of adult daughters on being raised by a mother with a psychotic disorder, i.e. bipolar mood disorder with psychotic features, schizophrenia or schizo-affective disorder. My completed thesis will be found in the library at the University of the Witwatersrand.

If you agree to participate in my research, I will conduct an interview with you at a time and location of your choice. The interview will involve about 15 prepared questions and a number of follow-up questions. It should last about one hour more or less. With your permission, I will audiotape and take notes during the interview. The recording is to accurately record the information you provide, and will be used for transcription and analysis purposes only. If you choose not to be audiotaped, I will take notes instead. If you agree to

being audiotaped but feel uncomfortable at any time during the interview, I can turn off the recorder at your request. If you do not wish to continue, you can stop the interview at any time.

There is no direct benefit to you from taking part in this study. It is hoped that the research will add to our understanding of the subjective experience of being raised by a mother with a psychotic disorder. The interviews may result in psychological distress. If you should feel that this occurs after the interview, please contact the Emthonjeni Community Psychology Centre at the University of the Witwatersrand. This is a free counselling service. It is strongly recommended that you attend a few counselling sessions should you feel any discomfort during or after the interview. Please contact Nthabiseng to make an appointment on (011) 717 4513. Should you experience distress during the interview process, you are welcome to end your participation.

Your study data will be handled as confidentially as possible. In order to protect the privacy of the individuals participating in the study, individual names and other personally identifiable information will not be used. Pseudonyms will be used. To minimise the risks to confidentiality, we will keep the transcriptions and the audio recordings of your interview in a password-protected file on my and my supervisor's computer. Only the researcher and supervisor will have access to the audio recordings and full transcriptions. If this research is published in a journal, excerpts of the interview will be published. In addition, the study will be available online and in the University of the Witwatersrand's library. Should you wish for the results of the study, please contact me via email and I will send them to you.

Participation in this research is completely voluntary. You are free to decline to take part in the project. You can decline to answer any questions and are free to stop taking part in the project at any time. Whether or not you choose to participate in the research and whether or not you choose to answer a question or continue participating in the project, there will be no penalty to you. The level of detail you wish to give is completely up to you.

If you have any questions about this research, please feel free to contact me. I can be reached at 0763074392 or sarah.kathrine.day@gmail.com. If you wish to contact my supervisor, Dr Yael Kadish, you can do so by emailing yael.kadish@wits.ac.za or phoning 011-7174547.

**Appendix C: Informed consent form**



**Psychology**

**School of Human & Community Development**

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Private Bag 3, Wits 2050, South Africa. Telephone: +27 11-717-4500/2/3/4. Fax: +27-11-717-4559

**Informed consent form**

- As participation is completely voluntary, you have the right to withdraw from the study at any time. You may also refuse to answer any question and the level of detail you wish to divulge is up to you.
- The interview will be audiotaped. However, if at any time this should make you uncomfortable, the audio recorder will be turned off.
- The data will be treated confidentially. Your name will be replaced by a pseudonym and any identifying factors will be removed.
- Only the researcher and supervisor will have access to the interview recordings and full transcriptions.

**CONSENT**

If any questions about this research have been answered to your satisfaction and you would like to take part in the research, please print and sign your name below.

I have read the above and agree to participate in the research.

\_\_\_\_\_

Participant's Name (*please print*)

\_\_\_\_\_

Participant's Signature

Date

**An exploration of the recollections of adult daughters on being raised by a mother with  
a psychotic disorder**

**Research Report**

**School of Human and Community Development**

**University of the Witwatersrand**

**Submitted by**

Ms Sarah Day 831450

**16 February 2015**

**Supervisor**

Dr Yael Kadish

### **Acknowledgements**


I would like to express my deep gratitude to Dr. Yael Kadish, my research supervisor, for her patient guidance and useful critique of my research. I would like to express my very great appreciation to Professor Kevin Whitehead, Professor Brett Bowman and Dr. Sherianne Kramer for encouraging my critical thinking and for providing the methodological training that has made the submission of this research report possible.

Thank you to all of my participants who were willing to share their time and experiences to make this research possible.

I would finally like to extend my thanks to my parents who have always encouraged and supported my academic endeavours.

### **Declaration**

I, Sarah Kathrine Day, declare that this is my own unaided work. Where other peoples' work has been used, it has been duly cited and referenced. It is being submitted for the degree of Master in Psychology by Coursework and Research Report at the University of the Witwatersrand.



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Sarah Kathrine Day

16 February 2015

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## **Chapter one: Introduction, aims and rationale**

### **Introduction**

Mordoch and Hall (2002) state there is a dearth of research focusing on the subjective experiences of children raised by parents with a severe mental illness. Research that has been done on children raised by parents diagnosed with a mental illness has focused on the risk of genetic transmission (Apfel & Handel, 1993; Beardslee, Versage & Gladstone, 1998; Rutter & Plomin, 1997). Compared to the greater population, offspring of parents diagnosed with a schizophrenia spectrum disorder have a 10% chance of being diagnosed with a mental illness themselves, compared to 1% for the general population (Riley, Asherson & McGuffin, 2003 cited in Duncan & Browning, 2009).

Despite this, most children of parents with schizophrenia do not have this outcome (Duncan & Browning, 2009). Research focusing on the risk factors of these children neglects to examine the more subtle effects on children who go on to lead “successful” lives and do not develop pathology themselves (Bleuler, 1974; Duncan & Browning, 2009; Wan, Abel & Green, 2008); and when difficulties do arise, they may be transient (Wan, Abel & Green, 2008).

Only a handful of studies (Duncan & Browning, 2009; Dunn, 1993; Mander, Norton & Hoare, 1987; O’Connell, 2008; Williams, 1998) have examined the subjective experience of children growing up with a mother with a severe mental disorder. A review by Murphy, Peters, Jackson and Wilkes (2011) done on studies similar to this one found that predominant themes yielded by these studies were difficulty with emotional parental bonding, parental absence, parentification, childhood feelings of isolation and lack of support by external familial relationships, difficulty establishing and maintaining interpersonal trust throughout their life, devaluing of self, grief, worry, seeking escape and blocking emotions, healing,

hope and growth and the impact of stigma associated with mental illness. Some of these studies are elaborated upon in the next chapter.

This study examined the retrospective recollections of women who were raised by a mother with a severe mental illness with a psychotic component. These accounts were gathered using a semi-structured interview (see Appendix A) and analysed using interpretive phenomenological analysis (IPA).

### **Research aims**

The aims of this study are to examine how an adult daughter who grew up with mother with a severe mental illness with a psychotic component reflects on her experience in the context of an interview. Utilising a semi-structured, open-ended interview, the research aims to gain information from participants regarding their perceptions and recollections of their early childhood experiences, their relationship with their mothers during childhood and adulthood, and the presence and role of the mental health services. The data focuses both on the phenomenological (the participant's perceived experiences) and the interpretative (placing the interviews within a psychologically theoretical background) (Larkin, Watts & Clifton, 2006; Smith et al., 2009 cited in Van Parys, Smith & Rober, 2014).

### **Research questions**

1. How do adult daughters make sense of the experience of having had a mother with a psychotic disorder while growing up?
2. How do participants view their own coping skills and adaptive psychological mechanisms, in relation to their experiences of being raised by a mother with a severe mental illness with a psychotic component?

## **Research rationale**

This study explored the recollections of five women on their experiences of growing up with a mother who had a severe mental illness with a psychotic component, such as bipolar affective disorder with psychotic features, schizophrenia spectrum disorders and in one participant's case, borderline personality disorder with a distinct psychotic component. Women were selected for this study as it falls into a bigger study examining daughters' retrospective recollections of being raised by a mother with a psychotic disorder conducted by Dr Yael Kadish of the University of the Witwatersrand (the student's supervisor). This study will be taking an overarching psychoanalytic perspective, looking at psychic structures and psychological defence mechanisms across all the interviews collected by several students over the last five years. This study slots into the aforementioned larger study in that it provides data for the research to be conducted.

Only a handful of studies (Duncan & Browning, 2009; Dunn, 1993; Mander, Norton & Hoare, 1987; O'Connell, 2008; Williams, 1998) have examined the subjective experience of children growing up with a mother with a severe mental disorder. The subject of subjective experience has largely been neglected in favour of the examination of genetic risk of transmission (Apfel & Handel, 1993; Beardslee, Versage & Gladstone, 1998; Rutter & Plomin, 1997). This study is valuable as it attempts to add to the limited body of knowledge on the subjective experiences of these children.

There is heterogeneity in the manifestation, duration and severity of psychopathology, and in each person's ability to cope, personality characteristics and social circumstances (Brockington et al., 2011). The presence of psychopathology does not necessarily detract from a parent's ability to be an exemplary caregiver. However, the possible ways in which mental disorders affect parenting, which include parental preoccupation, emotional unavailability of the parent, anger and hostility towards the children

and demonstrating disturbed behaviour in front of their children, which may prove frightening. While not present in all cases, children raised by parents with severe mental illness may be exposed to neglect, emotional neglect and abuse and physical abuse (Brockington et al., 2011). Considering these possible consequences of maternal mental illness and the complicated nature of the heterogeneity of experience, it is important to examine the perceived impact of these experiences on the children of these mothers. Severe mental disorders with psychotic components were selected for this study because IPA requires a homogenous sample (Smith et al., 2009 cited in Van Parys, Smith & Rober, 2014).

Research that focuses on parental mental illness and psychopathology as an adult outcome of these children frames children as passive receivers of their environments (Mayall, 2002; Qvortrup, 1985; Van Parys, Smith & Rober, 2014). The use of IPA gives the participant an active voice. Qualitative methodology, utilising IPA, provides a more appropriate forum for addressing such a research concern as it aims to tap into and explore these heterogeneous experiences (as reported by participants) rather than limiting them through quantification. Qualitative methodology acknowledges that experiences often cannot be clustered into neat framework and that it is inherent messy and overlapping (Miles, Huberman & Saldaña, 2014).

## Chapter two: Literature review

### Introduction

Living with severe mental illness in the mother presents a variety of challenges (Montgomery, 2005). A mother's ability to respond to and address the challenges presented by severe mental illness is limited by a lack of resources, choices and invisibility as a mother by others, including those who work in the mental health sector (Montgomery, 2005). The impact of a parent's diagnosis of mental illness has far-reaching implications for the child. The nature of mental illness is episodic and recurrent. This means that a mother may experience an episode of acute symptoms across more than one of the child's developmental stages and this may result in an accumulation of risk for behavioural and psychological problems for the child (Hammen, 1997). The majority of research that has been done on children with a parent diagnosed with a mental illness has been concerned with how the children are at risk of behavioural and psychological problems themselves because of genetic transmission (Apfel & Handel, 1993; Beardslee et al., 1998; Hall, 2004; Rutter, 1989, 1990; Smith, 2004) and environmental factors (Beardslee et al., 1998; Nicholson, Sweeney & Geller, 1998a, b; Rutter, 1989; Rutter & Plomin, 1997).

Children of parents with a mental disorder are not just vulnerable to developing a mental disorder themselves, due to genetic transmission of risk, but are vulnerable to exposure to deprivation, an absence of social support, exposure to marital conflict and disorganised family lives (Brockington et al., 2011). Children of parents with mental disorders may be exposed to child maltreatment, such as physical abuse and emotional neglect and abuse (Brockington et al., 2011).

Some infant disturbances can be related to parenting (Brockington et al., 2011). A study by Wan, Warren, Salmon and Abel (2008) examined the responsiveness of mothers

diagnosed with a psychotic disorder in comparison to mothers diagnosed with affective disorders. The mothers' interactions with their infants were observed in a laboratory setting. Psychotic mothers reported a low rate of responsiveness, which was similar to mothers with affective disorders. Mothers with affective disorders were distracted visually, which made them unresponsive to their infant's behaviour (Wan et al., 2008). In contrast, psychotic mothers became psychologically withdrawn. This suggests that the reasons for low responsiveness differ. Psychotic mothers tend to become unresponsive when their infants stop self-initiating behaviour. Psychotic mothers differ in three important ways: they may display negative response to positive infant behaviours, psychological unresponsiveness and abnormal behaviour in front of their infant (Wan et al., 2008). This could be because of the presence of positive symptoms and social-cognitive deficits. Despite this, no infant inertness, low inhibition or negativeness was found. This contrasts with mothers with affective disorders, as they only respond negatively to negative infant behaviour (Wan et al., 2008).

Parental mental illness may also influence parenting style. Depression in mothers may result in them seeing the maternal role as negative, which in turn may result in them resorting to more use of punishment (McLoyd, Jayaratne, Ceballo & Borquez, 1994) and an inability to set standards without using too harsh a punishment due to feeling uncertain as a mother (Mowbray, Oyserman & Ross, 1995). Robinson, Mandlco, Olsen and Hart (1995) state that mothers with mental illness may use permissive parenting, which means that children have very little structure, low discipline and are subject to low parental demands. Both these parenting styles are related to negative outcomes for the children (Coleman & Karraker, 1997). The child may also display over-compliant behaviour in order to deal with the parent's unpredictability. In addition, ambiguous communication given by the parent is prevalent. One parent may contradict the demands or expectations of the other parent. Of more concern is

that the child's life is intruded upon by the delusions and hallucinations of the parent (Cooklin, 2006).

Bleuler's (1974) classic work examined 184 children whose parents were diagnosed with schizophrenia. He found that the children faced many adversities and a developmentally inappropriate level of responsibility. They had to look after both themselves and their parents and lived in environments that were considered to be deprived. This has been theorised to have both long- and short-term effects on the child, and would likely result in negative mental health outcomes in adulthood. Bleuler (1978) noted that his patients' children were well adjusted socially, despite having difficult childhoods. However, Bleuler (1974) notes that even if they appear to be successful later in life, the effects of being raised by a parent with schizophrenia may translate into more subtle difficulties.

### **Risk and resilience**

Research that emphasises risk does not necessarily offer an explanation about the resilience of children who have been raised by a parent with a severe mental illness (Duncan & Browning, 2009), and frames these children as passive receivers of their parents' adverse behaviour (Van Parys et al., 2014). The risk/resilience discourse in research is powerful and is based in the larger discourses of contemporary childhood and risk. An overreaching theme in the literature is that children who are living with parents who have been diagnosed as being mentally ill are at risk of being diagnosed with a psychiatric disorder themselves; those who are not diagnosed with a mental illness are viewed as extraordinarily resilient (Gopfert, Webster & Seeman, 1996; Nicholson et al., 1998a, b; Smith, 2004). These discourses claim that childhood is a critical development stage where children need protection due to their physical and psychological vulnerability (Beck, 1992; Douglas, 1990; Lupton, 1995; Scott, Jackson & Beckett-Milburn, 1998; Valentine, 1996). Childhood is seen by some theorists as a preparatory stage rather than a participatory stage (Mayall, 2002; Qvortrup, 1985). Events in

childhood are emphasised as having a link to adult outcomes instead of considering the significance for the child at that current stage of development. Considering future implications is important; however, consideration of the present well-being of the child is also of great importance (Prout, 2001).

Gladstone, Boydell & McKeever (2006) argue that new lines of enquiry should be opened in terms of the subjective experience of children being raised by a mentally ill parent. The dominance of the risk/resilience discourse should be critiqued, especially the view of the child as passive, developing and unfinished. Recasting of children opens up new lines of enquiry in terms of their experiences of having a parent diagnosed with mental illness (Hutchby & Moran-Ellis, 1998; Mayall, 2002). The danger of casting children into the “at-risk” category is that it is a status that follows them into adulthood, especially with regard to the formation of social relationships (Gladstone et al., 2006).

### **Qualitative studies**

Mordoch and Hall (2002) argue that the child’s experience of growing up with a mother diagnosed with a mental illness has been neglected. Little is known of the effect of this on children, due to a lack of literature that seeks a subjective response from the children themselves (Nicholson, Biebel, Hinden, Henry & Stier, 2001).

Mander, Norton and Hoare (1987) did a case study on an 11-year-old girl, called G, whose mother had grandiose delusions and visual hallucinations. During the time the mother was in hospital, the impact on G was not considered. If G had been assessed upon this admission, many of the problems she encountered may have been averted. G engaged in shoplifting and her school attendance was irregular as she stayed home to look after her mother. G was very protective of her mother and often interrupted her to prevent her talking about her experiences. G’s case study supports that the child may be concerned with the parent’s safety

and attempt to fulfil the role of caregiver (Cooklin, 2006). However, some theorists argue that the caregiver role of children in families that have a parent diagnosed with mental illness is a protective factor, because it gives the child a constructive family role. Little research has been done on finding out how children experience the premature caregiving role (Gladstone et al., 2006).

When interviewed, G claimed that she experienced the same hallucinations and delusions as her mother when interviewed in the presence of her mother. This could be because wanted to comply with her mother's request for confirmation of her experiences. Cooklin (2006) states that some children may imitate the symptoms the parents present with for defensive purposes. However, when interviewed alone, she showed no sign of any symptoms of psychosis. There were detrimental effects on her cognitive abilities due to her irregular school attendance and she showed a childlike immaturity. G is an example of how the children of mothers diagnosed with mental illness can often be invisible to the mental health care workers who are treating their mother, unless any abuse or neglect is clearly visible (Gladstone et al., 2006).

Williams (1998) did a study examining a group therapy situation with four women who were raised by a mentally ill mother. Two of the mothers had bipolar affective disorder, one had a diagnosis of schizophrenia, and the other had suspected schizophrenia and alcoholism. The fathers of the women whose mothers had schizophrenia sexually abused them, and the fathers of the women whose mothers had bipolar affective disorder were distant (Williams, 1998). Three of the women were mothers themselves and often spoke about parenting issues. In the follow-up study, the women reported ongoing burdens with regard to childcare. Themes that emerged from this study were hatred of self and mother, current lack of support from extended family, current parenting difficulties, ongoing stigma and isolation.

The group therapy process allowed for strong identification between the participants, which resulted in a willingness to self-disclose (Williams, 1998).

Although the participants in this study were viewed as resilient by others, they had difficulty attributing this quality to themselves (Williams, 1998). The participants all appeared to be functioning well and they were all well-dressed, well-groomed and had acquired good jobs. However, while the participants displayed a competent image, they spoke of internal distress in the context of group therapy. Williams (1998) theorised that the women had created false selves as a coping strategy. This strategy had both negative and positive outcomes. While they supported the others in group therapy, they felt unsupported themselves. However, the reason for the participants' resilience is unclear. They had no alternative main adult to provide a protective factor. This development of appearing to be well-adjusted may be an early adaption in order to take control of their self-care (Williams, 1998).

Dunn (1993) did a study on the experience of growing up with a psychotic mother. There were nine participants in the study, four men and five women. One of the participants had a diagnosis of schizophrenia themselves. Similar to the study by Williams (1998), the participants' fathers were emotionally or physically distant. Dunn (1993) found themes of abuse and neglect, isolation, guilt and loyalty, and grievances with mental-health services and support (Dunn, 1993). In terms of abuse and neglect, some participants described maternal withdrawal. Some mothers' ability to provide basic care was compromised. In some cases there was physical abuse and in one case, sexual abuse. Interestingly, one statement by a participant noted that the people who should have noticed what was happening did not (Dunn, 1993). This links back to the proposed invisibility of children of a mentally ill parent (Gladstone et al., 2006).

Participants felt isolated from their peers, their community and their family (Dunn, 1993). In addition, no explanation was offered of what was happening with their mother's illness. This resulted in confusion, and psychotic episodes were found to be frightening. The theme of guilt and loyalty is linked to isolation. The participants described the need to be loyal to their mother, despite it being difficult to live with her (Dunn, 1993). Loyalty to the parent is common in such situations, despite their experiences (Cooklin, 2006). Some participants felt as though they had somehow contributed to their mother's illness. In addition, some felt guilty for being healthier than their mother or guilty for moving away. Most participants found contact with the mental health services negative. Mental health professionals blamed the children or gave them too much responsibility to "blow the whistle" on their mother (Dunn, 1993).

Living in a family where one of the parents has been diagnosed with a mental illness is complex and challenging. Family members are often blamed for the member's illness. Family members must deal with the care of the family member who is ill as well as combating feelings of guilt and partial responsibility (Boyd & Nihart, 1998; Canadian Mental Health Association, 1991; Dunn, 1993). Self-blame and taking responsibility for the family's problems may occur in result of this (Cooklin, 2006).

Eight out of nine of the participants entered into therapy during their adult life. Most found it helpful (Dunn, 1993). However, the study did not ask what motivated them to do so. Interestingly, the participants who engaged in therapy gave rich data sets and were better able to verbalise their feelings. Therapy allowed participants to overcome feelings of shyness, feelings of being different, and fear of reprisal from their mothers. Dunn (1993) asks for future research to orientate around such questions as it could add to our understanding of resilience and coping. In terms of resilience, most participants had an adult that they found to

be supportive and with whom they felt safe. This person provided a protective factor for the participants (Dunn, 1993).

The study by Duncan and Browning (2009) examined the attachment problems of now-adult children of parents with schizophrenia, using qualitative methods. The study consisted of 23 participants, of whom four were men and 19 were women. Four of the participants' fathers had schizophrenia. The study used a semi-structured, in-depth interview; it did not directly assess attachment style but used the narratives produced by the participants to extrapolate. The participants' accounts were heterogeneous but a number of commonalities emerged (Duncan & Browning, 2009). The accounts produced by the participants centred on mistrust of others and difficulties achieving the vulnerability needed for intimate relationships. Their retrospective accounts described their parent as being psychologically absent and reported a lack of closeness, love and bonding between them and their mother. The participants recall detaching from their parent with schizophrenia and they speak of their feelings of caution as to their parent's unpredictable behaviour. These experiences may have left a lasting legacy of relationship difficulties that affects the participants' adulthood (Duncan & Browning, 2009).

The issue of children with parents diagnosed as mentally ill is complex. Gladstone et al. (2006) call for research that examines children's subjective experiences through direct contact with them. It is for this reason that the present study explores this question. Through accounts given by an adult who grew up with a mentally ill parent, access can be gained to the way in which the experience is reflected upon in an interaction.

## **Chapter three: Methodology**

### **Methods**

This study utilised qualitative research, using the specific method of interpretive phenomenological analysis (IPA). According to Larkin et al. (2006) IPA has two primary objectives. The first requirement is phenomenological and is committed to providing a “voice” for the preoccupations of the participant, and the second is the interpretive requirement that seeks to place the narratives of the participant into a psychological context. By using IPA, it is possible to explore how the participants make sense and meaning of growing up with a mother diagnosed with a mental illness. IPA involves both an empathetic and a questioning hermeneutic (Smith & Osborne, 2008).

As well as documenting the participants’ reflections on their experiences, the researcher examines the entire research process from a more critical stance, as per IPA guidelines (Larkin et al., 2006; Smith & Osborne, 2008). This involves examining the participant’s narratives in more nuanced ways. In addition, it is important to consider how the interview process influences the data (Smith & Osborne, 2008). The aim of IPA is not to gain objective knowledge about the experience; rather it emphasises the participant’s perception (Smith & Eatough, 2008). The experience the participant is reflecting on cannot be accessed during an interview, and the interview remains an account constructed by both the participant and the interviewer (Larkin et al., 2006; Silverman, 2004). Through the interview process, only the way in which the participant reflects on the event can be captured and analysed.

### **Sampling**

The sampling method that was used is purposive sampling. The sample consisted of five women whose mothers suffered from a psychotic mental illness. A condition of participation in this study was that participants’ mothers must have experienced at least one

episode of psychosis, preferably diagnosed by a psychiatrist, during the period in which the participant was growing up. The study requires participants to be over the age of 18, as that is the age at which a person is legally considered to be an adult according to South African law. Due to the possibility of distress, participants should not have had an episode of diagnosed mental illness themselves within a two-year period prior to participating in the study. Before the interview, the participants were asked if they had suffered from an episode of severe mental illness within the last two years.

Three of the five participants were known to the researcher (the ethical ramifications of this are discussed in the ethical guidelines section) and were approached and invited to participate in the study. Two of the participants found out about the study via word of mouth and approached the researcher as they wished to participate. The diagnoses of the mothers were heterogeneous. *Pseudonym* Anna is 23 years old. Her mother was diagnosed with schizo-affective disorder during her childhood. The affective disorder that accompanied the schizophrenia is bipolar affective disorder. Donna is 23 years old and her mother was diagnosed with bipolar affective disorder and alcoholism.

Chrissie's mother was diagnosed with bipolar affective disorder during her childhood. Chrissie is also in her early twenties. She did not fulfil the criterion of not being diagnosed with type II bipolar affective disorder within the last two years, but because of her ongoing psychotherapy and her compliance with her medication it was deemed that she had enough external formal support to deal with any distress that might arise from the interview. This was discussed prior to the interview taking place.

Belinda was the oldest participant and the only one whose mother is deceased. Her mother was only diagnosed with borderline personality disorder when she was 70. Although Belinda's mother does not satisfy the criterion of being diagnosed with a disorder that falls

within the schizophrenia spectrum and delusional disorders, her interview was included because she reported that her mother had paranoid features.

Ginny is 41 years old. Her mother was not formally diagnosed by a psychiatrist; however, Ginny believes that she has experienced being raised by a mother with a severe mental illness and her interview provided valuable data, so it was included.

The study was conducted at a location and time of the participant's choice. The researcher had two available venues should the participant prefer to use those. All others with access to these venues were notified timeously that the room was unavailable when an interview was scheduled. Some of the participants preferred to stipulate their own venues.

### **Data gathering**

The instrument that was used is a semi-structured interview. Semi-structured, open-ended interviews allow for participants to be active agents in the research process (Smith & Eatouge, 2008). An open-ended interview is usually so called because although the questions are predetermined by the interviewer, the interviewer is not aware of what content the interviewees' answers will hold (Thibodeaux, n.d.). Interviews allow the researcher to access people's reflections on their experiences, memories and perceptions (Zhang & Wildemuth, 2009).

The interview took place at the time and location of the participant's choice. Each participant was interviewed for approximately one hour; due to the nature of the semi-structured interview, interview times varied for each participant. Before the interview took place, the first step was to gain informed consent. The participants were given a participant information sheet (see Appendix B). The aims of the study were discussed and made as clear and transparent as possible (Burman, 1994). The research form addressed issues of anonymity and gave a promise to the participant that she could terminate the interview at any

stage for any reason without any consequences. Accessibility to the data was also addressed (Burman, 1994).

The use of an audio-tape recorder was discussed with the participant. Consent for the use of the audio-tape was gained by the participant signing the permission form (see Appendices B and C). The reasons why the recording is used, how it is used and how it helps the researcher were included in the discussion (Burman, 1994). As IPA seeks to give voice to the participants, it is important to use the participant's own words during the analysis, which is why audio-recording is imperative. Audio-recording is an important part of the interview process, as it is impossible to write down everything verbatim that is said in the interview. Audio-recording enables the researcher to concentrate on what the respondent is saying, including non-verbal expressions. Recording by hand only captures the gist of what is being said (Smith & Osborne, 2008).

A list of 15 questions was compiled (see Appendix A for the interview schedule). Preparing a set of questions beforehand helps conceptualise which areas the researcher wishes to access. It also helps the researcher to predict any difficulties the interview may encounter (Smith & Eatouge, 2008). By acknowledging these issues, questions can be structured in a way that is sensitive. Having a set of prepared questions allows the researcher to be confident and relaxed (Smith & Eatouge, 2008). The interview began with general questions in order to gain rapport, and more sensitive questions were asked later in the interview (Smith & Osborne, 2008).

The research questions were conceptualised after reading through past research and aiming to target certain experiences: childhood experiences of growing up with a mother with a severe mental illness, current and past relationship with the mother, coping strategies, experiences of the mental health services, and experiences of therapy (see Appendix A for

interview schedule). In order to reduce bias, the questions constructed by the interviewer aimed to be neutral, which means they did not lead the interviewee in a specific direction (Smith & Osborne, 2008); the way in which a question is asked can influence the way in which the respondent responds. Some of the questions could make use of a more specific prompt when the participant is struggling to answer the question (Smith & Osborne, 2008). Although the interviewer's role is to guide and facilitate the interview process, it is impossible for him or her not to influence the respondent's answers in some way. This is because the interview process is an interactional one and the researcher cannot escape being a participant (Larkin et al., 2006; Smith & Osborne, 2008). However, as much as possible, the researcher will ask questions in a way that does not steer the conversation in a specific direction (Smith & Eatouge, 2008).

The emphasis in semi-structured, open-ended interviewing is not on the prepared questions. It is important that the researcher is able to negotiate between the interview schedule and following up novel lines of enquiry that the participant offers (Eatouge & Smith, 2008). This allows the researcher to follow the participants' concerns and interests. The sequence the questions follow is not important (Smith & Osborne, 2008). All the interviewees were given the same basic interview. However, the follow-up questions in some cases were different. While the study required all participants to have experienced having a mother diagnosed with a mental illness growing up, their experiences were not homogenous and some things were more influential in one participant's life than another's (Burman, 1994).

An interview is an interactive process that forms a meaning-making conversation. The interactive process means that it is a constructive process (Holstein & Gubrium, 1995); meaning is constructed between the interviewer and the interviewee. It is important to remember that participants are not reporters on reality; instead, they construct it during the

interview process (Speer, 2002b). The use of a semi-structured interview allows the participant to take greater control and ownership of the research process. The benefits of this are that greater rapport is established, the data produced is richer and more lines of enquiry are explored. Disadvantages of the semi-structured interview are that it is more time-consuming to analyse such data sets and it is harder to analyse the transcript (Smith & Osborne, 2008).

## **Data analysis**

### **Step one**

The aim of the analytical process is not to measure the frequency of the themes that emerge, but rather their content and complexity (Smith & Osborne, 2008). After the interviews were completed, the transcription phase was undertaken. The audio tape-recording was converted to a written transcript where significant pauses, laughs, tears, inflections and deflections and false starts were noted. There were left and right margins for the later stages of analysis (Smith & Osborne, 2008). Burman (1994) notes that in the process of converting an audio transcript to a written transcript, a lot of content is lost, with a resulting loss of objectivity. Therefore it is important to note in the transcript the tone of voice, significant body language and emotion displayed by the participant.

### **Step two**

The transcript was read through a number of times so that the researcher could become familiar with the text (Smith & Osborne, 2008). The interview material was read in relation to the research question (Burman, 1994). The left-hand margin was used to note anything interesting the participant may have said. These initial notes were not clustered or grouped in any way (Smith & Osborne, 2008) but were unfocused (Willig, 2008).

**Step three**

Once this process of reading and notation was finished, the right-hand margin was used to list emerging themes. The themes generated aimed to answer the researcher's questions as well as to give voice to the participant's primary concerns, as per IPA (Larkin et al., 2006). Once this was complete, the themes were listed on a separate piece of paper. Connections between themes were clustered together. Some of these themes consisted of subordinate concepts (Smith & Osborne, 2008). Phrases from the transcript were used to support the emerging themes (Smith & Osborne, 2008). This process is important because the analysis should do justice to both the research concerns and the participants' preoccupations (Burman, 1994).

**Step four**

Once this process was complete, a table was produced that ordered the themes coherently and placed subordinate themes under a main theme (Smith & Osborne, 2008). The analysis paid attention to analytic reflexivity. The analysis should be placed within an account of its production and acknowledge constraints, limits and possibilities created by the researcher's position as an analyst (Burman, 1994). Analysis requires interpretation, and inherent in this is incompleteness and partiality; a transcript can be vulnerable to over-interpretation and misinterpretation. A text can always be read in multiple ways; it is important to acknowledge that any analysis done on the transcripts is only one way of reading them (Burman, 1994).

The analysis of a transcript is inexhaustive and partial. While it is important to acknowledge this, the researcher must also accept that an analysis remains unfinished (Burman, 1994). As this study is designed to fulfil the requirements of a Master's degree, there are limitations on space and time and this limited the analysis of the transcripts.

Especially in this study, it is important to examine the effect of the researcher's prior relationships with the research participants (Burman, 1994). Three out of the five participants were known to the researcher. While it was initially anticipated that the pre-existing relationship would make the participant more comfortable and open to disclose, the experiences of the interviews proved to be the opposite. The participants known to the researchers tended to offer less information and the researcher had to use more follow-up questions to get information. The participants unknown to the researcher seemed to speak more freely and offer information more spontaneously. The researcher was careful not to force the participants to say more than they were willing to by noticing hesitance and noting it down.

### **Step five**

Once the analysis was complete, it was written up. The analysis was expanded during the write-up and themes were translated into a narrative account. Once this was completed, an analytic comment was made (Smith & Osborne, 2008). In the write-up, when passages are selected to elaborate a point, limitations on length dictate that the whole transcript cannot be used. What is chosen and what is ignored has an effect on the content of the research. The selection of the content of the transcript for the research report reflects the researcher's questions, ideas about the participants, ideas about the topic at hand and many other unintentional things. While it is impossible to remove this effect, it is important for the researcher to remain reflexive about it (Bucholtz, 2000).

### **Quality**

Plausibility of the conclusions drawn from the data is an important consideration of quality criteria with qualitative research (Miles et al., 2014). It is important that the conclusions drawn from the data are directly related to the data and make sense. In order to do this, the researcher has provided the quote from which the conclusions are drawn in order

to demonstrate that the conclusions are based within the data and readers of the report are able to consider whether the conclusions are appropriate. By doing this, this also links to Tracy's (2010) call for qualitative research to engage in sincerity, which involves demonstrating transparency. Plausibility of the conclusions needs to extend beyond the used of intuition and requires commitment to verification (Miles et al., 2014). This involves basing the conclusions within previous research, stating how they align and disalign with the current state of knowledge on the topic.

In addition to examining the transparency of the plausibility of the conclusions of the study it is important to outline the procedural process with as much transparency as possible (Miles et al., 2014; Tracy, 2010). These processes need to be clear enough to be evaluated by an outsider (Miles et al., 2014; Tracy, 2010). In the case of the research report, the conclusions and procedures will be evaluated by two examiners: an internal and an external examiner. This aspect also correlates with reliability, in that a peer review aspect is available to evaluate the piece of research (Miles et al., 2014).

Miles et al., (2014) makes an important differentiation between plausibility and confirmability. While this research reports seeks to make the analysis of the participants accounts logical and locating it within the current body of knowledge surrounding experiences of daughters who have grown up with a mother with a psychotic disorder, it cannot seek to make any generalisations about the topic.

While phenomenology does not adhere to the notion that there is a single reality, this does not mean that there is no 'wrong' way to analyses the data (Miles et al., 2014). The analysis needs to be based in reasonable conclusions. According to Miles et al., (2014) this means that the researcher needs to acknowledge that qualitative research cannot be grouped

into neat clusters or themes and that it is inherently messy and difficult to classify neatly.

This is called the holistic fallacy (Miles et al., 2014).

Other aspects of reliability that needs to be considered in the research process are that the participants need to be placed within their context, the process acquiring the participants needs to be accurately described, specifications on the limits of participation is specified (see sampling for exclusion criteria for participating in the study), and acknowledgement of the generalisability of the study (Miles et al., 2014).

### **Reflexivity**

The researcher acts as both a participant and an observer (Speer, 2002a). The researcher should not appropriate data to suit his or her own theoretical agenda or subjectivity. By examining the interview process as an interactional product, the contours of the agendas of both the researcher and the respondent should be made transparent. Even when the researcher attempts to minimise his or her impact on the data collection and analysis process, the interview remains a product of interaction (Speer, 2002a). However, the researcher must not try to steer the interview or analyse the data in such a way that it suits the researcher's theoretical or political ideology. The researcher must try not to examine the data through a subjective lens, but rather as it presents itself.

Respondents should take an active rather than a passive role in the interview process. The researcher's involvement should also be analysed (Holstein & Gubrium, 1995; Larkin et al., 2006; Speer, 2002a, b). Stances that require the researcher to be neutral and separate from the respondent imply that the researcher is somehow ontologically distinct from the respondent (Speer, 2002b). Instead, this research focused on the interview as a social interaction where both the researcher and the respondent engaged in meaning-making, instead of looking at it as a neutral instrument or something particularly vulnerable to distortion. The

researcher engaged reflexively with how the interactional process unfolds and how meaning is constructively made (Holstein & Gubrium, 1995). Both these standpoints move away from the respondent being a passive knowledge holder (Speer, 2002a, b; Holstein & Gubrium, 1995).

After the interview, the researcher noted her own feelings and impressions surrounding the interview. While transcribing the interviews, the researcher noted any bias or leading questions. Further subjective impressions and feelings were noted on the interview transcripts before analysis began.

### **Ethical considerations**

The participants in this study may be considered a potentially a vulnerable population. In order to address this concern, the proposal was sent to an external ethics review board to be approved before any research commenced. Because the participants were potentially vulnerable, it is possible that they may have felt psychological distress during or after the research process. Because of the strong likelihood of secondary trauma, all participants were strongly recommended to attend a free counselling service at the Emthonjeni Centre at the University of the Witwatersrand. Details of how to make an appointment were made available on the participant information sheet (see Appendix A). However, some of the participants were already in therapy and they reported that they would return to their current therapist. This was discussed with the participant before commencing the interview. If the participant feel distressed during the interview, the interview was stopped and the researcher engaged in containment. Afterwards, the participant was asked if she wished to stop the interview process. If she did, then the data collected in that interview was discarded. Some of the participants felt quite emotional when talking about various aspects of their experiences, but emphasised that they wished to continue speaking about them.

In addition, a participant was not included if she had experienced an episode of diagnosed mental illness within two years of participating in this study. However, a concession was made for one participant who had been diagnosed two years previously, as she was in weekly therapy, compliant with medication and the diagnosis fell just within the two-year limit. This was stated upfront on the posters advertising participation in the study. In addition, before the interview began, the participants were asked whether they had suffered an episode of serious mental illness within the last two years. If it became apparent in the process of the interview that the participant had been experiencing symptoms of severe mental illness that had been undiagnosed, or the participant had concealed that they had experienced an episode of mental illness in the last two years, the interview was stopped and the data discarded. A debriefing session followed and the reasons why the interview was stopped were discussed with the participant, and any concerns or emotions expressed by the participant were addressed.

This study opened with a very short briefing session, where informed consent was gained in order to conduct the interviews. The aims and the overall purpose of the study were openly discussed (Burman, 1994; Brinkman & Kvale, 2008). At this point, any risks and benefits, as well as issues of confidentiality, were discussed with the participant. It was stated that any data that could identify the participant would be removed and each participant would be given a pseudonym (Brinkman & Kvale, 2008). There was no direct benefit to taking part in the study; however, the participants may have found that telling their story could be an empowering process. The risk of the study was that the participants may have felt psychological distress during or after the interview, which may uncover experiences and memories that the participant had not dealt with or may not be ready to deal with, and these may have caused discomfort or distress. It may have been necessary for the participant to seek therapy after the interview in order to deal with these emotions, which is why free

counselling at the Emthonjeni Centre at the University of the Witwatersrand was provided. Feelings of guilt may occur, due to divulging this information. In the consent form, participants were informed that they could withdraw from the study at any time during the research process with no consequences. In addition, participants could refuse to answer specific questions and choose the level of detail with which they wished to answer. It is vital that the participants knew that participating in this study was voluntary (Brinkman & Kvale, 2008).

The use of a tape recorder also required a consent form to be signed by the participant (Burman, 1994). The consent form stated that the researcher and the supervisor alone have access to the transcripts and informed the participants about the researcher's right to publish the interview or some of it, subject to issues of confidentiality (Brinkman & Kvale, 2008). The recordings of the interviews and the transcripts were kept in a password-protected file on the researcher's and supervisor's computers. A written agreement between the researcher and the participant was signed and the consent forms were filed in a locked cabinet (Brinkman & Kvale, 2008). Debriefing occurred at the end of the interview. The research participants were given an opportunity to voice any feelings or concerns that they wished to discuss and were advised that they could have access to the transcript and the analysis if they so wished (Brinkman & Kvale, 2008).

The sample was difficult to obtain as only two people who were not known to the researcher responded to the research call, which meant that the researcher had to resort to a sample of people known to her. It is perhaps not advisable to interview friends or colleagues on sensitive topics, as this might change the pre-existing relationship once the researcher comes to know the details of participant's traumatic experiences. Additionally, participants may feel emotionally exposed in later interactions, which they could not have foreseen prior

to consenting to participate. Lastly, participants may feel that their ability to exert their right to refuse participation or to withdraw from the study may be influenced by their existing relationship with the researcher. However, due to the difficult nature of acquiring the sample needed for the study, it was not possible to exclude participants known to the researcher; extra care was taken with these participants.

Where a potential participant is known to the researcher before the study, the dynamics of the friendship will influence the way the data is produced. This aspect of possible bias was dealt with by the researcher assuring the potential participant in the strongest possible terms that she was absolutely free to participate or not and should not feel pressured by knowing the researcher. Should the participant agree to participate, before beginning the interview the researcher strongly adhered to the ethical principles of confidentiality and anonymity of the data. The researcher stipulated that this implied that she will never to divulge any of the material outside the research context and that the participant's identity would be disguised in the research write-up. It was clearly stated that the level of detail that participants wished to divulge was completely up to them. Participants were informed that they did not have to answer all the questions. If the researcher saw that a participant seemed to be experiencing difficulty or distress during the interview, she asked if the participant wished to take a break, or stop the interview entirely.

Recruiting participants known to the researcher may allow for possible bias in the research results. In order to deal with this, all analysis was grounded in the data that stemmed from the interview. No other information that was gained prior to the interview, such as knowledge the researcher may have about a participant, was used. Interestingly in this study, the researcher's previous relationship with the participant made her less open to discussing her experiences and the interviews were significantly shorter and details were less spontaneously offered. The interviews with strangers had richer data and a lot more content.



## Chapter four: Discussion of findings

### Introduction

This research report identified six main themes: 1. Relationship with mother: then and now; 1.1 Child and adolescent recollections; 1.2 Adult recollections; 2. Abuse and neglect; 2.1 Neglect; 2.2 Physical abuse; Emotional abuse and neglect; 3. Isolation, secrets and facades; 4. Emotional responses and adult relationships; 4.1 Self-concept and relationship with others; 4.2 Anger, guilt, ambivalence and sorrow; 5. Protective relationships; 5.1 The role of therapy; 5.2 Protective family members; and 6. Mental health services and the role of the diagnosis; 6.1 The absent mental health system and resistance to psychiatric treatment and 6.2 The importance of the diagnosis.

As found in this study, outcomes for adult children of mother's with a severe mental illness are heterogeneous (Brockington et al., 2011; Duncan & Browning, 2009). Most of the participants reported good grades, except Donna, and four went on to pursue tertiary education. Of these four, two completed their tertiary-level education and the other two were currently studying. The participant who did not manage to achieve at school and dropped out of tertiary education does have a job and is thinking about continuing her education later in her life. The richest dataset came from the oldest of the participants, Belinda, who provided a picture of her childhood all the way up to having to care for her mother in her old age. She provided insight into how she has adapted over the years and has had more time to deal with her experiences during her upbringing.

All the participants reported that while they may appear to be well-adjusted, the effects of their upbringing have had pervasive effects into their adult life. Three of the five participants reported having suffered a mental illness themselves sometime in their lives;

however, all believed they had adjusted better than their mothers did. All were compliant with their medication and sought treatment.

When speaking about their experiences, many of the participants chose to focus on their positive outcomes and progress with aspects of their difficulties with relationships and personal perception. Their recollections emphasised hope and their achievements to date rather than focusing on the negative experiences.

Only one of the five participants' mothers was in active psychiatric care. The rest had rejected psychiatric treatment and denied there was problem. Many of these daughters were not aware of the nature of their experiences and spoke about a concerning lack of strategies to identify parents with severe mental illness who are in need of support.

## **1. Theme one: Relationship with mother: Then and now**

### **1.1 Childhood and adolescent recollections**

As in the meta-analysis done by Murphy et al. (2011), the participants found their mothers' behaviour "difficult and confusing" (p. 3433) and reported tumultuous relationships with their mothers during their childhood, characterised by hatred, resentment, guilt and personal distance. Recollections of their mothers were characterised by ambivalent and avoidant reactions and the participants reported a lack of closeness, nurturance and love, similar to the participants in Duncan and Browning's (2009) study. However, it is important to note that this study did not assess the attachment styles of the participants.

All the participants can remember instances of unusual behaviour exhibited by their mothers. Anna recalled her mother's paranoia:

"My mom's quite a character but um - when she doesn't - not when she gets her own way. [...] My mom used to shout, "Call the police, call the police!" Run around. She stopped taking her medications. She

started seeing things ... [she] starts thinking that the FBI's out to get her, she starts seeing ghosts, she starts thinking her daughter's planning to kill her with her father. It's just ridiculous. You know, it really becomes - it becomes a joke the way they act sometimes ..."

The episodes of paranoia occurred after her mother stopped taking her medication. During this time Anna was viewed as the "enemy". Anna did not describe her experiences as frightening, but viewed her mother's behaviour as absurd.

Belinda spoke about how her mother had superstitions that she and her sister had to participate in.

"She also had a lot of superstitions which I found very, very strange. I mean, for instance, when we cut our nails or had our hair cut, we had to collect all our hair and burn it. So you could imagine this was quite an exercise, having to make a fire and then burn this because if somebody got hold of this - it was like our body parts. If somebody got hold of this they would put on bad spells etc. And we just had to do it."

Like G, in the case study described by Mander et al., (1987) some of the participants (Belinda and Donna) participated in their mother's unusual behaviour. Each participant reports a different motive for and appraisal of their participation in their mother's mental illness. Belinda reported participating in these behaviours to avoid confrontation with her mother, not because she thought the behaviour was valid. She reports being aware that the behaviour was unusual. She further recalled:

"I often felt that I had been hit between the eyes, you know, because I would come out with things and people would shake their heads and say, "Where did you get that crazy idea?" And I realise then that it had become part of my thinking, in a way, some of it."

She did also report that when she was immersed in the working world, interacting more with people other than her mother, she realised that some of her mother's unusual thinking patterns and behaviours had infiltrated her own way of thinking and behaviour. She only became aware of this through her interactions with others.

Donna stated:

"And what scares me the most is, when I drink, I understand her and like I can get along with her and the crazy shit she says and does, I can laugh at now but I understand it, which scares the crap out of me. Obviously I don't want to say I'm going to end up like her cause that's horrible to say but I really don't want to."

Donna participated in her mother's behaviour differently and mimicked her mother's treatment of her. She continued to do this this in her interactions with her mother by drinking with her. She elaborated:

"I'm scared because she started drinking at about my age and - I think she started drinking at about 22 or 23. So it's been a long time and I feel like I enjoy drinking quite a bit but I don't - I really don't like that effect of being really drunk and sick so it kind of doesn't push me to drinking every day and sometimes I test myself and say, "Listen, I'm not going to drink for a week or two. I'm going to see what's in control and what's not.""

This caused anxiety that she would one day become like her mother and she continually tested how long she could go without drinking. When recalling specific incidences of unusual behaviour during her childhood, Donna recollected:

"It's just - she's the most irrational woman on this planet. And like the smallest things would trigger her. Like it was crazy. My dad would boil the kettle and she would go fucking ballistic and then she

would throw hot water and mugs at him and I remember like, she - I think she locked me - ja she locked me outside a few times and I got so crazy and mad at her ..."

From the above quote, it can be seen that Donna employs humour to relay her accounts. She also reported responding to her mother's unusual behaviour with anger. She further recalled reacting in a manner that mirrored her mother's lack of reality testing. These behaviours included setting off firecrackers and locking her mother out of the house.

"I locked her in the garage. And then I went back after an hour and she had fallen asleep in the car, drunk [...] And we used to do crazy shit like set firecrackers outside her room because we were angry with her ..."

Ginny also reported her mother's lack of expression of love:

"I don't actually remember her saying, "Ginny, I love you." Her love was incredibly conditional. We had to be good. We had to do things her way and then she would be nice to us, sort of thing."

Ginny spoke about her mother's oscillation between regarding her as "the favourite daughter" and as "her juvenile delinquent" and her desperation to win her mother's love. It seems from her recollections that her mother's love was not freely available and that she needed to work for it and comply with her mother's demands. Despite being viewed as the "favourite daughter" she stated that she felt that she "could never do anything right."

Chrissie reported:

"... if I honestly had to believe she was evil then I would be in a situation where I would have to question why two people who didn't love me would have me and you know, a part of me has to believe that somehow she does love me. Somehow, not showing me affection but

buying me everything that she can afford to buy me is her way of telling me that she loves me. [...] I feel that some part of me loves her and I feel some part of me respects the fact that she had me and raised me the best way she could. She didn't send me to live with my biological father. You know, she has taken over the role as mother but not very well. You know, I feel my basic needs were always met. I had everything I wanted – and I always say this: I had everything I wanted but nothing I needed. I got the latest phone. I got a car, like I said nice clothes. If I wanted to do something, I probably could.”

Just before the above extract, Chrissie talked about how she assigns blame regarding her mother's behaviour to her illness (see theme five for further discussion). The alternative to believing that her mother's lack of affection and lack of ability to take up the maternal role were due to her illness was that these things were intrinsic to her nature and that her mother did not love her, a state of affairs that would be terrible for her. Chrissie reported that she never lacked basic care and material goods. She rationalised that this was the way her mother demonstrated her affection. When Chrissie spoke about how her mother provided for her financially, her primary concern did not focus on the provision of her basic needs but on the “luxury” material provisions as a way for her mother to demonstrate her underlying love. Chrissie rationalised this behaviour by saying that although her mother could not provide the nurturing role that she longed for, she was able to provide for her basic needs and encourage her learning. While it did not seem to be of primary concern to Chrissie, her mother fulfilled some of her learning needs by providing private schooling and opportunities to follow her career path.

She reported that even though her mother had not taken up the maternal role as well as Chrissie would have liked (fulfilling the nurturing role), she had done the best she could.

She focused on the possibility that her mother could have done worse and justified her statement by saying that she could have been forced to live with her biological father, which she framed as a worse alternative. She acknowledged that her mother's illness has impaired her ability to take up the maternal role. As a result of this, Chrissie conceded that she must have some respect and love for her mother. However, her use of the words "some part of me" suggested that it is not an overt love and respect.

Communication was also impaired by the mother denying or forgetting the conflict that arose between her and the participant, which resulted in an inability to engage in conflict resolution. Chrissie reported that this denial resulted in a lack of self-trust when recalling her appraisal of the event. Therapy has been an important aspect of Chrissie's coming to terms with the denial of events.

"And the next day she denied everything. It was like it never even happened. You know, learning a bit about it in therapy, is whenever you go through what is basically an abusive relationship that I had with her and she denies it, it takes away a little bit of my reality. So you start questioning it. Maybe I imagined it. Maybe it didn't really happen like that."

Ginny reported that when she spoke to her mother about all the things that had happened during her childhood, her mother had denied them and said that they had a happy childhood. Ginny addressed this by speaking to her sister to validate her experiences because her mother denied them.

"- But she's denying that all of this stuff happened when I was younger. She's saying, 'I'm not sure what you're on about. We had a loving childhood' [...] I remember because I was sharing the emails with Lauren at the time and saying, 'This is what mom was saying. Am I imagining things or did these things happen or didn't they?' Cause

I started, kind of, doubting myself. And they both [Lauren and Sharon] emailed me back and said, 'No, these things did happen. Mom's in denial. She's delusional'."

Donna also recalled a lack of resolution and stated that because her mother forgot much of their conflict, she felt that holding onto anger was futile.

"... and then the next morning, just to top it off, she forgets fucking everything so bring anything, you can't hold grudges, you can't do anything. You just gotta learn to get over it and carry on."

## **1.2 Adult recollections**

Unlike in the study by O'Connell (2008), all of the participants, except Ginny, reported that they had been able to repair their relationship and forgive their mothers. Many participants used strategies such as limiting time spent with their mother to improve their relationship. Some reported that moving out allowed them to begin repairing their relationships. Many of the participants utilised distancing, emotionally and physically leaving the situation, as a coping mechanism, such as was found in other research (Duncan & Browning, 2009; Mordoch & Hall, 2008 cited in Murphy et al., 2011). Each of the participants in this study used various tactics to physically and/or emotionally distance herself from her mother, both in childhood and adulthood. This coping mechanism seemed to still play a prolific role for each of them in maintaining their relationship with their mother.

During their childhood two of the participants, Donna and Chrissie, reported staying late at school and university in order to delay returning home. Donna reported:

"I liked to stay at school longer than what you should. You obviously go to school until 14:00 or 15:00, so I just fit in a lot of sport so I could come home a lot later."

Chrissie said, providing a lot more detail and reasoning:

"Coming home was just horrible. I used to, in first year, I didn't want to go home so I used to sit at this bar in the square and then I used to do my homework there, study there, just avoid her. Luckily my step-dad, being kind and understanding, was willing to pick me up at, you know, 20:00, 21:00 or 22:00 at night and that helped me escape a lot. On holiday, I would be on campus studying in the library, even if I had nothing to study for I would make up some kind of excuse to just be removed from the household and her crazy tangents."

Many of the participants, especially Chrissie, reported that moving out of the house and/or starting work was important for their own mental health. Chrissie stated:

"If you get to know me you'll also realise I speak of my step-father very highly because in my mind he saved my life. He was the one, knowing that he couldn't afford it, finally told me that I was allowed to move out of the house. And I believe that's when I started living."

Anna was the only participant who had been removed from her mother during periods of her childhood and she believed that this is what stopped her becoming like her mother. Anna acknowledged that removal from her situation by her grandparents and the physical distance that granted her were probably what helped her to cope with her experiences.

"I know that if you're in a family too long you start to model their behaviour. I think it's pseudo - you know like they say that you mustn't be around mentally ill people because you start modelling and you become mentally ill unless you're removed and my grandparents helped me a lot."

Donna and Anna all talked about needing to limit physical contact with their mothers. Distancing played an important role in maintaining their current relationship. Donna reported that she could love her mother "from a distance", suggesting that personal space is an

important coping mechanism. When speaking about how she managed to improve her relationship with her mother, Anna reported that she did it by “limiting her time” and that she “can’t be around her too much.”

All of the participants reported utilising emotional distancing in order to cope with their experiences. The ways in which this manifested ranged from refusing to talk about personal topics with the mother, refusing to get drawn into conflict, wishing to be removed from the situation during childhood and feelings of indifference towards the mother. Most poignantly, when examining the participants’ reported indifference towards their mothers, Donna stated:

“If I get a phone call saying, “Hey, you know your mom’s stuck here or she doesn’t have money or she doesn’t have a place to stay or she doesn’t have a job”, I’m just numb to it. I don’t care. I mean for a long time, I used to kind of wait for that call to say, “Hey, could you please identify your mother’s body”’ and I’d be like, “Yus, relief!””

However, there is a tension in what she is saying when she later states:

“I understand her a lot more now where before I used to get so frustrated and angry because she made no fucking sense at all. And I was just, irritated. I was like, “Why’s this crazy woman doing these things?” And she’s explained a few more things to me now, why all these things happen and this and this and that. She has apologised but it does just feel empty and I don’t want apologies. I just, to be honest, I just want her to be happy and live her life. If I only see her once a year, it’s fine by me. As long as I know she’s safe, she’s got money, she’s got a job, she’s got a partner and she’s living. That’s it. It’s cool by me.”

It seems that, although Donna reported feeling indifferent to her mother, she did still care and wanted her mother to live a self-fulfilling life. She maintained that she still wanted the distance but wanted not to have to worry about her mother, which is currently not the case. She reported that apologies given by her mother seemed empty.

Ginny has cut her mother out of her life not only physically but emotionally. The statement below demonstrates her feelings of indifference towards her mother. However, there seems to be some uncertainty surrounding how she would feel in this situation.

"I don't know how I will feel if I got news that she had passed away. Will I cry? Will I go to the funeral even? At the moment, my answer is no."

**Belinda reported using emotional distancing to cope with her mother:**

"I remember my husband saying he will never - "We will always be together. You will never leave." And I said to him - One day we were at my mom's place and he could see how I distanced myself. She was having another tantrum and my sister was - you know, she would hook you in. She knew just what hurt. She would throw out these things and she would immediately start defending herself and then it would end up in a screaming match. And she tried - she said something to me and I said, "Okay, if that's how you feel. And I carried on - I remember we were having supper, I carried on dishing up for the rest of the family. And my husband always watched this and I think he'd quite enjoy this interaction, seeing me get upset, and he said, "I can't believe how you're handling your mother." And I said, "Yes, it's taken time but I realised that it's not impossible." And I said, "The same goes for you." I said, "I can't say that the divorce won't hurt but I can say that I can now see that I can do the same with you and

I can unhook myself emotionally from you and I will do it." And that's exactly what I did."

This mechanism allowed her to refuse to be drawn into conflict, take control over her interactions with her mother and speak her mind about her mother's behaviour. It also allowed her to claim back her life from her mother's control.

Belinda, Anna and Chrissie found that realising that their mother had an illness allowed them to gain insight into her behaviour. Chrissie recalled: "The understanding also came when I was diagnosed with it." Chrissie had been diagnosed with type II bipolar affective disorder two years before and this was pivotal to her understanding her mother's behaviour (see the final theme for further discussion). Anna remembered:

"As soon as I entered in psychology, I became educated. I started realising, geez, there's a real big problem. And ah - and through therapy and actually through the campus psychology, there I actually formed a good relationship with my mom. As soon as I understood her and I actually felt sad for her. I felt sad for her because - I forgave her obviously for everything. I also tried to forgive myself because there are two sides to a story. I wasn't an angel either. I was - I was difficult because I was feeling this way and I was a difficult person as well."

Anna realised this when she started study psychology at tertiary level and recalled that this allowed her to forgive both her mother and herself. Interesting to note is that Anna still frames her mother's illness in such a way that she (Anna) is partially accountable.

Belinda stated:

"I think once we realised it was a mental illness - [the understanding came] [...] Had it been explained that this was actually a mental illness, there isn't really a cure. We can treat symptoms.

That's how it is. They're very difficult to live with but that's just how it is. I think we would have understood early on ..."

Belinda reported that her mother was only diagnosed during her seventies. When speaking about how her understanding of her mother's illness had changed over time, she stated that the understanding came when she was diagnosed (this is discussed further in the final theme).

Chrissie, however, reported when asked about her current relationship with her mother that "It's better?" The question suggests that it is moderately better but still lacking in some aspects. It being better, however, does not suggest that the relationship is good. Her primary concern about her relationship with her mother remains a lack of communication. However, as with both Anna and Donna, moving out and gaining space was an important coping mechanism. Chrissie emphasised that moving out was the most beneficial thing for both her relationship with her mother and her ability to live a normal life. However, despite this Chrissie remained quite protective of her mother and stated that she did not allow other people to speak badly of her.

"I don't allow too many people to use the phrase, "Your mother is a bitch" in front of me. I do take offense to that. I do believe that if you understand the situation fully - the only person I wouldn't tell to stop is my best friend because he almost entirely understands the situation as well as I do. Other people, don't say that. It's kind of offensive. I'm allowed to say that. You can't say that."

Both Anna and Donna reported feelings of sympathy towards their mother. Donna reported that she "just started feeling sorry for her". Anna's accounts are quite similar and she stated that she "actually feel[s] sad for her". However, the participants who managed to

forgive their mothers reflected that this did not negate the effects of their experiences and that they still struggled with a lack of self-worth.

Ginny was the only participant to cut off contact with her mother, and did so when she was 36. She stated:

"You know it was in 2010 that I finally - I was 36. Mom was having a go at me for what decisions I'd made in my life and I eventually decided so far and no further and kicked her out and I was angry for a long time afterwards because she actually cost me a job."

This is interesting to note, as the other participants are much younger than Ginny and their relationship with their mother still appeared to be fluid. So, although at the time the research was conducted they were able to forgive their mothers and establish what they reported to be a better relationship, this may change over time.

Ginny reported utilising a colleague's narrative about cutting contact with his family to gain "courage" to have no further contact with her own mother. This was important for dealing with her feelings of guilt.

"It was actually one of my colleagues who told me that when he married his wife, he took on her surname and he cut his family out because he wanted nothing to do with his family, they were that bad. That gave me the courage to say eventually, so far and no further and kick mom out of my life and not feel guilty about it."

Belinda was the only participant to speak about her grief and sorrow at the loss of opportunity that her mother's illness brought.

"I would say another emotion was sorrow in a way that we didn't know. Or sorrow that that some of the relationship had been damaged by the illness and looking back on her good times we could have had a lot

more good times. I get emotional thinking about it. [...] I think this is the heartbreak I think with mental illness. It's just so, because it's in the head, it involves everything: emotion, thinking, all the rest of it, whereas somebody who is in a wheelchair you can still relate to and have a relationship with. [...] You could just look at it and think, "This person has a problem and this is how we handle it." And then get on with it. You can't do that with borderline. There's no way - there are helpings with this book, there're coping strategies, there are ways of making the person realise what they are doing and working - if they really feel strongly enough about the relationship, mainly couples and that who want to stay together, but one has borderline personality, but it's difficult. It's not cut and dried. [...] You have to look for different strategies all the time. You're constantly thinking of ways to try to cope."

Belinda felt sorrow for the loss of the relationship and "good times" with her mother. She elaborated by saying that dealing with physical disability was easier than dealing with a mental disorder, and that while it is possible to come up with a consistent method of coping with a physical disorder, with a mental disorder a person has to constantly develop new strategies.

All the participants reported feeling anger towards their mothers. The reasons ranged from anger because the mother did not seek treatment, anger because of her lack of reality testing, and anger because of various actions by their mothers. These feelings persisted into adulthood and many of the participants still felt anger.

## **2. Theme two: Abuse and neglect**

According to Brockington et al., (2011) the needs of children that parents must address are basic needs, safety and emotional warmth. The potential harmful effect of

parental mental pathology is child maltreatment, which includes physical abuse, neglect and emotional abuse and neglect. Each of the participants reported that she had experienced either physical abuse, neglect or/and emotional abuse and neglect.

## **2.1 Neglect**

Neglect is defined as “the persistent failure to meet a child’s basic needs and rights, resulting in serious impairment of health and development” (Dubowitz, Newton & Litrownik, 2005 cited in Brockington et al., 2011: 97). It includes the parent failing to feed their children, leaving them unattended for an extended period of time, failing to teach or look after basic hygiene, failing to provide timely health care and parentification (Smith, 2003). In this study, the participants reported that their basic needs were often fulfilled. While none of the participants reported experiencing homelessness and poverty, this could be attributed to the sample being primarily middle-class. In addition to this, all the participants had had a protective caregiver who was able to step in and fulfil their basic needs. However the participants in this study did experience parentification and were often tasked with cooking, cleaning and looking after younger siblings.

Belinda recalls:

“I think she had periods of depression which immobilised her but when she didn’t, she looked after us very well, in fact, over-protectively. She definitely was a helicopter mom. But we were clean most times. She would be really worried about our cleanliness and food and that sort of thing. Then looking back, the depression would set in and then it would be the case where she was just so immobilised she wouldn’t care and that’s when we would take over. Sometimes she would go to bed for three weeks and we would just have to take over. We would do the washing, the ironing, and my dad would help. In the evening, he would fill in and feed and shopping. She would sort of

run everything from bed and say, 'Go run down and buy X, Y and Z for supper tonight' and then we would often - sometimes she would - often she would get up and cook but some of the time we would just have to. She would just leave it in the middle. Just put the stove off and say, 'I just can't do this anymore' and go to bed and we would have to continue."

Belinda recounts that the only time her basic needs were neglected was when her mother suffered episodes of debilitating depression. During these episodes, Belinda, her sister and her father took over the household duties. However, when her mother was well, she tended to be over-protective and always concerned with their basic needs. Belinda framed her mother's over-protectiveness positively. This may be because she compares it to her mother's episodes of depression, when there seems to have been an absence of care, and over-protectiveness is preferable to a complete absence of care. These are two extreme parenting styles and neither is optimal. When her mother suffered debilitating depressive episodes, her father and sister played a protective role in being able to spread the responsibility of cooking and cleaning between them.

Many of the participants were required to fill a parental role in the family before they were emotionally or developmentally prepared for it. However, as Gladstone et al. (2006) warn, there has been little exploration of what the child's caring duties entail or how they experience their role as a caregiver. This study had mixed results regarding the experiences of their caregiver role. For the majority of participants, the caregiver role entailed cooking, cleaning and looking after younger siblings. These responsibilities were experienced by many participants as being beyond their abilities and maturity; the effect of this seems to have been that participants felt they had missed out on a normal carefree childhood.

One of the participants, Donna, reported that in addition to this she had had to look after her mother.

"... my role was to like take care of her, all of us. Like when my dad left, I had to do everything. I had to help cook, clean, all of that, so - and then make sure she would wake up, not get too drunk, fall asleep in some strange area and die or - basically the role was to look after, especially when my dad left, like I couldn't leave her home alone because I felt too guilty ..."

She reported that having to look after her mother caused her feelings of guilt and isolation. She was unable to leave her mother unattended because of the possible consequences, and she assigned responsibility to herself to manage these. This role came about because of the removal of her father, who was the protective adult.

When speaking about her caregiver role, Belinda stated:

"... we'd start making beds. One would clean floors, one would do dishes and by the time my mother arrived, the house would be sparkling and we would have a tray of tea waiting for and sandwiches and everything and we would say that we've been working so hard. Never occurred to us that we had actually been at school and we'd clean the house in the afternoon that we had been working hard. We had the energy so we just did it. That's - we were always counter balancing, seeing what we could do to de-stress her. So we took over a lot of things that probably we shouldn't have at that stage."

In contrast to this, Belinda did not find that the caregiver role she played, cooking and cleaning for her mother and looking after her younger brother, was damaging for her. As with the research done by Smith (2004), it seems as though taking on the caregiver role provided

Belinda with a survival role that gave her the tools to manage her mother's emotional outbursts.

Ginny reported on the caring role she had to play for her siblings and being placed in a position of being an "informant" for her mother.

"I kind of unknowingly became a bit of an informant with regards to the rest of the family, Lauren and Sharon and Dan. You know, if mom wanted to know anything about them, how they were feeling and that she came to me because they all spoke - they all came to me. They all came and chatted to me about stuff and ja - So I kind of ended up in a very awkward position and it didn't make me feel very good. And all the time I just blocked off what I needed to do cause Lauren needed to talk, Sharon needed to talk, Dan needed to talk, so I was there for them and I felt so bad about being the favourite daughter and even though I could never seem to do anything right."

Ginny had ambivalent feelings about her role as a caregiver for her younger siblings. She reflected that her mother used her to gain information about her siblings and she had to play a "double-agent" role, as her siblings used to speak to her about how they were feeling. Because of the difficulty of the situation, she denied her own needs and placed the needs of her siblings above her own. In this case, the role of caregiver for her siblings placed an increased strain on Ginny, as her own needs were neglected.

Both Chrissie and Donna reported that having to take on responsibility early resulted in premature psychological maturation and they felt that they had missed out on the childhood experience. Chrissie reported:

"But I don't feel that I lived as vitally as other people did because a part of me was always, "So I've skipped a step. I'm now an adult. I need to take hold of my life." [...] I'm the kind of person that can

live with people about the same ages, say ranging from 19 to 22. I'm 21. So when they go out at nine or ten at night, I came out in my dressing gown and I say, 'Be safe kids. Call me if you need a ride home. Don't drive drunk.' Lock the gate behind them. You know, I was always sort of mothering them. It's very hard for me to find friendships ..."

Chrissie found that her experience of being forced into early maturity now makes it difficult for her to relate to her peers, and she often plays a "caregiver" role for them. Donna said something similar:

"I just want to be a reckless kid one day. I just want to go wild, run around naked, and if somebody asks me why, 'Cause I'm a kid! So shut up.' And then they go, 'Okay.'"

## **2.2 Physical abuse**

Parenting styles characterised by clarity and consistency are deemed to be the most beneficial for children's development (Louw & Louw, 2007; Seeman, 2010). Many of the participants experienced their mothers as lacking consistency and clarity because of their unpredictable moods and behaviour and the lack of logic that governed this, which exposed the participants to an unsafe home environment characterised by what they experienced as inappropriate expressions of anger. This inconsistency made it very difficult for participants to develop a sense of appropriate social boundaries and to discriminate between acceptable and unacceptable behaviour. In addition, the maternal volatility and inconsistency meant that they were unable to modify their behaviour in order to avoid punitive responses. Many of the participants reported that they withdrew from their mothers in order to avoid punishment. In addition to a lack of consistent and clear boundaries, this irrationality hampered open communication, causing conflict that often resulted in violence, verbal and/or physical abuse.

One of the participants, Ginny, reported that her mother's unpredictable behaviour exposed her to unsafe situations, such as walking around the neighbourhood at two in the morning to look for her mother's husband, who was their adoptive father.

"Gone wondering the streets at night at 2 o'clock in the morning looking for Chris because he's run out the house and mom's then collapsed into a crying heap on the floor begging him to come back and, 'Please you must go and find him!' She can't be without him."

Anna recounted that when she made a request to her mother in a public sphere, her mother hit her. However, the primary concern of Anna's account is not the physical abuse but her feelings of humiliation.

"I was at the movies with my friend, meeting my friend, and I went to go ask my mom for extra money, I don't have enough for the movie and when I asked her she slapped me in the face and it wasn't so much the slapping me in the face, it was the embarrassment that everyone was looking around me and that was a one of the few instances in my life where I was embarrassed by her ..."

**Chrissie stated:**

"So walking to the kitchen and all of a sudden, you know this loving mother that I had five minutes ago turns around and she was like, 'Why are you chatting to people about me?' But it was really aggressive and she started calling me names. I don't remember her exact words. And then she grabbed me by the arms and I said, 'Don't do this to me.' She was like, 'You're such a skank. You're such a whore.' And then she started hitting me and punching me and she actually gave me a blue eye."

Chrissie remembered an instance where her mother's paranoia caused her to misconstrue that a conversation Chrissie was having on the phone with her friend was about her (the mother). Her mother responded with physical and verbal aggression. Her account described her experiences of her mother's reactions as unpredictable.

### **2.3 Emotional abuse and neglect**

Although participants' mothers did not suffer from the same psychotic disorder and their experiences of unusual maternal behaviours were different, they all described their mother's behaviour when ill as unpredictable and out of touch with reality. These experiences caused them to feel very frightened and unsafe. This concurs with the findings of Duncan and Browning (2009).

Most of the participants' experiences revolved around a lack of maternal emotional attunement and responsivity to their needs (Seeman, 2010). Responsivity to children's needs is characterised by open communication, low levels of criticism, high levels of emotional warmth and praise, consistency and reasonable limits (Seeman, 2010). Brockington et al. (2011) define emotional neglect to be when parents are unable to respond to their children's needs for affection and assistance because they are emotionally distant. Emotional abuse is characterised by hostility towards the child that is belittling, humiliating, conveys worthlessness, ignores them and isolates them. The participants in this study reported both emotional abuse and a lack of emotional attunement.

Ginny recalled:

"She would always goad Chris into having an argument with her and then she would be yelling and screaming at him from about ten o'clock at night until god knows what time in the morning. Very often in the week as well and she had a habit of after a couple of hours of yelling and screaming at Chris, then coming into Lauren and my room,

waking us up and bringing us into the lounge wherever it was that they were arguing and basically then just saying, 'Your father this. Your father that. This is what the argument is all about.' And just basically involving us in the argument, which had nothing to do with us in the first place. So yeah, a lot of the time we were woken-well, apart from the fact that we were awake anyway when they started arguing, we were hauled out of bed and involved in the argument and, you know, Chris was our step-father so we automatically took my mom's side for the most of the time and until Lauren and I were about 13, 14, then we started realising that Chris isn't the problem and we started trying to be nice to him, I suppose, in the argument, not always taking my mom's side and basically just taking my mom's side to keep her happy and quiet, to quieten her down and calm her down. But yeah, I've taken a knife out of my mom's hand during an argument. We've taken her fingers out of Chris' hair."

Involvement and exposure to domestic violence is also considered to be emotional abuse (Brockington et al., 2011). Ginny recollected often having to join in the domestic disputes between her mother and her adoptive father. This also exposed them to violence, such as needing to take a knife out of her mother's hand.

Many of the participants experienced a lack of attunement by the mothers. As experienced by the participants in Duncan and Browning's (2009) study, their mother's reactions were nonsensical to the participants and resulted in feelings of mistrust, instability and insecurity. Anna stated:

"... it was all of the instability over the years. It's fine, everyone has problems but it's the leftovers of the all the insecurities I have. It's the big problem with me now. The insecurity of having - feeling like a burden to my grandparents feeling so dependent on them

the whole time, since I was young and I'm still dependent on them financially so that is quite a big thing."

Anna particularly reported that because of the lack of stability in her home life, a search for stability in her life has become a prominent concern. She reported that the most difficult thing to come to terms with as an adult was the instability and feelings of insecurity. It was not just her mother's mental illness that she reported finding damaging, but the circumstances surrounding it. Being sent between her mother and her grandparents seemed to create a lack of stability and a feeling that she did not have anywhere that she belonged.

As with the study by Duncan and Browning (2009), many of the participants reported that their mother was "psychologically 'absent'" (Duncan & Browning 2009: 84) as opposed to physically absent. Most of the participants reported a lack of warmth and instances where their emotional needs were not met. Despite giving examples of physical and verbal abuse, Chrissie described the worst instance of her mother's behaviour as her mother's unresponsiveness with regards to her needs, which resulted in reduced affection and lack of support.

"Growing up I did ice-skating. I skated for Gauteng North and then I did a lot of competitions but I remember one in particular. Between the ages of six and eight, I'm not sure what the time from exactly was, when I fell twice while doing my, you know, piece on the ice. And there's the tradition in ice-skating where the parents and everyone throws teddy bears and roses on the ice rink for you. So, you bend down to pick it up then you get off the ice. I remember that day in particular she didn't throw anything on the ice for me and when I got to her, she completely ignored me. She didn't look at me. She was like, 'Your stuff is in the bag.' So it was this complete feeling of, you know, you're young, you're trying to get your parents' approval yet nothing I ever did was good enough because it

was always surrounded by how she was feeling and how her outbursts were making me feel.”

**Ginny reports:**

“... we [Ginny, Sharon and Lauren] kind of realised that what we’ve been through was kind of emotional abuse and those scars are really hard to see.”

This hostility to her displayed by her mother made her feel as though she could never do anything right, and her low self-esteem has persisted into adulthood. Ginny as an adult regards what she experienced with her mother to be emotional abuse and stated that the effects are long-lasting and persistent.

Many of the other participants reported high levels of hostility and criticism from their mothers. While at times the participants experienced their mother as absent, interactions with her were also characterised by intrusiveness. The primary concern shown in Ginny’s account is that her mother violated the boundaries between mother and daughter and did not fulfil the appropriate maternal role. Inappropriate disclosure by a mother to a daughter is a form of emotional abuse.

“... the level of friendship and discussions that she had with me about, you know, especially about sexual problems she was having with Chris, which a mother should not really be sharing with her daughter.”

Donna spoke about how her mother’s persistent belittling and criticism had influenced her perception of self and how she still struggled with how she views herself. Particularly, a concern raised by Donna is that she was unsure of her mother’s current perceptions of her and if they are positive or not.

"... she knows how to get to your weak spots. She would tell me I was stupid, was fat, I was ugly. So many things and I believed it for a long time. I thought I pretty incapable, pretty fat and ugly, pretty useless. Still do sometimes. But I guess you get over it after a while. [...] Being called stupid all the time [was the hardest to get over] and being told I was incapable and being told, basically, I was too ugly for anyone to love, all the normal things you actually want in life: Someone to accept you, someone to have a normal conversation with you, to find you attractive, to want to be with you. I didn't think I would have any of that because I was too incapable and ugly. So I don't know why she did it. She still does. She went through a stage where she was like, 'Oh my god, Donna, you're so fat and huge and blah, blah, blah.' And now she's like, 'Why you so skinny? Blah, blah, blah, blah, blah!' It is one extreme to the next. I never know if she actually, genuinely thinks I'm her pretty daughter. I don't know what she tells people. Sometimes she doesn't even tell them I exist. So honestly I don't even know what she says to them."

### **3. Theme three: Isolation, secrets and facades**

Many previous studies (Brockington et al., 2011; Dunn, 1993; Foreman, 1998; Gladstone, Boydell, Seeman & McKeever., 2011; Seeman, 2010; Williams; 1998) found that social isolation, among other factors, is more common in families where a parent has a mental illness and this is more likely to result in negative outcomes for the children. There are two types of isolation that the participants brought up during the interview. The first is social isolation due to fear of stigma. The second is that their mothers also dissuaded them from engaging in peer relationships. According to Brockington et al. (2011), isolating of children by mothers is considered to fall under emotional neglect and abuse and is called social deprivation. The participants in this study who were isolated from their peers and

extended family members reflected that this resulted in a lack of input of ideas from external sources, a lack of support structure and an inability to seek out help.

Many of the participants reported that during their younger years they did not speak about their experiences with their mother to other people due to their fear of stigma. Anna stated:

"I felt a lot of people, firstly, were not educated enough, were ignorant, and I think a lot of friends also judged me for a mental illness. I think people looked down at me having a mother like that."

Anna recalled that she did not speak to people because she felt they would not understand her because of their ignorance of mental illness, and this resulted in stigma. Earlier in the interview she stated that she believed that no one understood her, including both her parents and her grandparents. While Anna desired someone to speak to regarding her experiences, she nevertheless did not initiate conversations with her peers due to fear of stigma and a belief that they did not possess enough knowledge about mental disorders to be able to provide adequate support. This, did, however, result in isolation from her peers.

Donna also did not speak about her home situation. However, her motivation was not a fear of stigma due to her mother's mental illness, but a desire to not be viewed negatively by others in terms of being "needy and weak". From the extract below, it seems that Donna desires to be seen as self-sufficient and is reluctant to display vulnerability. At this point in her life she does talk about her mother's mental illness but tells it as a joke as she is afraid others might pity her.

"In the beginning I obviously didn't want to talk about it because I didn't want to come across as like needy and weak and complaining and this and that so in my mind that's how I thought I was going to come across. And I still do. That's why I hate talking about it sometimes

but it is better. The way I tell them is like a big fat joke so they laugh and I don't tell them about the seriousness. I guess to me it's still not serious and if I do, like I'm talking to you now, I guess you can see that it's somewhat serious. But they don't take it seriously. They just think it's one fat joke, which I like because I don't want them to treat me differently. I don't want them to go, 'Oh shame. Your mother did this to you and you had to go through that.'"

When offered an opportunity to speak about her home situation by the principal of the school, Belinda did not take up the offer because she believed that others would not understand her situation. She concluded that she had taken up the role of maintaining the image of the family that her mother was adamant to preserve, instead of speaking about her situation. Her silence about her family situation can also be seen as protective of her parents, and taking a caregiver role in protecting the image cultivated by the family, as can be seen in the following excerpt.

"“You better get home. Your mother's really worried about you.” So I went off and the next day the headmistress called me in and said, ‘I've always seen you as a very sort of ...’ She used another word but I think one could say ‘mousy sort of person’. I was always in the corner apologising and trying to stay out the way and do everything right and that all that sort of thing. And she said, ‘After your mother phoned yesterday and the way she screamed at me, I began to understand.’ And she said, ‘Is there anything you want to discuss? Can we have a talk?’ And I - I mean I was in, second last year or matric year of school and that was the first time - of course, and again you can't explain to people but for so many years you have brought up - I suppose it's a way, it's called enabling really, you have surrounded this person of projecting this view that we are this perfect family and everything's fine and this type of thing and of

course we were. There wasn't time to step out of line or rebel or anything because we were so busy looking after my mother so we had taken over as carers. And I think it was the first time that somebody had asked this sort of question but I couldn't talk to her. I said, 'No, no.' She said, 'Do you want to talk to me about your home life?' And I said, 'No. No there's nothing wrong. It's all fine. Sorry she shouted at you. I'm sorry about that.'"

Pertaining to the second type of isolation, Belinda spoke about how her isolation from peers allowed her mother's unusual ideas and behaviours to become her own. Exposure to external people during her time working was of paramount importance in identifying the areas in which her mother's thinking had become her own. Although she was an adult, she was still able to identify and adapt her maladaptive ways of thinking.

"I often felt that I had been hit between the eyes, you know, because I would come out with things and people would shake their heads and say, "Where did you get that crazy idea?" And I realise then that it had become part of my thinking, in a way, some of it. Some of it, the very bizarre thoughts, I still shook my head about but many ideas that she had brought us up with, I didn't realise had become part of my thinking so it was only when I - because of course we weren't allowed to have friends, we weren't allowed to go to friends, etc. So I had no sort of peer - very little peer interaction. I mean I can remember my whole teenage years I went to a movie once with friends and that was just such a big occasion. We went into town by bus and we saw a movie one afternoon and that was just a highlight that really never happened again. It wasn't really before 16 where I was allowed to go out without her. So I had no peer relationships to, sort of, bounce ideas off. So the only people I got ideas off really were my teachers and they didn't go into those sorts of things. You know we obviously just did school work, and my mother. So a lot of

ideas about life I got from her so it was only when I started working that I actually realised that there was another way of looking at things."

Two of the participants experienced being isolated from their peers by their mother. For one of the participants, this was a central issue when discussing her childhood. Ginny recalled that her mother controlled who she could interact with and when she could go out with friends. Invariably, she found that she could not go out and eventually stopped asking. She recollected:

"Friends at school - I was allowed to have friends but as soon as I started, you know, acting in a way that my mom didn't like so if I stepped out of line or back chatted her or something like that, it was all my friend's fault and then I had to then - I wasn't allowed to be friends with them anymore and I was the one that had to go tell them the next day at school, "Sorry, my mom doesn't want us to be friends anymore. We're not allowed to be friends." Which was quite-quite hard.[...] Every time we had friends invite us out for stuff, you know, we first had to get mom's permission obviously. And she would, after a mirage of questions about, "When is it going to happen? How long is it going to happen? Who's going to be there? Who's not going to be there? What you going to do?" She wanted a blow by blow account of everything we were going to do before she would eventually say no, we couldn't go. So, I mean by the time we were teenagers when friends invited us out we would just no straight away because we knew we'd never be allowed."

In addition to isolating Ginny from her peers, her mother isolated her from her father and her grandmother. Once her mother had cut her father out of their lives, Ginny was never encouraged to speak about him or contact him. Her mother isolated her from her grandmother

by telling her that Ginny needed to be treated strictly (as can be seen below). This resulted in her removing two possible support structures for Ginny that may have acted as protective figures. Her isolation from her grandmother was an emotional isolation and resulted in feelings of anger and hurt.

“When I was younger I thought my Ouma hated me because she always treated me at arms-length and she always seemed to be very stern with me and I always thought I was doing something wrong whenever I was in her presence and she told me recently that that was because mom had told her that from day one I was going to be a teenage delinquent and I had to be treated very strictly and all that sort of stuff, which I feel pretty offended about.”

#### **4. Theme four: Emotional responses and adult relationships**

##### **4.1 Anger, guilt, ambivalence and sorrow**

As described in previous literature (Dunn, 1993; Gladstone et al., 2011; NaMetris, 2013), guilt and self-blame emerge from many of the participants' accounts. Some of them appeared to have experienced feelings of guilt, although their reasons differed. However, this was not true for all of the participants: two, Chrissie and Belinda, said that they did not feel guilt. Anna was the only participant to experience feelings of self-blame.

Ginny's account revolved around feeling guilty about her hatred for her mother and her feeling that it is a daughter's duty to love her mother.

“I think we were in our teenage years that we really, that I really started hating - started hating what was happening but feeling guilty for hating my mom because she's my mom and I must love her.”

Donna is the only participant to perceive that she was abandoning her mother, as described by the participants in the research by Dunn (1993). This could be because the rest

of the participants' mothers were reported to be relatively financially secure or have a financial support system in place. Donna's mother was the only one experiencing poverty and homelessness. Donna also felt the responsibility to provide for her mother, which she does not have the financial and emotional resources to do. Donna's guilt also seems to revolve around feeling as though she is moving on with her life and is generally having good experiences, while her mother is not.

"... when I'm feeling like I'm having a really good time, I just - I start getting guilty 'cause I know my mom is staying somewhere where she really doesn't want to be. She's staying with people she really doesn't want to be with. She's in a situation - she's stuck in a hole and she can't find the top. And then here I am, having so much fun with the food I wanna eat, with the people I wanna be around, with the drinks I wanna drink, with whatever I wanna do and she's stuck. So I do feel guilty ..."

Belinda maintained that she did not have strong feelings of guilt in relation to her mother. She said that whatever harm (her word) she may have caused in relation to her mother was offset by a multitude of positive actions that she and her sister had put into the relationship with their mother. In an interesting quote (below) she allowed herself a sort of margin for error by acknowledging her flaws and that her relationship with her mother could not always be conflict-free. This quote seems to show her internal wrestling. She stated later that she often had to curb her feelings and stop herself from engaging in conflict with her mother because she was not always able to resolve the conflict effectively.

"Not so much guilt in that I think it was balanced in that I know what we put into the relationship, my sister and I, was over and above whatever harm, and I mean it maybe verbally or something like that, when I shout at her or get angry with her, I think we had a lot

of plus on our side. There obviously minuses. We weren't perfect individuals ..."

Interestingly, while Belinda never openly stated that she blamed herself for her mother's behaviour, she reported that she often felt apologetic for being present as it put her mother in a bad mood.

"I think because I remember early on just, you know, thinking, 'Well I didn't really do anything.' Or, it wasn't so much things I hadn't done. That I just felt apologetic anyway, thinking just by here I'm putting her in a bad mood."

Although her rationalisation of her lack of guilt is different to Belinda's, Chrissie, by assigning responsibility for her mother's actions to her mother, was able to avoid feelings of guilt and self-blame.

"I never quite thought it was my fault. It's not my fault that she reacted that way."

Anna's feelings were different from Belinda's and Chrissie's. She reported that before she fully understood what a mental disorder was, a revelation she had when she began studying psychology, she blamed her mother's behaviour on herself.

"I knew there was a big problem. I blamed it on myself."

#### **4.2 Self-concept and relationships with others**

Many of the participants struggled and are still struggling with a somewhat negative sense of themselves, as found in other research (Gladstone et al., 2006; O'Connell, 2002 cited in Murphy et al., 2011; O'Connell, 2008) which includes feelings such as: a sense of incompetence, low self-esteem, self-blame, and feeling unworthy of love to a greater or lesser extent. They reported that these negative perceptions impacted their current and past

relationships with others. For example, Donna spoke about how her mother's constant belittling had resulted in a persistent lack of self-worth.

"I believed it for a long time. I thought I pretty incapable, pretty fat and ugly, pretty useless. Still do sometimes."

Anna also feels she lacks self-worth and is incapable:

"... the best thing for me to do was actually to get married and have kids. That was the only function for me to do. I wasn't smart enough to do anything else and aim for stability."

Ginny reflected an over-concern about her self-worth in relation to others. She doubted whether she would ever get to the point where she had dealt with all the difficulties.

"Trying not to be so worried about what other people think. Am I good enough? Getting that feeling of total incompetence and humiliation as soon as I make a mistake. I'm getting there slowly but I don't know if I'll ever get there fully."

Some of the participants, such as Anna and Donna, were in stable, long-term relationships. Anna reported that her boyfriend had been a source of stability:

"... what has helped me a lot was my boyfriend. It was the first time in my life where I felt stability."

Chrissie and Belinda reported difficulties with the selection of an appropriate intimate partner and inability to leave the relationship. These are discussed in more detail below.

Ginny was the only participant not to be in a relationship at the time of the study. She reported:

"41. I'm still single. I'm not good at relationships. I don't want to meet someone and have to introduce them to her and to have her

destroy his life as well. I don't want to have kids. Part of that reason is that I don't want to pass on any genes that I've inherited from her. 'Cause I know there's something not right. I don't want to become her as a mother."

The reason she provided is that she does not wish to have to introduce her husband to her mother and she is afraid of having children because she believes that there is a genetic component to her mother's behaviour that may be passed on. This motivation has little to do with a mistrust of others, but involves fear of becoming her mother and passing those genes on. She reported that her fear of becoming like her mother had motivated her choice not to have children of her own and not to enter into a serious relationship.

One of the participants, Chrissie, reported that she still found it difficult to make friends because she viewed herself as more mature than and as having different interests to her peer groups. During her childhood, her friends formed important lifelines for coping. Donna, too, found that her best friend was an important coping mechanism as she used to be able to confide in the friend and express her feelings and experiences. None of the participants reported having difficulty making friends because they were different.

Chrissie reported:

"It's the same with friendships and people I work with, constantly seeking acceptance. When people are mean to me I don't go, 'Hey, that person's mean.' I go, "What did I do wrong to make them react that way?"

Some of the participants reported difficulties with conflict and assigned blame to themselves. Chrissie did report that she constantly sought acceptance from others and assigned responsibility for others' reactions to herself. This quote demonstrated Chrissie's lack of self-confidence and a seeming inability to stand up for herself. The risk of

acknowledging that the other person may be in the wrong means a loss of acceptance from that person. She seems to modify her behaviour and reactions to remain accepted by others. This is perhaps indicative of a negative view of self. It also seems to show that she engages in a lot of self-criticism.

A few of the participants reported a hyper-sensitivity to the emotional states of others, which they directly linked to having to monitor and manage their mother's emotional states. Anna reported that she needed to constantly win her mother's trust, because her mother thought that she was a threat during the periods where she was off her medication and her positive symptoms were very prevalent. She reflected that she only knew that she did this when she realised she was doing it in other relationships. She reported that she did this because she believed that if she were to be herself, she would be rejected by others. Her lack of self-esteem governs her interactions with others and she believes that if she were to be herself she would not be worthy of love by others.

"... as soon as I express who I am, then people don't like me so just the people pleasing. I think it's influenced the always being kind and sweet and I think that is a part of my nature but I think a lot of the time I don't do it because of that, I do it because I feel like worthless."

While Donna was in a long-term, intimate relationship, she also struggled with feelings of self-blame when any conflict arose in the relationship.

"... for a long time where I would just blame myself for everything. It affects my relationship with my boyfriend. I blame myself for everything. Even if - it could be something so ridiculous and I'll apologise."

In other studies (Duncan & Browning, 2009; Williams, 1998), long-standing relationship issues among adult offspring of mentally ill mothers are characterised by a lack of trust and a hyper-vigilance of others' emotional states. However, the participants in this study did not report a lack of trust towards other people. More prevalent were reports of selection of a destructive intimate partner and an inability to leave a damaging relationship.

There was variability in the participants' relationships. Difficulties with intimate relationships and friendships were reported by some of the participants. Belinda reported that two months after marrying her first husband, she knew that she had married a man who wasn't right for her and if she had waited a bit longer before getting married she would have realised this. Interestingly, Belinda selected a husband who has the same disorder as her mother. She says that the periods when he regarded her as a wonderful woman were what kept her in the relationship for so long, but eventually she was able to emotionally detach herself and leave the relationship. However, her second marriage, she reported, is a functional one. Her selection of an inappropriate partner did not persist throughout her life.

"And probably if I had somebody I could have gone to and a different upbringing - I'm doing a Freudian blame on upbringing - I'm not blaming it at all. It just happened to be there and of course it causes different things to happen. But I think if I had been brought up in a different family I would have maybe - If I had somebody who said, 'Look, just take it easy and don't get married immediately', I might have seen this or like today, living with somebody, you could actually - I mean once we were married it took me two months to realise, boy, I've done the wrong thing. Then again the splitting would take over and then I was marvellous and I would think maybe not. It was a total roller-coaster all the time."

Chrissie reported:

“And I was in a relationship two years ago, well, I’m still in this relationship and things have improved, with a drug addict. And because I was so afraid of being alone, so afraid of not being loved, I chose to compromise my varsity marks, fail the entire year – I think I passed two modules out of say ten. I compromised everything. My whole and entire life was revolved around trying to seek acceptance from one person and even though he is clean now and things are a lot better I still think had I been raised a little bit differently, had I had the comfort I need, I would have had the courage to walk away from something like that.”

In the above excerpt Chrissie discussed being in a relationship she believes she should have left but could not. Her fears of leaving the relationship revolve around a fear of being alone and being unworthy of love and she struggles with feelings of co-dependence. She reported that the consequences of this were that she had to compromise her university career and her independence to live a life separate from her intimate partner.

## **5. Theme five: Protective relationships**

### **5.1 The role of therapy**

All but one of the participants in this study entered therapy at some stage before the interviews were conducted. Following the research by Dunn (1993) this study set out to explore the participants’ reasons for entering therapy and what role therapy played in their making sense of their experiences. While Dunn (1993) called for research that examined differences between the participants who entered therapy and those who did not, this study could not examine these differences because of the small sample size and because only one participant did not enter therapy. It was impossible to make inferences. However, most of the participants who had entered therapy were able to give insightful, rich accounts of their experiences, while the account of the one who did not was less rich in detail (Dunn, 1993).

However, one participant who did enter therapy was hesitant to provide a detailed and rich account. This could be because the participant knew the researcher before the interview and was therefore reluctant to give greater detail. However, this cannot be measured and there is no definitive way of saying that entering therapy gave the participants the ability to provide richer data sets than those who did not.

The participants entered therapy for a variety of reasons. Belinda entered marriage counselling and subsequently was asked to book private sessions. Although the initial reason was not to deal with her experiences with her mother, it became a vital process in becoming emotionally detached from her and dealing with her experiences. She stated:

“But I did go to counselling and I worked through it and it was really very painful in the beginning and my sister did the same thing and she said to me, “I can’t believe how I’m crying – every time I talk about mama I’m crying.” But it was very painful but that was actually a saving grace. That actually working through it because afterwards I could detach myself.”

Chrissie reports:

“I knew I needed the help. I knew that the knowledge they had was what I needed. [...] So I realised that I needed the help. I needed to be diagnosed. I needed to be put on my meds. So for me, having all of this is a very clinical process. I go there, I spill my guts as honestly as I can. There’s nothing that I hide. It is what it is. They have the tools and can recognise from an outside perspective which I cannot do myself. So I cannot read my psychology textbook and say, ‘Oh, let me cure myself’ because I don’t see it from that outside perspective where if I tell you about a story, you can analyse it. You weren’t immediately involved. [...] You know, it’s like instead of working through my issues like I know I’m not crazy, I

know I'm sick, but giving me pills isn't going to take away things that I still need to talk about."

After an incident of excessive anger, fear of becoming like her mother prompted Chrissie to enter therapy. Therapy gave her insight into her current issues and tools to resolve them and it gave her the chance to address current relationship issues so that they did not persist in later relationships. In addition to this, Chrissie said that with medication and therapy she was able to manage her bipolar affective disorder and "live a relatively normal life". However, Chrissie emphasised that medication alone would not help her address her experiences and that therapy was necessary.

Anna spoke about therapy being quite common in her life:

"I can't remember a time I wasn't in therapy, that's the problem. I've been in therapy as long as I remember. Obviously, when I went to school there was like psychologists and when I went to university there were psychologists. So I always continually saw - whether it was paid or whether it was just free service, but I just felt it was good to talk to someone because I felt a lot of people, firstly, were not educated enough, were ignorant, and I think a lot of friends also judged me for a mental illness. I think people looked down at me having a mother like that. Secondly, um, it was good to discuss things with someone, like, a caregiver. I felt like I never had someone to really talk to so it was almost nice to have a mother figure in therapy. It sounds silly. But it was good in that sense. The older I get, the more I realise that a therapist is just another person who can't help with everything. You have to help yourself. I think when I was younger I was more dependent, but now I'm becoming less dependent.

Um. (2.0) I don't trust psychologists anymore ... It was just like, um, I just started realising that they don't have the answers to everything. I just started realising - the older I'm getting, just realising that people don't have the answers to everything."

Psychologists initially played the role of a caregiver in her life, acting as her mother figure, and she described being dependent on them. She also used therapy as a way to replace sharing her experiences at peer level. At the end of the extract she talked about disillusionment with the therapeutic process when she realised that therapists are people too. This later statement suggests that she used to elevate the position of the psychologist.

Ginny went through two sets of counselling and went on anti-depressants for a period of time. She found that it was only the second experience of counselling that made a difference in her life. She used counselling in a similar way to Chrissie: to gain insight into her current reactions.

"... the cognitive behavioural therapy helped me kind of make sense of my reactions to everyday things: why I was getting so angry, why I was reacting the way I was to just normal everyday things that most people would shrug off. So it just helped me look at how I can change how I react, which I think has helped."

## **5.2 Protective family members**

As in many other studies (Cooklin, 2006; Duncan & Browning, 2009; Dunn, 1993; Robinson et al., 2008, cited in Murphy et al., 2011), all of the participants had one specific close relationship with a parent that provided a protective factor and allowed for development of resilience. Many of the adults who fulfilled these roles were fathers and step-fathers, and they helped with both practical and emotional coping. They took on aspects of care that included household chores and financial support, and provided an emotionally safe space.

However, many of the participants reported that their father-figure was caught between defending the participant and avoiding conflict himself.

Both Anna and Donna had protective adults who compensated for the neglect by their mothers. Donna's mother spent most of her money on alcohol and lost the house. Donna, when talking about her father, said:

"... my dad, obviously, he got divorced from my mom, like he - I give him a fucking gold medal because he stayed with her for sixteen years and then he decided, okay, that's enough. I can't do this anymore. Okay, so obviously in the beginning, my dad's role was to be a dad and take care of us, and then he spent a lot of time with us 'cause he wanted to avoid my mom as much as possible. He was always around and he helped with everything and then, very kind and caring. [...] Only years after [they had been divorced], when shit hit the fan, did we move in with my dad."

Donna's father played a protective role when Donna was able to go and live with him and avoid joining her mother in poverty and homelessness. However, before that Donna's father had been the primary caregiver and provided both for both the basic and emotional needs of his children.

Anna, speaking about the role of her grandparents, stated:

"I just felt pushed around a lot. I just felt like I never really had a home and I was really unstable because I don't know where I'm moving next, you know? Cause my parents fight for me and they wanna fight for me, bring in a lawyer to take me away from my grandparents then my grandparents want me back - No! They didn't want me back 'cause they had their own problems. So, then I wanted to go back, so it was confusing."

Anna spoke about how her grandparents played an important role financially and were able to support her learning and basic needs. They provided financially for both her and her mother. When speaking about the caregiver role her grandparents provided, Anna's primary concern was their vital, supportive role in her life. They represented a protective factor and, by providing her mother with the financial means, her mother was able to provide for her basic needs. Anna reported that her grandparents provided a caregiver role for both her and her mother. Seeman (2010) reports that when the mother retains legal custody it is often other family members such as fathers and grandparents who take over the caregiver role, and this creates a risk of inconsistent rearing. This was especially true for Anna, who was often moved between her grandparent's care and her mother's care. The result was that Anna had feelings of instability and of being a burden. She spoke about her desperate need for acceptance by her grandparents.

Siblings played a role in some of the participants' experiences. Donna stated that although her brother did not play an active role in the caregiving duties, he still played a vital role in allowing her to talk about her experiences. Ginny experienced the same and still uses her sister to talk about her experiences and try to make sense of everything that happened.

"... her and I had a very close relationship. We'd find comfort in each other, spend time with each other."

Chrissie recalls:

"I adopted people I felt close to me as my siblings. I adopted my best friend's mom as my mom. When she passed away, that became my loss because my mother died. You know, she was the one I could talk to. She would cry with you when you did badly on a test. You could tell her about it and she would comfort you."

Chrissie, an only child, found that she deeply desired siblings and so she adopted her close friends as family. These “siblings” provided the same protective role as Ginny and Donna’s siblings. In addition to this, Chrissie used her friends’ mothers as confidants to talk about her experiences and, as with O’Connell’s (2008) study, she found that time spent with one friend’s mother provided a valuable mother figure for her. As with Dunn’s (1993) research, Chrissie aggressively sought out support structures in other people. However, she was the only participant to do so.

## **6. Theme six: Mental health services and the role of the diagnosis**

### **6.1 The absent mental health system and resistance to psychiatric treatment**

A review by Gladstone et al. (2006) focuses on the invisible children of mentally ill parents. However, in this study, the participants recall that even their seriously mentally ill mothers were invisible to the mental health system, which was either absent or not considered helpful by the family. Very few of the participants’ mothers underwent psychiatric treatment for their disorder. It was not a lack of availability of support that prevented the mothers from seeking treatment and support but a lack of willingness, because of their own sense of the stigma of being labelled mentally ill and general misperceptions of the treatment of mental illness. The other family members, in the case of Anna and Ginny, were complicit in this lack of help-seeking behaviour. As a result the participants experienced minimal intervention by formal institutions or organisations such as the mental health services; two of the participants did, however, receive some support from social workers. Anna stated:

“Everyone in my family still denies it. She doesn’t have a problem. [...] They just think a lot of the time she’s lazy or she’s stupid. I don’t think they – maybe they think it’s all in the head. That’s the thing. Especially with Italian families, they don’t really believe in

mental disorders. You don't have depression. You're just feeling sorry for yourself."

This denial of the illness may have led to a lack of sufficient support by the family members. Ginny also reported that her mother refused any treatment, remembering "Mom didn't think she needed counselling. She always knew better than the doctors." In addition to this her adoptive father did not want anyone from outside seeing what was happening in the family.

"And that was something Chris didn't want either. He almost got angry when you said you were going to call the police or something. He didn't want anyone outside the family to know what was going on."

Anna spoke about how, even though her mother had contact with psychiatric institutes and psychiatrists, no intervention was ever provided for Anna. When asked if she had received any intervention from formal institutions, she recalled:

"No. Not at all. And that's why I think South Africa's - South Africa doesn't have those services available to people who need it. [...] There was a social worker when I was younger. She was actually like a nun. So Sister - I forgot her name. Sister Something. She was actually a nun but she was also a social worker. She intervened for a very little while. But she didn't intervene with me. She intervened with my mother. So it wasn't really an intervention in terms of me."

She assigned responsibility for this lack of support for children of mentally ill parents to her context, being the South African mental health system. When she mentioned the social worker previously, she said she had an integral role to play in assisting with removing her from her mother; later in the interview she downplayed the role of the social services in terms

of emphasising that the intervention was directed at her mother and was not for her. She further recalled her mother's lack of compliance with her medication:

"No one [got her back on her medication]. Except when she was forced. She had to go to Denmar Clinic sometimes. It didn't really work. Because they can't take psychotic patients. She had to go to Weskoppies."

Previous to this extract, Anna described her mother's behaviour as "ridiculous" when she was off her medication and recalled how during these times she was often viewed as the enemy by her mother. She recalls that the only way that her mother went back on her medication was for her to be admitted to a psychiatric hospital.

**Belinda recalled:**

"... we were indoctrinated in a way that social services, well then they called it the welfare, you don't go there and if they do, they'll take you away and that. Because I think - and my dad years later, I realised about it, little things she told me (I was an adult, I could read between the lines). My dad had also been at this meeting - they had called this meeting and said, 'Look, we will take this child away because you are physically abusing her and you've got to work at this' sort of thing so we were brought up with this idea, if you complain, the welfare will take you away."

Belinda's mother's fear of being labelled "mad" prevented her from seeking treatment and support for her episodes of depression and delayed her diagnosis with borderline personality disorder. Belinda reported that there was a social worker present; however, she was too young to remember the instance. She recalled that she was told that neighbours reported her parents for physical abuse because they had physically beaten Belinda. The

social worker threatened to take her away should the abuse continue. However, the intervention by the social services was ineffective. Her mother used the possibility of being taken away by the social services as a threat should any of her children speak to other people about what was happening at home. This isolated her from potential formal support structures, because when given the opportunity to speak to an outside support system, she refused.

Speaking about her own struggle with bipolar affective disorder, Chrissie talked about her own mother's refusal to seek treatment and take her medication:

"If I take my medicine I have a relatively normal life. So the resentment towards her is, 'Why didn't you go get help? Why did you raise me the way you did? You know, basically drive your marriage into the ground.' She has such little friends. She was basically declared medically unfit to work because of it. Why would you let it get to the point where everybody that you know doesn't really love you? It's just like, why would you let it get to that point? So when I experienced that I understood and I told her this as well and I get it but it can be treated. There is help for it."

Her position – being diagnosed with the same mental disorder as her mother – is the basis of her resentment and anger towards her mother. While experiencing the same problem as her mother made it possible to empathise with her, it also became a source of contention because Chrissie sought help and her mother did not. Chrissie reported believing that by seeking treatment, it is possible to live a "normal" life. Her mother could have done the same. Chrissie seemed to attribute her mother's loss of job and friends and the breakdown of her marriage to her mental illness. By emphasising that there had been help available for her mother's illness, she was perhaps saying that staying "ill" is a choice and that her mother

would have fulfilled the nurturing role she longed for if she had sought treatment much earlier. If she had done this, Chrissie may not have experienced what she did.

## **6.2 The importance of diagnosis**

The diagnosis of each participant's mother played an important role in most of the participants' understanding and "forgiveness" of their mother. From these accounts, it is possible to see the diagnosis of the disorder as providing some sort of protective factor for the children. In some cases, the participant was able to assign blame for her mother's behaviour to the mental illness instead of to her mother. Four of the five participants' mothers were diagnosed formally by a psychiatrist or doctor. Especially pertinent is Ginny, whose mother has never been diagnosed with a mental disorder.

"So we've kind of just been chatting about it every now and again trying to figure it out and we've come to the conclusion that there must be something mentally wrong with mom but we just don't know what. We don't know. I've done a bit of a read of what schizophrenia and Bipolar, what all these mental illnesses are and none of them really quite fit with what we remember so we're not sure what is there but - I don't know if it makes it easier to think that mom's got a mental illness and that's why she was the way she was or - I suppose it would be because if she was quite sane and normal and she still treated us like that then she's quite a horrible person and I think that would be harder to accept."

The lack of a diagnosis means the participant experiences a lack of resolution. The alternative to her mother having a mental illness was worse, which is that her mother was inherently unloving.

The same can be seen with Chrissie:

“But having suffered from depression myself, I understood that there were grey areas [...] I tried to handle it the best I could and I tried and made sense of what she was going through, which is why when people ask me if I hate my mother, I would say but I hate what she did and I hate what her disease has done to her. She is not inherently an evil person. She is just a ... (3.0) She was acting out on her disease ... It is the only way I can truly make peace because if I honestly had to believe she was evil then I would be in a situation where I would have to question why two people who didn't love me would have me and you know, a part of me has to believe that somehow she does love me.”

The diagnosis provides a “scapegoat” for her feelings of resentment and anger towards her mother. She can rationalise that it was the mental illness that prevented her mother from displaying affection and providing the nurturing role she perceives that a mother should play. Assigning the blame for her mother's actions to the diagnosis is a protective factor for Chrissie. She also uses her own experiences of having a mental illness, depression, to explain her position of empathy for her mother. As with Ginny, the alternative to believing her mother's behaviour stemmed from her mental illness is far worse for her to cope with.

Anna spoke about how the diagnosis provided her with a sense that she was not alone in her experiences and made it possible to improve her relationship with her mother.

“Yes, I think I was ignorant a lot of the time. I didn't think there was a mental disorder. Now I understand what Schizophrenia is. Now I'm much more patient with her. And I'm accepting and giving [...] I think after I understood my mom, we had a good relationship and I think that understanding grew through awareness, through therapy, to understand why she does what she does because a lot of the time I thought it was her. To actually realise that, hey, this is a

disorder. Here are the symptoms. The person has paranoia. A person (3.0) if it's really like a textbook explanation of my mom. I was like 'Wow, there's other people going through this as well.'"

**Belinda stated:**

"But I don't think it actually benefits anybody by trying to pull the wool over their eyes or downplaying it. It's a very difficult illness to live with."

Belinda's mother was only diagnosed in her seventies, and the diagnosis provided Belinda with some understanding of her experiences during her childhood and her mother's reactions. However, she queried the way in which family members of the mentally ill person are told the diagnosis. Using her position as the leader of a support group for people with schizophrenia and bipolar affective disorder, and her experiences dealing with family members, she stated that it is better to tell the family clearly and in detail the diagnosis of their family member and explain what to expect and how to deal with it, and validate their feelings of anger and guilt. The diagnosis should be given in a way that provides tools for every member of the family to deal with it.

## **Chapter five: Conclusion, limitations and recommendations for future research**

### **Conclusion**

The aim of this research project was to examine how participants – now adult daughters who grew up with a mother with a severe mental illness – reflected on their experiences in the context of an interview. It is important to note that this study represents just one possible reading of many of the accounts provided by the participants. The second aim of the study was to examine how resilient the participants thought themselves to be. The use of IPA allowed for analysis of the participants' lived experiences. The study achieved both aims.

Five participants took part in the study. Each of the participants' mothers experienced severe mental illness with a psychotic component. Four of the five mothers were diagnosed by a psychiatrist. The one participant whose mother was not diagnosed by a psychiatrist was included because she believed she had the experience of growing up with a mother who had a severe mental illness with a psychotic component. Her interview also proved valuable, so was included. The participants' age range was between 21 and 60 years old, with a majority of the participants in their twenties.

The data was collected using a semi-structured, open-ended interview. The interviews were audio-recorded, with participants' consent, and later transcribed. The data was then coded and themed using IPA. Six themes emerged, with a number of sub-themes. The main themes were the relationship with mother: then and now; abuse and neglect; isolation, secrets and facades; emotional responses and adult relationships; protective relationships; and mental health services and the role of the diagnosis.

Each of the participants believed that having a mother with a severe mental illness had an effect on their development and these effects have persisted into their adult life. The participants' accounts of their experiences revolved around their difficult childhood

relationship with their mother, characterised by a lack of maternal responsiveness, inappropriate expressions of anger and feelings of never being able to do anything right. As found in the study by Duncan and Browning (2009), the participants reported that they lacked closeness with their mother. Despite this, some of the participants remain incredibly loyal to their mothers. The participants recall always needing to manage their mother's emotions and developed various strategies for avoiding conflict. The participants found that they had to continually assess how to cope with the situation to avoid conflict.

All but one of the participants reported that they were able to repair their relationship with their mother. Many of the participants found that they were able to "forgive" their mother when they understood that she had a mental illness. The strategies the participants used were emotional and physical distancing. They found that if they managed to limit the time spent with their mother they were able to cope. For some of the participants, detaching emotionally was essential for dealing with their experiences and managing their mother.

The participants felt a variety of types of guilt. One felt guilt for hating her mother, another felt guilt for her perceived abandonment of her mother by living her life independently and another felt self-blame, assigning responsibility for her mother's illness to herself. Two of the participants reported feeling no guilt at all. One said that she provided enough counter-balances (kindness to her mother) to outweigh any "harm" (her word) she may have done in the relationship.

The participants faced two distinct types of isolation. Some of the participants self-isolated because they felt that their peers could not understand and would judge them. The other type was that their mother dissuaded them from entering peer relationships. This social deprivation, as outlined by Brockington et al. (2011), resulted in a lack of input from external

sources, removed potential support structures and dissuaded participants from seeking external assistance.

Their childhood reflections often focused on physical and emotional abuse and neglect and they spoke about how these things had had a pervasive negative effect in their lives, resulting in a lack of self-esteem and continued relationship difficulties. These relationship difficulties consist of selecting destructive intimate partners, continual searching for acceptance at the expense of self, co-dependence and self-blame. However, many of the participants emphasised their attempts to overcome these difficulties, as opposed to focusing on the difficulties themselves.

Important coping mechanisms for each of the participants were: having a protective adult who often took over the household responsibilities; emotional and physical distancing; and therapy later in life. The aspect of therapy that proved most helpful for all the participants who underwent it was focusing on why they react and behave the way they do and how this influences their relationships. An important coping mechanism for most of the participants was being told their mother's diagnosis. This allowed for forgiveness of the mother and acceptance of their situation. For some of the participants, this provided the tools necessary to improve their relationship with their mother. For the one participant who did not have a diagnosis of mental illness, there was some lack of resolution and she considered that the alternative to her mother having a severe mental illness – that her mother was inherently unloving – was worse. The diagnosis provided a protective factor for the daughter. For all the participants, mental health services were absent; for those who were exposed to social services, they found them ineffective and their role was minimal.

### **Limitations and recommendations for future research**

The sample of the study consisted of predominantly white, middle-class participants. Due to the difficulty of gathering a sample, the researcher was only approached by this sample. For future research it would be interesting to have a sample that contained different cultures and income groups to this study. In addition, the nature of qualitative research means that generalisations cannot be made due to the small sample size. The sample was also self-selected, which prevents generalisability. Due to the nature of this sample, there is an elite bias (Miles et al., 2014) as the study could not examine the voices of people who have experiences growing up with a mother with a psychotic disorder but have a substantially less privileged socio-economic position within society.

The accounts given by the participants are retrospective, which means that the narratives generated in this study must be treated as personal accounts. Due to the time and spatial constraints of doing this study for a Master's degree, the analysis of the transcripts is partial. Further analysis can be done on the current transcripts for future studies done by the researcher.

Although this research delineated the data into six themes and a number of subthemes, it is important to consider that while the act of clustering themes acts to organise the data into neat boxes of knowledge, because of the nature of these accounts, there is overlap within the themes. Miles et al., (2014) state that while we seek to categorise data into small, meaningful and carefully delineated meaning, it is important to remember that the process is not always straight forward and there is much overlap.

While Miles et al., (2014) state that utilising numbers to count the number of times an instance occurs across the study in order to delineate themes, this was not strictly adhered to in this study. Qualitative research has often been criticised for being largely based on

intuition (Miles et al., 2014). While this study did not strictly adhere to numbers, it examined each instance according to which participants describe it happening to them and which participants do not describe such an instance. This was also commented on.

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**Appendix A: Interview schedule**

1. This research is about daughters who were raised by mothers who suffered from psychotic mental illness. Do you believe you had this experience? If so can you please describe your experiences of your mother's mental illness in your childhood?
2. Do you have specific memories of any unusual behaviour of your mother when she was mentally ill?
3. Do you remember how you made sense of her behaviour? Do you recall how you felt at the time?
4. Did anyone explain to you what was happening with your mother when she was mentally ill in your childhood?
5. What was the role of the other family members during your childhood?
6. Overall, what was your childhood relationship with your mother like?
7. If you feel that your mother's mental illness had an effect on your development and/or on the way you are today, can you tell me about this?
8. Growing up, do you think your mother's mental illness affected your relationship with her, either positively or negatively?
9. Has your understanding of these experiences change over time? If so, how?
10. How do you think you have dealt with these experiences?
11. What is your relationship with your mother like currently?
12. Did you have any contact with the mental health services while growing up?
13. Do you talk to anyone about your experiences? If so, how have people reacted?
14. Have you had therapy at any time in your life to process your childhood experiences? If so has this been helpful? If not, why not?
15. Is there something else you would like to add about your experience that I haven't yet asked about?

**Appendix B: Participant information sheet****Psychology****School of Human & Community Development**

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Private Bag 3, Wits 2050, South Africa. Telephone: +27 11-717-4500/2/3/4. Fax: +27-11-717-4559

**Participant information sheet****An exploration of the recollections of adult daughters on being raised by a mother with a psychotic disorder**

My name is Sarah Day. I am currently pursuing my MA in Psychology by Coursework and Research Report at the University of the Witwatersrand, Johannesburg, working under my supervisor, Dr Yael Kadish, in the School of Human and Community Development. In order to fulfil the requirements of my degree, I am required to do a research report. I would like to invite you to take part in my research study, which concerns the exploration of recollections of adult daughters on being raised by a mother with a psychotic disorder, i.e. bipolar mood disorder with psychotic features, schizophrenia or schizo-affective disorder. My completed thesis will be found in the library at the University of the Witwatersrand.

If you agree to participate in my research, I will conduct an interview with you at a time and location of your choice. The interview will involve about 15 prepared questions and a number of follow-up questions. It should last about one hour more or less. With your permission, I will audiotape and take notes during the interview. The recording is to accurately record the information you provide, and will be used for transcription and analysis purposes only. If you choose not to be audiotaped, I will take notes instead. If you agree to

being audiotaped but feel uncomfortable at any time during the interview, I can turn off the recorder at your request. If you do not wish to continue, you can stop the interview at any time.

There is no direct benefit to you from taking part in this study. It is hoped that the research will add to our understanding of the subjective experience of being raised by a mother with a psychotic disorder. The interviews may result in psychological distress. If you should feel that this occurs after the interview, please contact the Emthonjeni Community Psychology Centre at the University of the Witwatersrand. This is a free counselling service. It is strongly recommended that you attend a few counselling sessions should you feel any discomfort during or after the interview. Please contact Nthabiseng to make an appointment on (011) 717 4513. Should you experience distress during the interview process, you are welcome to end your participation.

Your study data will be handled as confidentially as possible. In order to protect the privacy of the individuals participating in the study, individual names and other personally identifiable information will not be used. Pseudonyms will be used. To minimise the risks to confidentiality, we will keep the transcriptions and the audio recordings of your interview in a password-protected file on my and my supervisor's computer. Only the researcher and supervisor will have access to the audio recordings and full transcriptions. If this research is published in a journal, excerpts of the interview will be published. In addition, the study will be available online and in the University of the Witwatersrand's library. Should you wish for the results of the study, please contact me via email and I will send them to you.

Participation in this research is completely voluntary. You are free to decline to take part in the project. You can decline to answer any questions and are free to stop taking part in the project at any time. Whether or not you choose to participate in the research and whether or not you choose to answer a question or continue participating in the project, there will be no penalty to you. The level of detail you wish to give is completely up to you.

If you have any questions about this research, please feel free to contact me. I can be reached at 0763074392 or [sarah.kathrine.day@gmail.com](mailto:sarah.kathrine.day@gmail.com). If you wish to contact my supervisor, Dr Yael Kadish, you can do so by emailing [yael.kadish@wits.ac.za](mailto:yael.kadish@wits.ac.za) or phoning 011-7174547.

**Appendix C: Informed consent form**



**Psychology**

**School of Human & Community Development**

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**Informed consent form**

- As participation is completely voluntary, you have the right to withdraw from the study at any time. You may also refuse to answer any question and the level of detail you wish to divulge is up to you.
- The interview will be audiotaped. However, if at any time this should make you uncomfortable, the audio recorder will be turned off.
- The data will be treated confidentially. Your name will be replaced by a pseudonym and any identifying factors will be removed.
- Only the researcher and supervisor will have access to the interview recordings and full transcriptions.

**CONSENT**

If any questions about this research have been answered to your satisfaction and you would like to take part in the research, please print and sign your name below.

I have read the above and agree to participate in the research.

\_\_\_\_\_

Participant's Name (*please print*)

\_\_\_\_\_

Participant's Signature

Date