Becoming and being a mother: Reflections of the daughters of mothers who experienced enduring mental health difficulties

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This thesis has been submitted
in fulfilment of the Professional Doctorate
in Counselling Psychology,
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October 2016

Abstract

Mental health research across the discipline of psychology has been extensive. Much research relating to motherhood has focussed on the mental health of mothers and increasingly on the impact of this upon the welfare of children. The focus in this study was on the narratives of these children when they themselves become mothers. The aim was to gain qualitative insight into these women's experiences of mothering, and the role that they considered that their own childhood might play in their experiences as mothers. This qualitative study used Interpretative Phenomenological Analysis (IPA) to explore the experiences of nine mothers at various stages of their motherhood journey, who had experienced the 'enduring mental health difficulties' (EMHD) of their own mothers in their childhoods. The IPA analysis of semi-structured interviews revealed a complex interplay of themes. Narratives evolved across a natural timeline in which participants discussed their own journey as a mother over four main themes. They offered context from their childhood and also pre-pregnancy thought and experience, and presented their current sense of themselves as mothers and their reflections of their journey. This research offers further insights into some of the possible experiences and difficulties these daughters might face as mothers. It suggests that they may be particularly at risk of exhaustion and ensuing mental health issues, perhaps less because of the genetic factors that may be present, but more because of their desperation, in a global sense, to undo, or not to repeat their childhood experiences for their own children. Further research is needed not only into their struggles but into their incredible strengths as mothers, so that those to whom this research is most poignant can take inspiration from further accounts, and both therapists and society can best support daughters with this lived experience as children, as adults, and potentially as mothers.

Acknowledgements

I would like to thank the following people:

My participants for having the courage to share their stories.

My Supervisor Dr Deborah Rafalin for her expertise, clarity and support.

Professor Carla Willig whose unconditional positive regard in the last stages, was significantly responsible for my completion of this work.

Dr. Sue Williams for her inspiration and support.

Joan Barry, my Clinical Supervisor for her skill and experience, as well as her support and genuineness.

My wonderful friends for their help in support of me and my family as I could not have completed this research without them.

My siblings: my two brothers and especially my sister, for their bravery.

My husband, without whose love, encouragement and strength these pages would be blank.

My children, Joseph and Rosa, for 'being' the most incredible gifts in my life.

My father, whom I honour and thank unreservedly in the completion of this work.

My mother, from whose life I have learnt compassion and the meaning of 'unconditional love'.

Declaration

I grant powers of discretion to the Department of Psychology to allow this thesis to be copied in whole or in part without any further reference to me. This permission covers only single copies made for study purposes, subject to the normal conditions of acknowledgement.

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THE FOLLOWING PARTS OF THIS THESIS HAVE BEEN REDACTED FOR DATA PROTECTION REASONS:

p. 173-197, Client Study

Introduction to the Portfolio

The inspiration for this work transpired firstly through my professional experience of working as a Counselling Psychologist in Primary Care, and necessarily adopting a six-session Cognitive Behavioural Therapy (CBT) model of counselling psychology (Beck, Emery & Greenberg, (2005). I became aware of a number of clients who shared the background I had myself known, of a childhood in which their mothers had suffered enduring mental health difficulties (EMHDs). These women had often not put this fact forward, as implicated in their current distress. Often it felt that I had chanced upon this information, in that clients might leave their mother's mental health out of their description of what was troubling them. At first glance, and from a phenomenological perspective, this might seem to be a reason not to conduct the current study, as it was my perspective that assumed the level of relevance. Nevertheless, once clients began to include and incorporate their mother's EMHD with their childhoods, it was my experience that strong and useful connections and understandings were frequently made by the end of counselling and psychological work.

These understandings often occurred despite the limitations of a six-session model, and in many cases with the client having attended counselling before. I came to notice a particular repetition, by which a number of clients who were mothers, would give their reasons for not having mentioned their own mother's mental illness as being the result of either, a) not having thought this to be relevant, or b) that they had felt ashamed. The second impetus for this research came from my own experiences in childhood with my mother who was mentally ill, and also my own experience of becoming and being a mother myself.

In my work as a Counselling Psychologist, I often questioned my subjectivity in this research area and took this concern to my Clinical Supervisor. We discussed the benefits and risks of my lived experience with clients who presented with a background with some similar aspects to mine. This supervision content would not be unique to my particular background and, as best practice dictates, Counselling Psychologists would expect to form a therapeutic alliance in which they were continually reflective regarding their own sensitivities. However, it emerged that where my practice fell most under strain was concerning my clients' experiences of motherhood, and not their experiences of their own mothers *per se*. It seemed that the experiences of these women as mothers was less easy for me to 'bracket' (Creswell,

2008; Moustakas, 1994). This provided an incredible learning experience for me personally and professionally. My Supervisor's insights and her ability to allow me to work through my fears for my practice, whilst including aspects of my own personal life, were invaluable and partially instrumental in my desire to undertake this research. I gained greater insight into my own defensiveness about certain aspects of myself as a mother. This I believed improved my ability to facilitate my clients to explore their own deep, and sometimes dark feelings, about being mothers themselves.

I was aware of the difficult road ahead as a researcher in terms of balancing my skill and potentially my bias in this work. I was especially concerned to avoid skewing not only my research, but also my practice, in the direction of my own beliefs and feelings, such that I repeatedly worked and re-worked the analysis herein; with near complete changes on each occasion, and to a point which almost prevented my completion of this research. I undertook this research under some unavoidable and extreme circumstances relating to my own life as a mother and as a daughter. I feel therefore, that I have lived experiences of more than simply some aspects of shared background with participants, but that these experiences also reflect my own ability to persist and to 'strive', akin to what my participants have suggested to me that a mother who is a daughter of maternal mental illness might do.

The need to develop research to inform Counselling Psychologists' interventions for daughters of maternal mental health difficulties

Despite considerable research into the impact of mental health difficulties upon mothers, I found comparatively little research concerning the daughters of such mothers, plus a lack of research that is directly relevant to their experience should they in turn become mothers. To be clear, there is a large bank of research related to mothers who suffer mental illness (Bosanac, Bruist, & Burrows, 2003; Reupert & Maybery, 2007), for which psychology owes a great deal of its knowledge to quantitative research. There are also some excellent examples of qualitative research. Further, there are a number of examples where quantitative and qualitative methodology has been insightfully and usefully employed in this area (e.g., D'Arcangelo, 2004), offering equally important perspectives. Increasingly, much valuable research concerning the impact and experience of children and families, where a parent suffers mental illness, exists. Psychologists also owe a great deal to sociological research in

this regard (e.g., Oakley, 1992). However, although there is some research which explores the longitudinal experience of children of families affected by mental illness, there is little to inform psychology subjectively regarding the experience of becoming and being a mother, when that mother's childhood experience of their own mother was impacted by maternal mental ill health. This portfolio includes a Research Project in response to the lack of research described, and focusses on gaining insights through qualitative research, and a Critical Literature Review and a Case Study, that are also relevant to the research area. A brief introduction to each portfolio component follows.

The research component

The Research Project hopes to inform Counselling Psychology practice regarding the psychological understanding that could facilitate practitioners to support mothers whose individual and social identities developed in a childhood in which their own mothers experienced EMHDs. More specifically, this research hopes to begin to address a gap in the research regarding these women's maternal experiences, and potentially their 'maternal identities', or how they see themselves as mothers, and also their personal well-being. By using Interpretative Phenomenological Analysis (IPA) methodology, I aim to provide rigorous qualitative representation of these women's experiences as mothers.

The client study component

I have included in this portfolio a Client Study (Process Report combined) detailing my interactions and interventions and my relationship with Marian (a pseudonym), who was a client referred to me in a Primary Care setting, as suffering from Panic Disorder (Clark & Ehlers, 2006; Trower, Casey, & Dryden, 2003). I have chosen to present Marian for three reasons. First, her history is relative to this portfolio, in that she is a mother, whose own mother had suffered EMHD. Second, her children are adult and she has the perspective of hindsight. Third, our work together is an example of how in my early work as an Integrative Counselling Psychologist, I utilised Cognitive Behavioural Therapy (CBT) with clients who struggled with anxiety, and who presented as fearful that engagement in the counselling process would leave them at risk without their own defences. Marian especially tended to process success by looking for the pitfalls (Sanders, 1996).

There are some common threads in the Client Study connecting with the themes in the empirical piece in this early work. A specific example is Marian's fixed and deeply held belief that she was 'different' and more 'difficult', as in 'complex', than other clients. This meant that she seemed to see herself in some sense as less 'treatable' in comparison with 'others'.

Explored in this study, are the complexities for myself, particularly in my early experience, of collaboration with a client whose perspective rendered her seemingly unknowingly but highly resistant to strategies for change, and whose early life made it especially difficult for her to access the help and support she was so clearly seeking. I too shared elements of this early life, and it was necessary for me to be aware of this dynamic between us and to avoid assuming resistance, or the nature of this, too quickly. My challenge was to refrain from assumption and to cope with my own feelings of frustration which I felt stemmed from my own childhood with my own mother. It was also to contain my preoccupation with the enlightenment Marian was providing me about my own feelings as both a daughter of maternal mental illness, and a mother. My specific challenge was to keep my focus upon Marian and process.

Communication between us was not easy, two-way or flowing. However, through congruence and tentative exploration, and encouraging her to feel that she was in control of her therapy, I endeavoured to support Marian towards considering alternatives to her thinking. I aimed to encourage and reaffirm her competence to manage her own life and understand her emotional responses, especially given her childhood.

The critical literature review

In this portfolio, I have included a critical review of some relevant research into the experience of 'overburdened' children and young carers, and with a slant towards young carers of mentally ill parents, who are representative of the women presented in the main empirical research piece. All participants in the empirical piece had been young carers of mentally ill mothers, or had been involved in various ways in role reversal with their mothers.

Necessarily, in the interest of rigorous qualitative research, the evaluation of the research will be an integral part of this exploration. In the main, the general approach taken regarding young carers and overburdened children is the stance that these are not necessarily one and the same or interchangeable.

This Critical Literature Review focuses most closely upon three childhood factors. First, and in most detail, it investigates the experiences of children who have responsibilities for the adults who would ideally be supporting them; or, children who undertake roles prematurely and routinely that are usually and essentially parental or adult roles. In other words, these children are 'parentified' (Castro, Jones, & Mirsalimi, 2004; Mayseless, Bartholomew, Henderson, & Trinke, 2004; Thomas et al. 2003; Wells & Jones, 2000). Second, there is a greater focus upon 'mother-daughter relationships' (Agnew & Robideaux, 1998; Kabat, 1996; Messidor & Maru, 2015; Nathiel, 2007) and last, there is enhanced focus upon child carers of adults with mental health problems (e.g., Ahern, 2003; Aldridge, 2003/2006; Dierks, 2001; Falcov, 2004; Handley, Farrell, Josephs, Hankes, & Hazeltona, 2001). This Review explores research into the impact upon children of having been prematurely burdened by responsibility beyond their years. It discusses the highly complex concept of 'usual expectations' for children. It also includes discussion of research into the later implications for adulthood, with specific reference to diversity, attachment, and the relevance of different types of parentification together with their implications for the nature of the support or intervention needed in children's lives. This Research Review additionally documents the vital need for researchers to produce analysed individual dialogues of children who are overburdened, which can give accounts of their experiences and give rise to the best support, whilst this Review does not ignore the ethical complexity of such research.

Chapter 1. Methodological context to the research project

1.1 Methodological historical context

Historically, "psychology, in its attempt to be the 'science' of behaviour, has been desperate to find terms which are impersonal" (Gillett, 1995). However, the shift towards qualitative research has made the view of the 'personal' central to research. Wittgenstein (1953) drew attention to the fact that in order to understand behaviour we need to grasp the meaning which informs it. By this premise, it is necessary to interpret behaviour in terms of how the individual positions themselves in social context (Winch, 1958). Initially, this requirement for interpretation and empathy on the part of the researcher was unwelcomed by many as it was seen as a threat to the scientific status of psychology (see Gillett, 1995, p. 113). However, increasingly research methodology has been purpose-based with qualitative or quantitative techniques applied uniquely or in conjunction according to the phenomenon being studied (Willig & Stainton-Rogers, 2008; Nollaig et al., 2011).

Phenomenology diverges from the epistemology of traditional science in that it views phenomena as co-existent and interdependent. As Colaizzi wrote, "if the one cannot exist independently of the other, then neither can be the cause of the other" (1978, p. 54). The epistemological version of the qualitative-quantitative debate would still place these as two distinct paradigms, with the former seeking to explore meanings and constructions and the latter seeking to establish universal laws of cause and effect. There still exist preferences and beliefs, as well as phenomena, which cause researchers to place themselves within either paradigm. However, regardless of paradigm, psychology is the scientific study of the human mind and its functions, especially those affecting behaviour in a particular context and as such aims to be based on evidence. It is what is relevant as evidence, in terms of the question asked, which drives the choice of methodology in current Counselling Psychological research.

Whether what is researched can be seen to exist objectively or subjectively, is not the overall concern in Counselling Psychology research, but rather that results are useful and the most appropriate methodology and methods are used. However, an emphasis on the objectivity of

the researcher, or the reporting of the potential for a lack of objectivity, is common to all methodologies.

Considerable overlap is now recognised between and within research methodologies and paradigms. For example, as Frosh and Emerson (2005, p. 310) describe, "there is still variation among qualitative procedures between those that are *relatively* 'top down', dominated by theoretically-driven categories imposing an interpretive 'grid' on data in order to interrogate it… and those that are *relatively* 'bottom-up', eschewing theory as far as possible at least until the data has been examined… in terms of its own emergent properties". Phenomenology and Postpositivism may traditionally appear polar opposites in scientific inquiry (Racher & Robinson ,2003). However, the phenomenological concepts of 'intentionality and bracketing' for data collection, data analysis and the presentation of findings aim to retain the objectivity and the ability to remain questioning and critically reflective throughout the research process. This is central to the phenomenological method and is also a key feature of Postpositivism (Macnamara, 2005). By expanding psychology's repertoire of research methods, psychology has now a greater capacity to allow the researcher to be a valuable part of the research process themselves, and to enhance validity accordingly, for example by returning to the phenomena of interest and revisiting the perspective of those who experience them (Macnamara., 2005).

The prevailing research paradigm currently focuses more on blending methodology and methods in psychological studies. In 1994, Creswell wrote: "A qualitative study is defined as an inquiry process of understanding a social or human problem, based on building a complex, holistic picture, formed with words, reporting detailed views of informants, and conducted in a natural setting. Alternatively, a quantitative study, consistent with the quantitative paradigm, is an inquiry into a social or human problem, based on testing a theory composed of variables, measured with numbers, and analysed with statistical procedures, in order to determine whether the predictive generalizations of the theory hold true." However, currently, psychology is very much moving towards Pluralism in methodology and mixed methods rather than two distinct and separate paradigms, i.e. qualitative and quantitative. Creswell (1994) is an example of the changing thought in the last decade as he has revised his stance and now claims that "mixed methods research has come of age. To include only

quantitative and qualitative methods falls short of the major approaches being used today in the social and human sciences" (Creswell, Plano, Gutmann & Hanson, 2003; Creswell & Garrett, 2008). Therefore, the current research paradigm expresses less 'qualitative-versus-quantitative' methodology debates, but rather a consideration of methodology and method for a given stage of enquiry, and a given question within a process of enquiry. There exists a myriad of papers examining the qualitative-quantitative debate, and many authors now describe psychology as 'beyond this debate', as increasingly researchers consider and discuss the use of mixed methods research (Denzin & Lincoln, 2000); or adopting 'Pragmatism', (Yardley & Bishop, 2008), that is, by employing the methodology and methods deemed best to fulfil the research aim, or "multiperspectival analysis", drawing on "multimethodological research strategies" to "introduce a variety of ways of 'seeing and interpreting in the pursuit of knowledge'" (Kincheloe, 2001: 682, cited in, Frost, 2011. Ch.1, p5,6.).

In this study, however, I am placed within a qualitative and phenomenological paradigm in the belief that both numerical representation and statistical comparison would be inappropriate in the area studied here, as owing to the idiographic focus of the research aim, I need a platform for dialogue in order to explore the research question. Nevertheless, I recognise the immense contribution of quantitative research into mental health and the impact upon our understanding of self, family, and generations as well as its underpinning of my thinking and research. I also acknowledge that important insights will be brought to this subject through other qualitative methods.

My interest is specifically in the analysis of 'what people actually say' and in this research, my focus is upon its study through Interpretative Phenomenological Analysis (IPA) to provide my analysis of the participants' 'meaning' but with heightened awareness of the role of 'my meaning'. Therefore, in the methodological discussions which follow, I will be exploring the need to have an understanding of what research is considering when it reports issues of 'meaning' (Batthyany, 2014).

1.2 My thinking behind the choice of a qualitative and phenomenological approach

The aim of this study was to capture the 'meaning', in other words, the subjective experience and interpretation of motherhood for daughters of mothers with mental health difficulties; a background which I, as a researcher, also share with the participants. It was partly for this reason that I hold that sensitivity to multiple interpretations would be required, with unique interpretations being as informative and meaningful in terms of 'generavtity' for future research questions or applications to therapy as attention to commonalities.

The phenomenon of study in this research, therefore, is subjective 'experience' which cannot be objectified or quantified (Henwood & Pidgeon, 1992) and is, therefore, best studied qualitatively. Qualitative psychology with its roots in 'feminist-standpoint' research (for a more detailed discussion see Griffin, 1995) focuses on 'experience' rather than the measurement of the frequency of occurrence of a particular event or response (Smith, 1995, p. 122). However, qualitative data are not exclusive to qualitative research and come in many, and increasingly creative, forms within mixed method research. Many quantitative studies use forms of qualitative data within their design. The main difference is in the philosophical position behind the research, and the assumptions about what kinds of 'evidence' are seen as important in order to address the research question.

Both quantitative and qualitative research aim to discover the "truths that exist in the world and to use the scientific method as a way to build a more complete understanding of reality" (Thorne, 2000). However, qualitative research is underpinned by a recognition "that the relevant reality as far as human experience is concerned is that which takes place in subjective experience, in social context, and in historical time" (Thorne, 2000, p. 68).

I chose a qualitative methodology in order to represent the women in how they describe how they think and feel. However, it would be inaccurate to render 'experience' as the exclusive domain of qualitative research, as it could be argued that all psychological research investigates 'experience', albeit by different means. The choice of methodology reflects the meaning which is sought. Debates implying that any particular methodology is more meaningful than another are perhaps redundant as whether or not research is 'meaningful'

depends on whether the aim was meaningfully investigated by whatever approach is required to most effectively explore the research question, and not whether a type of methodology in itself is more meaningful than another. In this research, it is subjective accounts of experience which are sought.

1.2.1 Meaning and evidence

An issue for Psychological research is 'meaning', in that meaning *is* as it is perceived to be by the individual, or it may not be understood, even by the individual. Evidence for 'meaning' in phenomenological research is simply that participants found and expressed meaning in connection with a research question; therefore, as long as research is conducted rigorously; the meaning of the participants is the evidence. Therapy seeks to help clients to discover *their* meaning. Meaning is as meaning is perceived. Meaning may be the experience of 'a lack of meaning'. It may reflect disengagement (Frankl, 1969), continuous dissatisfaction (Schwartz & Ward, 2004) or emptiness and lack of direction (Damon, 2008). The absence of meaning may cause anxiety or depression and meaning that is expressed may be a defence against the negative feelings which uncertainty brings. In other words, it may be 'emotional compensation' (Batthyany, 2014). Meaning may be a perception of what is acceptable in a given context or culture (Robson, 2002).

In the current study, I aim to explore and describe the idiographic meaning emerging from each participant's account and to explore themes in order to inform therapeutic encounters for daughters who are mothers, and whose own mothers had EMHDs. Psychological work which may stem from this research might also be idiographic, and create different meanings due to their occurrence in alternative existential encounters, those between clients and therapists, and not between researchers and participants. Awareness, with reference to the idiographic nature of 'meaning', as it will be discussed in this research, is an important backdrop to understanding and interpreting the research findings and also those findings of IPA in general.

In this research, IPA, as a specific qualitative methodology, confers advantage in general over quantitative methods and also other qualitative methods in that it would facilitate the exploration of each participant's understandings, "as seen from inside their own socially

situated phenomenal worlds" (Henwood & Pidgeon, 1995, p. 116) and also incorporate my aim of investigating particular meanings for individuals and collecting contradictions and conflicts within individuals regarding their own experiences.

1.2.2 The influence of *my* meaning and the decision to use IPA

Counselling Psychology, as a discipline and as a vocation, recommends and indeed requires an understanding and critique of all methodologies, and advocates the importance of mixed methods research, (Betz & Fassinger, 2011). However, human phenomena are viewed as best studied using the methodology and methods which are most appropriate to the particular psychological and sociological framework within which they occur (Oakley, 1999; Onwuegbuzie & Leech (2005). This study places itself firmly within a phenomenological perspective in which it is understood that phenomena 'are' only as they exist in individual experience. In other words, what a given phenomenon means to one person may be very different to what the same phenomenon means to others. In this sense, it is not the *same* phenomenon at all, as the phenomenon is itself the 'meaning' made by the individual (Smith, 1999). Phenomenology cannot and does not try to approach the world with impartiality or objectivity. The phenomenological perspective is subjective. As Merleau-Ponty (1962, preface VIII) put it: *"*all my knowledge of the world, even my scientific knowledge, is gained from my own particular point of view".

Reconciling myself with the impact of my own inevitable subjectivity is complex. Despite the complexity, I vigorously assert the importance of continually revising my assumptions around meaning, as in my subjective knowledge, and minimising the potential for taking my own 'meaning' as given. Oguntokun (1988) cautions researchers who may be too close to a topic of the 'inherent problems of sameness'; specifically, the greater potential for influencing and over-interpreting in line with prior and personal expectations. Qualitative methods focus on the capture of subjective meaning, aiming to do so without the loss of rigour in the research process. In view of the fact that I, as the researcher, might share some of the same childhood experiences as the participants as seen by them subjectively, there was a need for a qualitative methodology which involved greater processing and reflection on my part during analysis. Counselling Psychology, regardless of paradigm, might view with scepticism the research findings of a researcher with such 'vested interest' particularly if

undeclared. This was one of the reasons for employing IPA as a methodology, as it both reconciled and utilised my potential lack of objectivity. It required me as a researcher to recognise my subjectivity and both to minimise it and utilise it with rigour and judiciousness in my research process.

In IPA research, a focus upon 'meaning' concerns how participants are making sense of their personal and social world. IPA is in its approach phenomenological in that its main area of study is the meaning which particular events, experiences or states hold for participants, i.e. the individual's perception (Smith, 2003). However, IPA also incorporates an active role for the researcher, as "the participants are trying to make sense of their world and the researcher is trying to make sense of the participant making sense of their world" (Smith, 2003, p. 52). This is known as a 'double hermeneutic'. As a researcher, there is an attempt to try to gain an 'insider's perspective' (Conrad 1987). However, access is complicated by the researcher's conceptions which in turn are necessary to make sense of that other personal world through a process of interpretation. I knew that my subjectivity could be both a strength and a weakness and that I needed a method that incorporated both my experience and sufficient methodological rigour.

The issue of how to provide reflexive and objective accounts of research has in the last decade been central to the development and the popularity of qualitative methodologies (Nielsen, 1990; Bhavnani, 1993; Cook & Fonow, 1984; Kirk & Miller, 1987; Maynard, 1994; Smith, 1996b; Dixon-Woods, Shaw, Agarwal & Smith, 2004). I have therefore chosen a phenomenological method and IPA specifically over any other qualitative or quantitative method, in order that I acknowledge my insider perspective (Conrad, 1987) within my research.

Within the qualitative psychology paradigm, IPA is becoming increasingly popular in the field of Counselling Psychology (Hefferon, & Gil Rodriguez, 2011), a discipline which itself has grown out of phenomenological practice. This is partly because it allows the researcher considerable flexibility to probe areas of interest as they emerge, and also because of the growing recognition of the value of subjectivity in psychological research in both participant and researcher (Smith, 2004). It was my hope that IPA would allow me to provide

sufficiently ‘thick description’ (Geertz, 1973) of the participants’ experiences, whilst at the same time the structure and transparency of its framework would elicit ‘confidence’ in the reader that the research was the result of an empirical encounter and not the product of my own imagination (Gaskell & Bauer, 2000). In my view, my subjectivity which stemmed from my own experiences could only be meaningful if this facilitated the messages of my participants.

Finally, as with all areas of psychological research, psychology owes much to quantitative research and discourse but designs are comparative and the variables are pre-established. I felt that if I utilised pre-established variables, my objectivity in their choice would be problematic. This would add, in my view, only the possibility of the relevance of certain variables (only those identified by myself) and might not offer sufficient further understanding of the impact of maternal mental health difficulties on individuals other than myself. I felt that IPA would, therefore, be an appropriate platform for participants to bring forward their views with maximum validity.

Chapter 2. Literature Review

2.1 Owning my preliminary thoughts

A considerable body of literature has attempted to address the issue of motherhood and mental health. Research areas have spanned adolescence (Birkeland, 2004; DeVito, 2007), pregnancy and postpartum depression (Salmela-Aro; Nurmi; Saisto & Halmesmaeki, 2001; Nicolson, Sep 2001; Nicolson, 2001- Psychology Press, 1998; Nicolson, 2003; Mauthner, 2003) and exploring serious mental illness (Mowbray, Oyserman & Bybee, 2000; Ackerson, 2003; Bosanac, Buist & Burrows, 2003; Diaz-Caneja, & Johnson, 2004**;** and including qualitative and also cross cultural research (e.g. Rodrigues, Patel, Jaswal & de Souza, 2003). Within this field, little attention has been accorded to how the daughters of mothers with EMHD might feel when they themselves become mothers. This research aims to explore the subjective views of motherhood for women whose own mothers suffered long-term mental ill-health throughout the duration of the participant's childhood. The researcher's preliminary thoughts were that these mothers were likely to have experienced changeability, inconsistency and instability in their own maternal role model, perhaps extremely so (Dierks, 2001) *and* that this might in turn have had an impact on their own experiences as mothers.

2.2 Lack of specifically relevant research

The phenomena for exploration in this study concerns the childhood and the motherhood experiences of daughters of mothers with EMHD and asks the broad research question: How might they integrate these experiences into their lives as mothers?

The aim of this research is to find out how the daughters of mothers with long-term EMHD perceive this childhood experience in relation to their adult experience of motherhood. This requires the exploration of their subjective experiences of childhood with their own mother in order to produce a narrative of some of the possible implications of their early experiences (as seen by them) upon their lives as mothers. The motivation for this research, in addition to my own personal experience, was the lack of specific research to underpin Counselling Psychology and to support these women.

Extensive literature searches showed that in fact literature was scarce in relation to the lifetime experiences in general of children of mothers with mental health difficulties and more reference to this was found in sociological (e.g. Oakley, 1992) and nursing (e.g. Oskouie, Zeighami & Joolaee, 2011) research rather than psychological. This meant information was often 'collated' rather than researched.

The emphasis in research into families who experience parental mental illness is often upon issues of risk in very young children and protective factors (e.g. Ahern, 2003; Aldridge & Becker, 1999/2003/2006; Bibou-Nakou, 2003; Cooklin, 2006) and most studies do not extend much beyond adolescence (e.g. Oyserman, Bybee & Mowbray, 2002), even in largescale projects such as 'The Greater Manchester Safeguarding Children Project', (2014), or the focus has been on the mental health purely of the mothers, or of the children themselves (Mowbray, Oyserman & Bybee, 2000; Ackerson, 2003; Bosanac, Buist & Burrows, 2003; Diaz-Caneja, & Johnson, 2004). Much of the research was found to be culturally specific (e.g. Salerma, 2001; Panter-Brick, 2011) and many of the papers were translations (e.g. Dierks, 2001), Wagenblass, 2001/2005), which also reflected specific cultural perspectives and aspects, which in itself is not a problem for research, but does highlight the need for more research reflecting varied contexts (e.g. Handley, Farrell, Josephs, Hankes, & Hazeltona, 2001). , which as stated above, simply reflects the need for more research.

There will not be the space in this research to enter into detailed discussion concerning the possible implications of broadly relevant research, or to draw together sufficiently the complexity of associated research. However, the research which has directly addressed being a child of a parent with mental illness points to the lack of an ability to offer a comprehensive model of the world which produces a positive place for themselves in it, and this suggests that outcomes for daughters of mothers with mental illness could be complex, in relation to how they see themselves in terms of having a positive model for parenting. Oskouie, Zeighami & Joolaee, (2011, p.32) presented findings that "parental mental illness leads to five major outcomes that involve communication, mental, educational, economic, and extra roles factors", and in discussion, they quote the relevance of Dunn's concept of guilt and loyalty, as reflecting a specific complication for children of mentally ill parents in their roles as caretakers (Dunn, 1993, cited in Oskouie, Zeighami & Joolaee, 2011, p.38). Oskouie, et al

further describe that, "The caregiving role is especially emotional for children living with a parent with mental illness; (as) they feel if they choose not to accept this responsibility, the family will face even greater burden (p.38). This suggests that daughters of mentally ill mothers, may have already experienced complex caretaking roles, prior to becoming mothers. The focus of research, particularly for daughters, has often been upon role-reversal in childhood, and the long term outcome of co-dependency in adult relationships (e.g. Ackerman, 1989); Agnew & Robideaux, 1998; Dear & Roberts, 2005; Wells. Glickauf & Cheryl, Jones Rebecca. (1999) and even the mother-daughter relationship as a protective factor in the mother's recovery, for example from depression (Mesidor & Maru, 2015). However, specific research exploring how daughters might feel as mothers, especially from a qualitative perspective is a gap in the literature. Research in general describes how frequent experiences of shame, guilt and stigmatisation experienced by children who grow up with parental mental illness (Corrigan & Miller, 2004) could have a negative impact upon adolescence and also have negative implications for adult relationships and self-esteem in general (Nathiel, 2007; Wells, Glickauf & Cheryl, 1999; Wells & Jones, 2000), and implicates being parentified specifically as related to the development of shame and low self-esteem in adulthood (Corrigan, & Miller, 2004).

Some research into maternal mental health and childhood adversity has been presented in order to provide an informative backdrop to this study by giving an understanding of the nature of the childhood circumstances that the participants in this study might have experienced particularly in terms of insecurity day to day (e.g. Stallard et al., 2004). Most of the existing research was set in a quantitative paradigm, , in the sense that it sought to establish reliable concepts, which, although highly informative, has less direct relevance to the phenomenological research question in this study. To date, little research relates directly and specifically to the impact of having had a mother with EMHD and the later experience of motherhood. My literature searches confirmed that vast research areas could be broadly relevant as offering context. Psychology owes a great debt. to quantitative research, both historically and currently, however, an issue for me as the researcher was the risk of immersing myself in a great deal of quantitative research and hence mindset, and being influenced by it whilst undertaking a phenomenological study. In the absence of much directly relevant research, the following areas are discussed for context.

2.3 The context of enquiry: How common are mental health difficulties?

Mental health problems affect many people's lives. The Mental Health Foundation reports that 1 in 4 people in the UK will experience some kind of mental health problem (The Mental Health Foundation, 2003; 2015); 1 in 6 people will have depression at some point in their life, a further 1 in 10 are likely to have a 'disabling anxiety disorder' and 1 in 100 may have schizophrenia or manic depression (The Mental Health Foundation, 2003; 2015).

Women are reported as more highly represented in terms of mental illness and men are more highly represented with drug and alcohol abuse problems. There are likely to be complexities involved in terms of social context and biased reporting. Approximately 20 per cent of women in England and 14 per cent of men are thought to have some form of mental illness, and 18 per cent of women and 11 per cent of men are thought to have a 'neurotic disorder' such as anxiety, depression, phobias and panic attacks. Men are said to be three times more likely than women to have alcohol dependence and twice as likely to have drug dependence; although this is still a significant problem for women as well (The Mental Health Foundation, 2003; 2015). Problems with mental health range between anxiety and depression to a loss of touch with everyday reality as can occur in psychotic disorders.

2.4 The need for support for all concerned

Many people with mental health difficulties manage these well but they can have a negative impact upon the longer term emotional wellbeing of the individual and also those around them. Although many factors can contribute to mental health problems such as genetic makeup, lifestyle and other pre-disposing social factors or life events, lack of support and information often exacerbates the difficulties for families. The Tasmanian children's project (Handley, Farrell, Josephs, Hanke and Hazeltona, 2001), conducted in Australia, discussed the needs of children with a parent with mental health difficulties and highlighted that mothers wanted their children to understand more about their illness. The research suggested that children will blame themselves for their parent's EMHD. Research has suggested that being given support and information can have a positive and mediating effect within families where a parent has EMHD (e.g. Oyserman, Bybee & Mowbray, 2002).

2.5 Being the 'mother': mothers with EMHD

Historically, research has focussed on the nature of mental illness, its causes and the behaviours associated with it. In more recent times, research has focussed upon the lives of people who experience mental ill-health and increasingly research has emerged which has addressed the issue of motherhood for mothers who experience EMHD (Rodrigues, Patel, Jaswal and De Souza, 2003). Much of the research looks at pre-disposition. The early experiences of mothers who suffer mental illness are key areas in this research (e.g. Milan, Lewis, Ethier, Kershaw and Ickovics, 2004). Researchers have attempted to find out what might predict (e.g. Sharp, Bramwell and Shar, 2004), precipitate, mediate and prevent mental illness (e.g. Lueders & Deneke, 2001), and what strategies might best 'treat' mothers with mental illness (e.g. Salmela, Nurmi, & Halmesmaeki, 2004). Other research has looked at the impact of motherhood upon the development of schizophrenia (e.g. Hearle & McGrath, 2000) and other mental illnesses (Bosanac, Buist and Burrows, 2003) in terms of the hormonal challenges and stress which childbirth and parenting may bring, especially where mothers are isolated and without support.

There is a large body of research which reports mothers' own accounts of depression (e.g. Rodrigues, Patel, Jaswal and De Souza, 2003; Nicolson, 2003; Mauthner, 2003), and of other mental illnesses (Dipple, Smith, Andrews and Evans, 2002; Diaz-Caneja & Johnson, 2004).

Research in connection with the area of maternal mental illness and parenting tends to focus on the experience of motherhood for women suffering with EMHD, and, understandably, the need to support them. Research has centred around such issues as: meeting the unmet needs of mentally ill women (Diaz-Caneja & Johnson, 2004), mental illness as a correlate to parental stress (Sepa, Frodi and Ludvigsson, 2004), women's stories of post-partum depression and coping with their baby (Dipple, Smith, Andrews and Evans, 2002; Mauthner, 2003), and the impact of motherhood upon women with a mental illness (Bosanac, Buist and Burrows, 2003; Hearle & McGrath, 2000). However, where a mother's own mother experienced EMHD, there is little research from which to look deeply into their view of their life with their mother and its impact upon motherhood for them.

2.6 Being the child: the effect of maternal EMHD upon child and adolescent welfare

The vast majority of research therefore has addressed maternal mental health and looks less on the possible adverse effects on their children. Research into the latter topic is fast increasing but there is less discussion of effects beyond adolescence. Adolescence is known to be a pivotal and stressful time. Oyserman, Bybee, Mowbray & Hart-Johnson, (2005, p.456) found several problematic aspects of parenting, which impacted children and in the longer term adolescents, which included, "permissive parenting generally and, particularly, lack of follow through and lack of parenting confidence, as well as a component of punitive parenting—verbal hostility. Oyserman, Bybee & Mowbray, (2002) further found that maternal mental illness, put adolescents at risk of depression. Research suggests that the long-term effects of parental mental health upon children are often adversity including self-blame and shame (Cooklin, 2006; Corrigan & Miller, 2004; Huntsman, 2008), poor educational outcomes and a greater likelihood to become involved in crime during adolescence (Preski & Shelton, 2001) and *low* self-esteem and insecure attachments in adult relationships (e.g. Miller, Warner, Wickramaratne and Weissman, 1999; Dierks, 2001; Raske, 2002; VanDeMark et al., 2005). A smaller (but expanding) body of research within work addressing parental competency has highlighted the need to pro-actively support children in families where a parent has EMHD (e.g. Wagenblass, 2001; 2005; Dierks, 2001). Research suggests that a high proportion of the children of mothers with EMHD will have a diagnosable disorder sometime in their life (e.g. Miller, Warner, Wickramaratne and Weissman, 1999). Aldridge and Becker (2003), in their qualitative interviews of young carers, found that children were often angry that they were left to care for their parent, feeling that they themselves were often 'unseen', even in assessments. Such findings highlight that there remains a need to be alert to behaviour which might present as 'acting out' or being unusually silent, but is indicative of distress which might be present (Cooklin, 2006; Corrigan & Miller, 2004).

Some research (e.g. Hagerty, Lynch-Sauer, Patusky, Bouwsema and Collier, 1992, cited in D'Arcangelo, 2004), has found that a 'sense of belonging' may be vital to both the maternal-child relationship and in turn parental competency. In a descriptive correlational study,

D'Arcangelo (2004) explored the relationship between 'sense of belonging' and parenting competency in a sample of 155 mothers, 69 with mental illness and 86 without mental illness. Descriptive results indicated that mothers with mental illness differed significantly from mothers without mental illness in their sense of belonging. D'Arcangelo (2004) found that mothers with EMHD scored lower on measures of warmth and the encouragement of independence and higher on measures of aggravation. This raises the possibility that their adult children may experience difficulties with both anxiety and lack of confidence. D'Arcangelo's (2004) work is an example of the effective use of both qualitative and quantitative methods, by which important concepts have emerged and underpinned both further research and therapy. However, the concepts for consideration were predetermined as D'Arcangelo used measuring instruments and there is no way of knowing what mothers in each group might have said if qualitative discussion had been more freely entered into. It would be useful therefore to explore how it feels as an adult looking back on being the child and specifically their reflections on their experiences as a mother, as is the subject of the current study.

Research has indicated that there is a lack of knowledge particularly in rural areas about the effect of maternal mental illness upon children's welfare (e.g. Raske, 2002), leaving many children in these areas unsupported. The service cohesion and co-ordination of mental health services within and between countries has been shown to differ greatly (Gopfert, 2004). Ideally, the quality of support for children of mentally ill mothers would not depend upon where the child lives (Hetherington & Baistow, 2001). A coherent and consistent (but adaptable) policy would be most helpful.

2.7 The hidden carers

Much research has shown the deleterious and lasting effects of maternal absence particularly in the case of bereavement (e.g. Nguyen & Gelman, 2002), but this has tended to overshadow the difficulties which can be experienced when the mother is alive but her emotional functioning is impaired. In the absence of a maternal figure in the family home, children - and some research suggests especially daughters (e.g. Mayseless et al., 2004) - often become young carers. Much of the research into role reversal applies to maternal bereavement, which is of course much needed and informative research. There may indeed be commonalities as

well as divergences between the experience of the bereavement of a mother who has died and the 'bereavement' and sense of persistent loss because of the mother's difficulty in relating, or absence from the home. Some research suggests that the emotional dependence of a mother with EMHD and the nature of the parent-child relationship could be more detrimental for daughters and for mother-daughter relationships (Alexander, 1993; 2003) particularly as daughters often replace the role of the mother because they have learnt to identify with that role. Research has also suggested that depression is a more common experience in daughters and conduct disorders are more common in boys.

In 1998, Dearden and Becker (in Underhill, 2003) surveyed 2,303 young carers from 69 young carers' projects in London. They found that children as young as five were having to assume the burden for relatives with mental health difficulties (as well as other disabling problems). They quote the Children's Society as saying that in London there are likely to be about 7,500 young people between the ages of four and nineteen who take on caring responsibilities. This project reported that 58 per cent of carers were caring for their mother and 29 percent overall were caring for a relative with mental health problems. It was also found that 1 in 5 carers provided intimate care and 1 in 3 regularly missed school and had educational difficulties because of their caring role. Dearden and Becker (1998) defined a young carer as "one who has responsibility for care which would be more appropriate for an adult; whose young life is restricted and/or who is giving care in the absence of other support". They also reported it as common for other relatives to rely on a child carer and to fail to appreciate the problems of this caring role for the child. Some research alludes to the appreciation of the child's role in support, for example as a source of support where mental illness exists in a parent (Mowbray, Oyserman & Bybee (2000) but this should be viewed with caution and in the context of prioritising support for the child.

2.8 Helping the child

The most recent and relevant research found on the needs of child carers of mentally ill parents was conducted in Germany. However, translations, were literal and difficult to interpret. Wagenblass (2001; 2005) conducted research in the Juvenile Welfare Service in Munich, Germany. Recommendations were made based implicitly on the problems experienced by young carers. To summarise these recommendations, Wagenblass advocates

the use of trained specialists in education and offers “criteria for the estimate of the life situation of the child”.

Wagenblass cautions that it is vital for the development of the child’s personality that basic needs are met, particularly emotional social and protective needs and warns that the consequences of ignoring these needs are likely to be grave. Wagenblass suggests removing the child only if necessary for mental and physical health and that considerations of this fact should include: the subjective experience of the child and their physical, emotional and intellectual welfare most particularly in terms of protecting them from family overload. Other concerns which were highlighted were the lack of information for the child, the tendency towards self-blame and what they refer to as “the disturbance picture” or the level of confusion for the child which they say is often caused by swings between periods of wellness and illness in the parent. This ‘disturbance picture’, may well impact longer term experiences, and potentially, in terms of the current research, daughter’s experiences as mothers.

Finally, Wagenblass urges consideration of material and social factors affecting the child’s experience and finds that children often compensate for family dysfunction. Wagenblass argues that children in this situation have the right to live age-appropriately, to have their own needs met over the illness of their parents, to be given the opportunity to talk through connected fears and to be given a free space where they are not exposed to illness. Wagenblass continues to advocate assessment of the life situation of the child and input into their lives as children, rather than removal of them from their home, and certainly rather than leaving a ‘status quo’ unaddressed.

2.9 Transgenerational effects

Transgenerational transmission of tendencies or characteristics as a concept (e.g. Grobler, 1995; Brassard, Hart, Stuart and Hardy, 2000) suggests that generational effects are socially determined which may be relevant to the present study in which I aim to hear the voice of daughters who become mothers.

The current study is potentially impacted by transgenerational effects. Mothers have historically felt blamed for the outcome of their children from many quarters (including psychology) and the following research is no exception in so far as it alludes to the

importance of mothers. However, the current study is complicated and unusual in the fact that motherhood and its complexity connects all the 'participants' in this research. The researcher, as a mother, has experienced many of the stresses of motherhood and is mindful of the fact that all the mothers in this study share the experience of being women and experiencing the emotionally complex task of mothering. Participants will be requested to speak about other mothers, their mothers, whilst they themselves are mothers of children who in the future may also have a narrative to offer about them. There is therefore no intention in this study to evaluate or judge any mother, as indeed the mothers of the participants in this study may well have been the daughters of mothers with EMHD themselves.

Research into generational effects has been predominantly quantitative in its methodological process and has highlighted important concepts, although this can tell us less about the phenomenological experience of those the research represents. Jones, Beach and Forehand (2001) in a longitudinal study conducted at two points (a year apart), found that mothers' initial depressive symptoms generated perceived stress in mother–adolescent relationships a year later, which in turn exacerbated the mothers' depression. This gives an example of how a tendency towards anxiety might be socially trans generationally transmitted. Much research into transgenerational transmission of tendencies or characteristics explores attachment issues (e.g. Grobler, 1995; Brassard, Hart, Stuart and Hardy, 2000; Connor, Sandi, 2006). Obegi, Morrison and Shaver, (2004) conducted research into the intergenerational transmission of attachment and their results generally supported their hypothesis that "mothers' adult attachment organization, but not fathers', is related to daughters' adult attachment organization". Significantly perhaps for daughters of mothers with EMHD was the finding that mothers' avoidance predicted daughters' avoidance. Avoidance referred to the "degree of discomfort experienced with physical and emotional closeness in romantic relationships" and this was the strongest predictor of daughters' attachment organization. Mothers' EMHD is likely to affect attachment (D'Arcangelo, 2004, Obegi, Morrison & Shaver, 2004) and it might be expected therefore that mothers in the present study would report some difficulties in bonding with their children. However, bonding is complex and there may be many aspects of childhood which impact individuals and attachment uniquely. For example, Elliot and Thrash (2004), researched the intergenerational transmission of the fear of failure, and found that a mother's fear of failure was linked to her use of 'love withdrawal' as a behavioral

technique in the management of her child. This technique in turn was linked to fear of failure in a sample of students at undergraduate level suggesting the potential for long-term effects. Interestingly, at least in this research, this effect was not found by the researchers for fathers.

2.10 Being the daughter: being a mother

The phenomena for exploration in this study concern the childhood and the motherhood experiences of daughters of mothers with EMHD and asks the question: How might they integrate these experiences into their lives as mothers? Without understanding these daughters as children, it is difficult to imagine the factors which could affect their adult lives and how they might respond to motherhood. The above research offers some potential insights. In considering how daughters of mothers with EMHD may experience becoming and being a mother, it may be helpful to think about how mothers in general experience motherhood; this includes research into the transition and adaptation to motherhood for first-time mothers. The focus here where research alludes to difficulties in adjustment to being a mother is often upon the mediating role of support in mothers' perceptions of their efficacy (Priel & Besser, 2002; Porter & Hsu, 2003), as well as the challenges faced at particular life stages where role conflict and social isolation might be a factor, for example adolescence (Birkeland, 2004), and motherhood; the focus of the current research. Much research into the transition to motherhood suggests that this can be a challenging time for all and that to a certain extent some level of distress and even depression should be seen as 'normal' in this process (Nicolson, 1998/2003). Nicolson concluded that post-natal depression is a normal response to a series of losses but is not conceptualised in that way in the dominant discourse. However, long-term depression cannot be seen as synonymous with initial shorter-term depression.

The need for proactive support was noted by Nicholson (2001), as services are often only available (though not sufficient) when parents or children have a diagnosable problem, or after abuse or neglect has been identified. A preventative stance is not often assumed. Ackerson (2003a) suggested that rather than focus on parents' deficits, researchers need to acknowledge the cyclical nature of mental illness, and an individual's parenting strengths. This might also lessen the stigma often associated with seeking treatment for many parents (Corrigan & Miller, 2004).

The literature also shows that although a number of life factors can affect the transition to motherhood, many studies have found an increase in positive experiences among women in pregnancy and motherhood. For example, Smith (1995) conducted an idiographic and primarily qualitative study of four women (age range 25 to 29) going through the transition to motherhood. Using IPA, Smith (1995) extrapolated from his analysis many examples of categories which might be seen as reflecting positive emotions such as 'happy', 'incredible', 'looking forward'. The intention in the current research is not to present a 'fairy-tale' transition to motherhood for mothers in general and a 'traumatic' transition for daughters of EMHD, as it is well documented that pregnancy and motherhood can be extremely stressful for many women. However, as Smith's research illustrates, although other categories reflected anxiety, particularly as the birth drew near, these anxieties were about the birth and less about an evaluation of themselves as potential mothers.

Bailey's (1999) research is an example of the connectedness that has been reported in new mothers, as Smith (1995) also found in his IPA research into the transition to motherhood. Bailey found that in pregnancy many women spoke of feeling that they had 'joined a club' (motherhood) and some felt that they been given an 'excuse to be vulnerable'. In terms of the influence of the social construction of gender (see Kitzinger, 1987; Capdevila, Ciclitira and Marzano, 2006) this may suggest that women feel the need to have permission to 'be vulnerable', rather than for example just accepting when they might feel vulnerable, or not necessarily needing to be vulnerable in order to be cared for. Bailey (1999) also found that for the most part women experienced pregnancy and the transition to motherhood as not involving a complete change in themselves but rather an increase in their awareness of different aspects of themselves. It may be therefore that for daughters of mothers with EMHD that some of the new aspects of themselves which come to the fore are problematic. It is possible, given their childhood experiences, that coping mechanisms learnt in that childhood which, for example, may have disguised what could be termed as a 'fragile sense of self' (Alexander, 2003), may be insufficient or unhelpful in their new role as mother. Given that the mothers in this study are likely as children to have been carers at least in some sense and beyond appropriateness for their age, it might be that 'mothering' might evoke some of the anxieties and feelings of exhaustion which they may have felt as children.

2.10.1 Bringing research together: an overview for the adult mothers

Mental health difficulties span all areas of research and touch all areas of experience. There can be no area of life and few families that are not touched in some way by mental health issues. The women studied here will represent a wide range of families and, for the purposes of this study, their mothers will represent a variety of ways in which humanity struggles in terms of mental health. There exists extensive research into the impact of mental health difficulties on individuals and quite often mothers themselves (Bosanac, Buist and Burrows 2003). Increasingly, there exists research into the impact of maternal mental illness upon children. Much research addresses the issue of role reversal, particularly for girls (Alexander, 1993; 2003) when a mother suffers mental health difficulties. However, daughters have been found in research to be protective factors for their mothers in the rehabilitation of major depression, and some research finds that this is not without two-way benefit (Mesidor & Maru, 2015) when sufficient support is in place.

The research area is vast in terms of socio-psychological research (e.g. Oakley, 1992). Most research expands profusely on the need for support, but it is expensive and sufficient support is rare. Increasingly, the focus of research such as this relates to exploring protective factors and supportive and therapeutic intervention, is to outline preventative and proactive measures as imperative to protect the adult's and child's wellbeing (Hetherington & Baistow, 2001; Dierks, 2001; Falcov, 1996; 1998; 1999).

Research which pertains to being a mother with EMHDs has often focussed upon the mother's mental illness and impact upon her experience of parenting (Diaz-Caneja & Johnson, 2004; Ackerson, 2003a; Bosanac, Buish and Burrows, 2003; Dipple, Smith, Andrews and Evans, 2002; Hearle & McGrath, 2000). However, research concerning the welfare of children where parents and particularly mothers have mental health difficulties has broadened, and concepts of attachment (Alexander, 1993; Obegi, Morrison and Shaver, 2004), co-dependency and young carers, role reversal, educational outcomes and personality and outcomes, especially long-term outcomes are often found to be of concern (Huntsman, 2008).

The impact of maternal EMHDs upon child welfare and wellbeing is complicated to assess. Aldridge (2006) has put forward that what has been missing from research is 'deeper insight' from qualitative studies about children's experiences of caring for parents with mental illness, which should be used to 'develop policy'. Aldridge interviewed children, parents and key workers and found that children experienced a broad range of detriment to emotional, social and educational wellbeing and specifically lack of confidence and a lack of a positive view of self. However, Aldridge also found that there were many instances of positive parent-child relationships, findings that reflect the complexity of the individual circumstances in which children find themselves, the need to avoid assumption and the benefit of listening to children (Wagenblass, 2001/2005; Aldridge, 2006).

It is complex to interview children and often not possible without adult impact upon what is said (Farrell, 2005a/2005b). The women in this study were children whose mothers suffered mental health difficulties throughout their childhood and can offer important insight into the lives of children as they describe how they experienced themselves as children and now as mothers. Retrospective though this will be, this is much needed research.

The most significant and overriding research finding to date reflects the vulnerability of children, where mothers suffer mental illness, as this can render them increasingly vulnerable to the abuse of others, or simply to neglect and sometimes from abuse from their mother. The potential lack of functioning of the mother leaves a specific 'gap' in care and therefore a vulnerability in terms of safety (Reupert & Maybery, 2007; Panter, Goodman and Eggerman. 2011). It has long been highlighted within research that children without mothers may be less protected (Wagenblass, 2001/2005). In addition, they may be at risk from their mother if her mental illness predisposes her to potentially harm them (Lazenbatt & Taylor, 2011). More often, it may be the lack of parental competency and watchfulness which leaves children vulnerable to neglect or abuse (Alexander, 1993; Evans, 2002; D'Arcangelo, 2004).

While the existence of mental illness in a parent *may* be present for children who experience abuse, this is not always so. However, it is likely that the mental health of mothers and the impact upon themselves and their children is still under-reported and this will not always be known to be affecting a child or an adolescent either by those close to them (Oyserman,

Bybee and Mowbray, 2002), or in schools, or throughout medical care *(*Bibou-Nakou, 2003). Research suggests that the negative impact upon the identity, self-image and self-concept of children often only surfaces during adolescence (Oyserman, Bybee and Mowbray, 2002; 2005). *Falcov (2*004) found in talking directly to children that they often felt to blame or responsible in their caring role as carers for a mentally ill parent (often their mother), were afraid of how others would view them, and frequently felt angry and unseen. It is often less obvious to a child that others will understand their need, even in comparison with other children whose caring role may be more visible to those around them.

A key feature of research which explores the concept of co-dependency in the long-term outcomes for children of mothers with mental illness is the impact upon education, especially when the child is also a young carer for their parent (Wagenblass 2005; 2001). Poor educational outcomes, often result in low self-esteem and low confidence, with children blaming themselves for perceived failure (Elliot, Fischer and Rennie, 1999).

Wagenblass (2001) highlighted comprehensively what she termed the ‘disturbance picture’ as being the central benchmark for concern and for the directing of appropriate input. Wagenblass strongly recommends listening to the child in their circumstance and assessing the extent to which the child is able to live and experience a life separate from their parent. Where that parent (often the mother) is mentally ill. Wagenblass suggests there can exist greater ‘disturbance’ in the life of the child which extends beyond the caring role.

Distinctions are wisely drawn between the varied circumstances in which young carers find themselves and specifically situations concerning the mental health of a parent. Research highlights an increased tendency for self-critical thought (Elliot & Thrash, 2004) and insecure and disorganised attachment (Breazeale, 2001) as common among children who grow up with the complexity of mental illness impacting upon their daily life experiences. Although tremendous resilience has also often been recorded (Aldridge, 2006), much research has described the emotional impact on self and identity for children of mentally ill parents. Findings include pervasive experiences of shame, humiliation and negative self-other comparison, as well as exhaustion and unrealistic expectations of themselves which research suggests persists at least through adolescence to adulthood (Oyserman, Bybee and Mowbray,

2005; Earley & Cushway, 2002; Wells & Jones, 2000) and can also lead to adult co-dependent relationships (Wells, Glickauf-Hughes and Jones, 1999).

Nathiel's (2007) qualitative study *Daughters of Madness* found that common to these women were experiences connected to shame, secrecy and confusion and conflicting self-other comparisons between their own experiences of 'family' and those that they saw around them. Women spoke of envying other children in their caring roles and many spoke of the complete isolation they experience in a world that they did not understand and no one else seemed to be able to help them to understand. This was a world they grew slowly to understand across the course of adulthood, and many women expressed regret at the sadness of their lives and their feelings that earlier support could have changed the quality of their adult lives significantly. Many women in Nathiel's study spoke of the denial that surrounded them and of the lack of information that had been available to them, both as children and adults. Both Nathiel (2007) and Aldridge's (1999/2003/2006) work speak separately in their unconnected research to the women and children represented in the present study and no doubt echo many of their experiences in their findings but not however, in terms of how it might be to be a mother themselves following the complexity of their childhoods.

It would be interesting to see what kind of self-other comparisons might be represented in the identities emanating from the interviews in this study. I might expect that gender and societal expectations may feature and from a feminist perspective, these women may experience greater pressure to be or to ally with a 'maternal construct' which is heavily advertised, described, and both glorified and vilified in the society that has surrounded their experiences as women and as mothers. Research suggests a strong sense of 'othering' for women in social comparison theory, with a broad and enduring impact in a variety of circumstances. Capdevila, Ciclitira and Marzano's (2006) exploration of social constructions around gender for women in their everyday lives describes how constructions of feminine gender serve to disempower and distort the lives of women and how the concept of the 'other' can serve to create, perpetuate and reinforce negative self-images of women, that is, 'If I am woman, who are they?'. The dominant discourse concerning being a mother and a woman, although culturally determined, often contains some kind of 'selflessness' and rarely promotes positive distinctiveness in terms of 'whatever kind of mother you are is fine' – but rather the

expectations for women of what a mother is, or should be and how they should think and even feel as a woman and mother; and even that they should be a mother, or if not a mother, then 'motherly'. This is still deep-rooted in women's sense of themselves historically, or in how they are told to 'sense' themselves. It is likely, that in terms of being mothers, the expectation from society is that these women have stable recognisable identities that reinforce what is expected of a woman and mother, as it is the dominant discourse for women. Further, because the discourse concerning motherhood in society is pervasive and can be uniform, it is not easy for women to be unique as mothers and to value themselves as they are. Women are unique and have unique childhoods, however, it may be that for the women in this study, positive distinctiveness as mothers was very challenging (Oyserman, Bybee & Mowbray 2002).

Research into co-dependence suggests that women who have grown up with other women with mental health difficulties may be likely to gravitate towards co-dependent adult relationships (Jones & Wells, 2000). Feminist critique is of the term 'co-dependence', especially where assumptions of gender are bound up in this concept and where the research focus has been upon daughters of parents with chemical dependency issues (Jaeger, Hahn and Weinraub, 2000). However, the behaviours and experiences which are discussed in co-dependence studies are well documented regardless of discussions of the term and are not necessarily gender specific, though the reasons and evaluations of these experiences may differ according to both gender and the research paradigm. In particular, for women, the pervasive concept that they are, or should be, 'carers' in society (Capdevila, Ciclitira and Marzano, 2006) features in how they are described and researched in studies of co-dependence, and of course research more generally.

In terms of social comparison, women who are the daughters of mothers who struggled with EMHD are often carers (Wagenblass, 2001; 2005). In addition, research suggests they are more likely to take on the role of absent or less functioning female adults in their lives (Underhill, 2003). This suggests that they may learn to value themselves in a caring role, or perhaps to feel more secure in knowing themselves or even appreciating themselves only through caring roles. This could in turn lead to the tendency to be self-critical of their abilities within 'caring roles' and where this is a significant part of their daily lives as children, this

could also feature in their seeking out similarly functioning relationships in adulthood (Jones, 2000; Castro, Jones and Mirsalimi, 2004).

Research into the concept of co-dependency in women puts forward the difficulties which women in particular may face in establishing a differentiated self, and the risk of experiencing an undifferentiated self or a lost self-owing to the complexity of their caring role and of the models of relating which surround them. Research also alludes to the possibility of 'intergenerational' effects socially, through social comparison and modelling (e.g. Elliot & Thrash, 2004).

2.10.2 Moving to motherhood

Research into post-natal depression (PND) has centred largely around the situations or characteristics which might precipitate depression, for example, high dependency and self-criticism in first-time mothers have been correlated with depressive symptomology (Priel & Besser, 2000), as have other variables which affect maternal adaption to motherhood such as perceived pre-natal adaptation (Kiehl, White and Marjorie, 2003). Research suggests that early responsibility and lack of support may cause individuals to be highly critical of themselves and that this in turn can have deleterious effects upon health and social well-being. Shaw (2004) in an American study of a nationally representative sample of adults ages 25 to 74 years found that lack of parental support during childhood was associated with increased levels of depressive symptoms and chronic conditions in adulthood. Shaw (2004), also asserts that "personal control, self- esteem, and social relationships" during adulthood accounted for much of these long-term associations and caution as to the importance of adopting a "life course perspective in studying the social determinants of health among adults". Nevertheless, this research suggests that low self-esteem in adulthood may have been related to early lack of support. Much research alludes to the short- and long-term consequences for children of mothers who suffer mental ill health and increasingly research is seeking to understand the lives of children living with mentally ill parents, especially mothers (Johnston & Swanson, 2004; Brynna Kroll, 2004). It may be that these children could be particularly prone to depression and anxiety when they become mothers.

Birth has been described as one of the most culturally and spiritually significant events for women (Khalaf & Callister, 1997, in DeSouza, 2004). DeSouza's work in New Zealand reported that "cultures with supportive rituals for new mothers have lower rates of postnatal distress (PND) and that women in Western countries are at high risk of developing PND". The role of support (Priel & Besser, 2002).) may be particularly relevant to the experience of the mothers in this study. Motherhood involves, among other things, the adaptation (usually permanently) to a new role and research shows that support is particularly needed at specific stages in life, especially any stage involving role conflict/social isolation, which may particularly affect new mothers, or mothers in general who may lack support (Birkeland, 2004).

2.11 The role for counselling psychology

Though interest in the development of maternal attachment and identity continues (Smith, 1999; Kretchmar & Jacobvitz, 2002; Steinberg, 2005), research which unites specifically maternal attachment to the formation of individual's perceptions of themselves comes in for much criticism. Critics describe discomfort with what they see as a one-size-fits-all mother-blaming culture which perpetuates history's emphasis upon women and maternal care, as being responsible for all societal ills. Such studies have been critiqued for emphasising an essentialist or unitary view of women and mothering (Arendell, 2000; Baber and Allen, 1992). Attachment and identity studies tend not to explain the diversity of the experiences of women as mothers, or to consider how motherhood evolves in varying relational and family contexts (Gerson, Alpers & Richardson, 1984; Glenn, Chang & Forcey, 1994). Stallard et al. (2004) pointed out that "the association between parental mental illness and child disturbance has been documented 'but' the experience of children coping with such illness has received comparatively little attention". They found that there was a need for a family-focused approach to parental mental ill-health as children were concerned about their parents, had little understanding of their parent's illness and often wanted more information.

Research has suggested that children of parents with mental health difficulties have an increased risk of psychological problems (Ahern, 2003) and can therefore be considered 'at-risk'. Some research aimed at establishing mediating strategies has looked at the need to encourage children to discuss their individual experiences (Dierks, 2001). Bibou-Nakou

(2003) pointed out that there is a need for support which is not currently met and that school practice needs to be improved in its ability to respond to the needs of children of mentally ill parents. There is a clear role for Counselling Psychology to play here as counselling psychologists have the skills and access to techniques which are rooted in psychological research and theory. As a skilled practitioner of more than one model and having the basis for the training and expertise in all models, counselling psychologists could help to prevent or minimise negative outcomes for these children. In addition, the mothers in this study are unlikely to have received support or counselling in their childhoods. It is hoped that this study will help counselling psychologists to further understand the nature of the childhoods of women whose mothers suffered mental illness and also their own subsequent experiences as mothers, in order that effective support may be given to these daughters as adults.

Research into the lifetime experiences of some of these children has shown regularities and commonalities in their individual experiences (e.g. Wagenblass, 2001; Nathiel, 2007) but there remains a gap in the research regarding their experiences as adults and as relevant to this research, the experience of these daughters when they themselves are mothers.

2.12 The aim

The aim of this study was to capture the meaning of motherhood for daughters of mothers with EMHD as a gap exists in the research regarding the experience of these daughters when they become mothers.

It is hoped that this research will help to gain some further insight into the views of women as adults when they experience motherhood, an event and a process to which their childhood experiences of their own mother's EMHD may be significant and pertinent. Further, this research hopes to add to the understanding of some of the kinds of experiences of motherhood which might reflect having been parented by a mother with enduring EMHD. The current research asks the question: "What might be the experience of the daughters of mothers affected by EMHD, when they themselves become mothers?"

Chapter 3. Method

3.1 Personal methodological reflexivity

I have included a comprehensive method section in this research because it is my epistemological stance that transparency is the essence of good IPA research. It is my belief that research can only be comprehensively evaluated by readers or participants if the fullest process is detailed. Interwoven throughout this section are my reflections on process which has been inspired by my diary and is as directly representative of the method, methodology and procedure that I undertook in this research.

3.2 Epistemological reflexivity

My primary focus as a researcher is in enabling people who are stuck or unhappy with their lives in some way (Glasser, 1998) to move forward. In this sense, my research allies with my therapeutic work. In the interest of transparency, I must disclose that I am essentially a counselling psychologist in both my research and in my field of work. I have been, I believe, careful to pay attention to this fact in both my interviewing and my interpretation of data, by owning this emphasis and keeping alert to this in my self-monitoring. Perhaps because of this underpinning, it is important to me that IPA research is 'useful', both to those studied and also to practitioners. Historically, hypotheses and the testing of hypotheses have been seen to determine whether or not research is useful. By its very construction and epistemological ethos, IPA cannot be seen to be offering either verification or falsification, and there has been considerable debate concerning exactly what IPA research offers to psychological research. For myself, as a researcher, I believe that IPA research must be defendable in terms of its rigorous and transparent process.

Perhaps also because of my own therapeutic underpinning, it is most important to me that IPA research is 'useful' to those studied. I knew that there could be a 'meeting of minds' easily forged which might predispose me to 'think I know' as a daughter of mental illness and as a researcher. This could lead me to be pre-disposed to make guesses too freely and then substantiate them. I was concerned that I could easily follow this road unconsciously and I had to question how I might know if I had done so. There have been criticisms of some IPA research in that it draws conclusions in a way that can be either too theory-based or over-

interpreted, i.e. not substantiated by the original data, and my aim was to remain acutely aware of this possibility, and not to lower this awareness until the last word of my written account. I would hope that my research is useful to therapists and if so, it will ultimately be useful to those studied.

3.3 The descriptive-interpretive debate

The Descriptive-Interpretive debate in itself evidences the difficulty in conducting good IPA research. It is necessary to simply describe in order to extract the initial observations from which themes eventually come. Having spent the first year of this doctoral research debating whether observations and themes accurately reflected the interview content, I have learnt how pivotal the early stages of analysis are when using IPA as a methodology. In IPA research, initial observations represent the point at which the researcher endeavours to try to see as objectively as possible what each participant is actually saying (Smith, 2009). The temptation is extremely strong to skimp on this stage and to angle observations towards a desired end. This will be equally so for professional researchers whose process can go comparatively unchallenged once their reputation is secured. This is, in my opinion, a good reason for conducting the extraction of initial observations with a team. However, the risk of collusion and influence is then high and therefore, this may be best done separately and independently by members of a team.

Whether particular IPA research is too descriptive or over-interpretative is also debatable. I would argue that ‘pure description’ has a valid place in research, as this comes from the participant directly, with minimal analysis. However, pure description is only a matter of degree and can only refer to an individual researcher’s attempt not to interpret the words of participants at all. There is no ‘pure’ language of description (Murray & Holmes, 2014). I would emphasise the need for the initial description to be full and for initial themes to also remain largely descriptive in order for the themes to represent the data from one interview without further analysis for as long as possible in the process. In this way, when the researcher openly begins to interpret, these themes are still very close to the actual spoken content of the interviews. Willig (2001) argues that in order to preserve the essential qualities of the interview, psychological concepts and terminology should be avoided until the researcher is identifying themes. As a researcher, I have come to know that the most

important aspect in maximising the validity of IPA research lies in the length of time a researcher can have the opportunity and the patience to stay within the early stages. It is most important that participants are represented by the researcher having remained as close as possible to the original statements for as long as possible so that those reading the research can see the process and hence from where the interpretations stem.

IPA research aims to present its findings as useful in the field of research. For me, for this to be so, it is vital for the researcher to repeatedly own all they know of the process by which they have chosen particular themes and what might underpin their choices and interpretations, and to show how they have tried to heighten their awareness of their own internal processes during analysis. It is therefore ensuring the clarity of the processes underpinning interpretations which is my primary focus as a researcher.

3.4 Alternative methodology

There are several methods which explore 'meaning making' (Smith, 2010) and lived experience to various degrees. These include diaries, focus groups and semi-structured interviews (Osborn & Smith, 1998), Grounded Theory (Glaser & Strauss, 1967; Willig, 2008), Discourse Analysis (Potter & Wetherell, 1987; Parker, 1992; 1994) and Narrative Theory (Osborn & Smith, 1998). I did not want to restrict my research to meaning making on my part as my philosophical underpinning was hermeneutic. I was drawn towards Discourse Analysis, but I did not want to restrict my enquiry to meaning through language, even though I was fascinated to learn how language and behaviour might be connected emotionally for the participants. Many therapists and researchers advocate that negative behaviour can be changed from within once consciousness is raised through the analysis of language (e.g. Potter & Wetherell, 1987) and I was interested to explore further how this could be helpful therapeutically in terms of clients whose circumstances and experiences might be reflected in the accounts of my participants. There were many points in this analysis where I had a strong desire to alternate my method between Discourse Analysis and IPA and it took some time before I realised the strength of my own unconsciousness and tendency to analyse and interpret through language. This realisation enabled me to endeavour to both avoid linguistic over-interpretation and to utilise interpretation when I felt reassured that this was methodologically justified.

Since the philosophy which underpinned this research was phenomenological, my choice of methodology was necessarily hermeneutic. I needed a methodology in which I acknowledge my own involvement (Smith, 2003).

In considering Grounded Theory, I further decided that I did not want to produce theory, in accordance with Grounded Theory principles, because I felt that my topic of study was too young to look towards overarching theory and also because I did not feel that this was appropriate for the area of study in which 'lived experience' and rich description were central. In Grounded Theory, multiple data sources contribute to challenge the emergent theory from, for example, diaries, literature and observations. The data are compared as the researcher looks for contradictions to challenge the theory in order to strengthen support for theory (Henwood & Pidgeon, 1995).

It felt most appropriate for me to gather the information which participants wanted to afford me and for me to make sense also, through 'attentive listening' to them, of their meaning making (Smith, 2003) whilst at the same time knowing that I was inevitably some part of that meaning making. Further, my own personal reflexivity suggested to me that I should involve myself in being 'with the other' (the notion of *Dasein* in Heidegger, 1962). As previously stated, I reflected on both the benefit and the risk, given my closeness to the topic of my research of the inter-subjectivity this would incur (Finlay, 2007). I was aware of the potential for bias that this would bring but I could not have envisaged just how difficult it would be, especially in the analysis, to bracket my own prejudices (Coyle & Rafalin, 2000; Schon, 1984).

3.5 Rationale for Interpretative Phenomenological Analysis (IPA)

In order to initiate this research with an understanding of the philosophy underpinning my work, I have addressed my rationale for the choice of methodology and method in the introduction to the portfolio. The following discussion will further support this justification by discussing what IPA is and is not, and why it was thought to be the optimal methodological choice.

This was a qualitative research design using semi-structured interviews and IPA (Smith, Flowers and Larkin, 2009). Interwoven below are aspects of the evaluations of IPA presented in Heffron & Gil-Rodriguez (2011). Semi-structured interviews offer flexibility to the interview process allowing the interviewer to be free to probe for more detailed responses or to engage in dialogue which can enhance clarification (Kvale, 1996). This allows an individual and personal relationship to evolve between participant and researcher thereby maximising the richness of themes. The limitations of semi-structured interviews and IPA can be said to be similar, in that the flaw is that their potentially enriching processes can only hold worth if the data has evolved through the mindfulness and research skills of the researcher. Semi-structured interviewing requires the researcher to remain open and to embrace the unexpected (Parker, 2005). However, in both the IPA method and in the semi-structured interview process there is considerable potential to influence the participants' responses. It is therefore necessary for the researcher to balance the aim of their research question with the road that the participant leads them down. Further, it is vital that the researcher reports both the content and the process with integrity and without egoistic intentions. The semi-structured interview questions are a guide with which there is the intention to cover aspects that might explore the research question.

IPA has been widely adopted by researchers across disciplines and specifically in the social sciences, such as health and psychology (Knudson & Coyle, 2002: Larkin & Griffiths, 2002; Coyle & Rafalin, 2000; Smith, Flowers & Osborn, 1997; Flowers, Smith, Sheeran & Beail, 1997; 1998). IPA was first introduced by Smith in 1991 and was initiated within health psychology. It has gained confidence and respect particularly in the field of Counselling Psychology for its ability to report 'lived experience' and a richness in the data which is difficult to achieve through quantitative methodologies. In addition, arguably, IPA allows participants to bring forth to researchers that which they feel is most relevant with less direction from the researcher, providing accounts as they emerge through collaborative enquiry and ultimately through 'an interaction between participants' accounts and the researcher's interpretative framework (Coyle & Rafalin, 2000, p. 27).

3.6 Interpretative Phenomenological Analysis: critique and evaluation

Criticism has been levelled at IPA, labelling this as the undergraduate's easy option and the default methodology for social scientists who do not feel comfortable with the numerical skill they assume to be necessary for quantitative research (Smith, 2010). I would argue that critics have failed to distinguish between 'accessible' and 'easy', and 'simple undertaking' versus 'skilled undertaking', in the sense that if something is accessible and skilled, it should be welcomed in social research. Psychology does not necessarily attract mathematicians and it remains that many students view themselves as either 'loving' mathematics or 'fearing' it. Further, many students labour under the misconception that it is necessary to be proficient in mathematics to undertake quantitative research. This is far from so, given that most of what is necessary to calculate is done by computer systems and most of what is necessary to understand is conceptual and applied. Qualitative methods have made research seem more accessible to a greater number of students. However, to complete good qualitative research can be extremely time consuming and involves detailed processes and reflections which require dedication, patience and highly intellectual reflexivity all of which are improved by experience and the reflective input of colleagues and course participants. Good research utilising any method depends upon the skill, intellect/emotional intelligence and transparency and reflectiveness of the researcher and the research process. I was familiar with my chosen method but nevertheless found myself exhausted by repeated re-analysis owing to the continual emergence of sudden insight into my own processes and the effect of these.

Smith (2008) outlines the key characteristic features of IPA as 1) idiographic, 2) inductive and 3) interrogative. Common criticism of IPA has questioned its value as a research method and has centred around a tendency towards lack of rigour and poor interpretative strength. However, the IPA method would not benefit from researchers taking an interrogative stance. It is vital however that IPA research, as with any method, is conducted in accordance with 'construct validity'. Indeed, if IPA research is well conducted, construct validity will be particularly high (see Smith et al., 2009; Yardley, 2000/2008 for discussions) as it describes what it intends to. This is very much a strength of the methodology which I chose in order to study daughters of mothers with EMHD.

IPA could be argued to have assumed a dominant position in qualitative research (Smith, 2010; Willig, 2008). However, the popularity of IPA among social scientists has in some way contributed towards the accusation that IPA is an easy option. There have been 294 empirical IPA papers published between 1996 and 2008 (Smith, 2010). Further, the multi-disciplinary representation of IPA has contributed to criticism that it is the methodology of default that results in poorly constructed projects in all applied fields. However, I would argue that the increasing diversity represented in IPA research, as reflected in many recent publications (Todd et al., 2010; Rizq & Target, 2008) is a positive step forward, particularly for psychology, which will look holistically across all subjects for information about 'lived experience' and which needs methodology to expand sensitively through therapeutic expertise (Smith, 2010). IPA's diversity demonstrates not only its accessibility but also its flexibility and applicability (Willig, 2001; Potter & Hepburn, 2005), however, Larkin et al. (2006) contend that the IPA methodology requires further development in order to offer a greater understanding of human experience.

In terms of construct validity, IPA should demonstrate applicably the hermeneutics relevant to the research question. In other words, IPA should demonstrate the meaning made by the participants by clear evidence of transparency on the part of the researcher. It is therefore the clarity and the depth which is of most importance in IPA (Smith, 2009). The highest quality of supervision during education, training and project work should be ensured by counselling psychologists in order to avoid projects being 'shoe-horned' into the IPA methodology and to prevent students' failure to realise that they have engaged in the research process in reverse by rushing the early stages of analysis in IPA. There is concern that education is such that many students do not sufficiently realise why this would be a problem for IPA, as well as for psychological research more generally (Barker et al., 2002; Punch, 2006).

A further criticism could be rooted in the philosophy underpinning quantitative methodology and thought, in that there is no comparison between groups in IPA. Smith argues the possibility for this, but advises that this should be in skilled hands (Smith, Flower & Larkin, 2009). However, the use of control groups or comparison groups can be seen as at odds with IPA phenomenologically. Although, for some researchers, IPA's emphasis upon convergence

and divergence within a participant group, requiring idiographic comparison with regard to a phenomenon, satisfies the need for comparison in order to achieve usefulness. To this end, participants are often purposively recruited. However, in this research, I decided not to match up participants too closely and to keep their relevance broad. I would justify this less homogeneous sample in terms of my particular research topic. As Smith expounds, sampling should be uniquely relevant to the research undertaken (Smith, 2010).

It is of interest that most criticism is levelled at an over-reliance upon and a perceived lack of understanding on the part of researchers as to the inherent processes of the IPA method (Smith, 2008). Smith (2010) is also often the person who most commonly responds to criticism and seems on occasions to be wanting to answer the challenges at some points by engaging his critics and endeavouring to explain how IPA does or should do what it has been criticised for not doing (Smith, 2008/2010). Smith speaks of the lack of agreement there seems to be as to how to raise the level of interpretation in analyses. This, Smith states, is responsible for the many broadly descriptive research projects which emerge (Smith, 2010). There is much controversy over whether IPA research is sufficiently interpretative or over interpretative in its theoretical and methodological underpinning and process (e.g. Giorgi, 2010). Countering such a breadth of arguments is complex, as by its very structure, IPA has to 'fight with itself' as part of its process. Against the backdrop of that debate, I seek to ascertain whether within the current research, IPA does or does not have the balance which it aims to achieve between the researcher's interpretation and the phenomenological position of the participants. The discourse is involved which further complicates the justification of choice of methodology for researchers. As Willig (2008) states, focus groups, for example, do not reach the individual articulating their lived experiences through which ambiguity, dynamic thinking and complex emotions can be processed through interactive reflection sufficiently and diaries do not give the possibility for dialogue and analysis. In synopsis, methods vary in their ability to offer the participant a way of bringing forward their views in partnership with the experience of a researcher. It could be argued that IPA offers most benefit to the counselling psychologist and that counselling psychologists in turn offer most in return to the process of IPA and its relevance to therapy and potential outcomes.

Much criticism is fairly pointed at poor versions of IPA and I would agree that counselling psychologists need to support each other in order to continually reflect on the quality of IPA research that is produced. There is a need also to demonstrate and discuss the construct validity for each research taking into account the variant of IPA which is being employed and the theoretical underpinnings relevant to it (Smith, 2008; Finlay, 2006b; Giorgi, 1985; Moustakas, 1994; Collis, 1978). Much concerns the difference between transcendental phenomenology (Moustakas, 1994) and hermeneutic phenomenology (Smith 2008) in that the former seeks to stay close to the information that the participants (co-researcher) gave without much interference and the latter seeks to be in joint partnership regarding the meaning made, such as is rooted in the concept of an insider's perspective (Conrad, 1987). Of utmost relevance, therefore, in terms of construct validity, would be that the research's analytic strategy be appropriate to both the research question and the process that happened between the researcher and participants (Robson, 2002).

My rationale for using IPA encompasses my appreciation of the pitfalls in IPA research, which should help to guide my research process effectively and the hermeneutic philosophy underpinning my research aim.

3.7 Personal reflexivity

Phenomenological research questions the possibility of an objective stance on the part the researcher and sees them as part of the phenomena that are being studied. Therefore, the researcher enters the arena and must account for what they can of their own involvement and motivation within this (Hycner, 1985; Moustakas, 1994). It is for this reason that my study may be open to criticisms concerning the level of subjectivity in that I may have been prone to extrapolate 'sensitivities' which were particularly relevant to me (Silverman, 1993; 1997; 2001).

First, as a woman and a mother, I recognised the potential for me to interpret the experiences of my participants as being similar to mine. However, as a researcher my aim was to accurately record their experience from their viewpoint. Second, as part of the tradition of Counselling Psychology and currently a counselling psychologist, I was aware of my desire

to facilitate personal development and well-being in my participants. However, as a researcher this was not my role.

Third, as a daughter of a mother with enduring mental illness I was aware that my personal standpoint could have been a threat to the meaningfulness and transferability (Seale, 1999; Gaskell & Bauer, 2000) of this research had I not been able to recognise this possibility (Dixon-Woods, Shaw, Agarwal & Smith, 2004). My own experience of the transition to motherhood was that it was, and is, a challenging process.

According to Gaskell and Bauer (2000), for research to be evaluated it is necessary to know the researcher's underlying assumptions, as no observation can be free of theory (Kirk & Miller, 1987), I have been mindful of the fact that my own experience predisposed me towards the perspective that being the daughter of a mother with mental health difficulties might be problematic for the adaptation to motherhood. On the other hand, my experience of the research area was relevant and beneficial in encouraging rapport (Kitzinger, 1987) in the interview process. Further, as a therapist, my experience of mothers, whose own mothers suffered mental illness, was not limited to my own experience.

In choosing IPA I have acknowledged that interpretation is a requirement of research. However, I reflected throughout upon the fact that the accurate representation of the perspective of my participants depended upon my acknowledgement of divergent perspectives, and that any 'probing' which IPA facilitates should be in response to what participants were actually telling me and not a reflection of my own internal processes.

It is my belief that my training in Counselling Psychology, which involves the continued development of the de-centring of my own position and my commitment to ethical practice were enhancements to this end. A confidence marker for me as researcher has been that I have changed as a result of my encounters with my participants and my analysis of their discourse.

3.8 The procedure

3.8.1 Sampling ethos and definitions

Purposive sampling and definitions: The participants were selected using purposive sampling based on few criteria. There was no attempt at demonstrating consistency in demographics and it is acknowledged that this will be a flaw in rigour in the eyes of some researchers in terms of generalising the findings (Fox & Hawton, 2004). However, as put forward by Robson (2002), design should reflect the goals of the study and it was my aim to be as least deterministic as possible and to throw open the debate as I had initiated it, with a broad research question. My aim was to provide a platform for participants which would support the work of counselling psychologists in supporting them. I respect the value of consistency but feel that this is only relevant if of direct importance to the research question.

There were no definitions made applicable to the participants or their life circumstances currently or as children. The requirement was that in their subjective experience, their own mother's mental health was poor and enduring. This lack of definition is further justified by the experience of most participants that mothers who were mentally ill were rarely diagnosed and that it was their adult experiences that had provided them with the information with which to loosely, and in my view accurately, make educated guesses themselves about their mother's mental health.

3.8.2 Sampling and inclusion criteria

Purposive sampling was employed in order to select participants who were representative of the phenomenon studied.

The initial inclusion criteria required that the participants were:

a) mothers

b) daughters of mothers with enduring mental health difficulties

(daughter's subjective assessment)

3.8.3 The participants

Nine participants who met the participation criteria volunteered through advertisements (see Appendix 6. p.261) for their initial descriptions of themselves). All participants who volunteered and wished to participate were interviewed and are represented in the analysis. By representing a range of ages and stages of motherhood, it was possible to quote different perspectives. The names of the participants have been altered to preserve confidentiality. In terms of demographic information, participants are labelled as early, mid or late in their decade, in order to give an impression rather than a focus to age, as my aim is not to direct any future therapy in terms of specific variables. The ages of their children and hence the length of time they had been a mother is only referred to if quotes have been used which highlighted this for a reason known to the participant concerned. The youngest child was five and the eldest child was thirty six, whose mothers entered this study.

3.8.4 Recruitment strategies and informed consent

Fliers were distributed outlining research and sampling requirements and containing the contact details of both myself and of my supervisor at my university (Appendix. 1. p.252). These were displayed together with information sheets (Appendix 2. p.253) giving information with regard to the protection of their wellbeing at the interview and post interview stages and were placed in settings where permission had been granted and where a variety of mothers in general were likely to attend. The information sheet included participants' right to withdraw at any time (Appendix 3. p.254). It was decided not to post fliers in any specialist settings in order to avoid any accidental or deliberate attempt to gain a homogenous sample with the exception of parent and child groups which were included and would necessarily but not exclusively have contained a greater number of younger mothers and younger children. However, few participants replied from these settings. Fliers were not originally placed in counselling settings for this reason. Once most participants were recruited, I posted a flier into one general counselling setting, operating as a local charity. Most participants replied to fliers placed in doctors' surgeries and schools, or were obtained through word of mouth from someone who had seen the flier in this setting. I realised in retrospect that a possible reason for this might be that participants could have inferred that the doctors and schools had approved the research. I have no confirmation of this but would

highlight that it may be important when displaying fliers in such settings to overtly state independence of that setting within the flier. I also placed fliers in my university but did not receive any contacts from this.

Prospective participants were invited to make contact by telephone, email or text message. This was followed up by an initial telephone contact during which I informally assessed that they were able to give informed consent by fully explaining the process of the interview, the confidentiality and their right to withdraw at any point, as well as my desire that they should withdraw at any time if I was causing them at any point to feel uncomfortable with the process. I informed participants briefly that I was a daughter of a mother with mental illness and an interview was arranged.

3.8.5 Recruitment response

The response rate was low but all who responded participated. It may be, as came to light during the research, that the reluctance to speak of this background determined the low response. One possible exclusion I might have put into effect, had response been greater, could have been where participants' mothers were deceased. However, I am now pleased that I did not have this choice as this enabled me to show that these women's experiences of their mothers endured.

3.8.6 Subjective nature of mother's mental health difficulties

The mental health difficulties which the participants felt that their own mothers had experienced are briefly outlined in Appendix 6 (p.261) which includes summaries of the information that participants initially told me about how they experienced their mothers in childhood during our initial telephone contact (which would have been unethical to record, as this constituted initial contact and not agreed participation) and was not taped. The following diagnoses may be represented: personality disorder; extreme periodical depression; debilitating anxiety exacerbated by an abusive relationship; paranoid schizophrenia; agoraphobia; chronic depression; alcoholism with depression.

3.9 Evolution of method

3.9.1 Conceptualising the interview

The first few attempts at advertisement did not produce any response. It took approximately six months to obtain the involvement of all nine participants. I began interviewing once I had stopped sampling. The purpose of this was to keep my mind open and to refrain from developing expectations which could influence each interview. I interviewed all nine participants in as quick succession as I could, given their availability. For transparency, it is important to own that I did experience the potential difficulty in preventing the content and my experience of one interview impinging upon another. I endeavoured to be as reflective and aware as I could to this possibility.

3.9.2 Individual interviews

Each interview was not achieved by "measurements" carried out at certain times, but by a situational self-construction which was to take place interactively during the interview (see Hauber, 1983). As the researcher, I was therefore part of the data and involved with the interviewee. I borrowed from Existential Counselling theory the concept of each meeting being a unique experience, never entered into before or since (Cohn, 1997). Accordingly, it was my aim to see less distinction between myself and the participant and to endeavour to assume no 'history' to the setting (Cohn, 1997, p. 33). Within the interview, my aim was to receive and record as precisely and relevantly as possible what participants wanted to say "accepting fully the interviewee as the only expert of his (sic) situation" (Kruger-Muller, 1999, p. 18).

I felt that it was of great importance that the interview was as relaxed as possible and resembled 'chatting' (Kitzinger, 1987; Wilkinson & Kitzinger, 1996). It is hoped that the fact that participants expressed in the interview that this was helpful to them was an indication of my success in this aim. Interviews were conducted firstly in accordance with BPS *Code of Conduct, Ethical Principles and Guidelines* (BPS, 1998; 2001), and secondly in accordance with the aim of the research.

3.9.3 The interview schedule

The semi-structured interview schedule consisted of a set of guide questions (Appendix 5.p257). My aim was to keep this questioning to a minimum although I had created an interview schedule with a comprehensive set of questions. However, I found it quite difficult to keep my own dialogue to a minimum and often said more than I had planned to. It was necessary to reflect upon this during the long analysis process. I had experienced sparse questioning as unnatural, especially given that participants were aware that I was the daughter of a mother who experienced EMHD, which I had owned for transparency.

The questions posed were broadly followed in each interview. However, the interviews were largely participant-led in order to promote a free flow of dialogue and not to overly predetermine the content of the interview. I had however, identified potential probes in advance to fall back upon if dialogue became stilted. I also allowed myself to be free to enter into the dialogue as directed by the participant and to facilitate an in-depth account in order to achieve my fullest understanding of each participant individually (Ritchie & Lewis, 2004).

3.9.4 Content of the interview

The design of the semi-structured interview schedule was used as a guide (Appendix 5. P257) and left considerable scope for the participant to direct the conversation. There were broad questions with prompts and one debriefing question which invited participants to speak about their experience of the interview. The main content of the interview aimed to gain insight into participants' understanding of their experience of motherhood, as well as their experience of their own mother in childhood and currently. Although the interview guide was substantial, I followed the participants' direction more often than my schedule. Refinement of the original interview schedule took place after discussions with my supervisor and colleagues. One adjustment was made after the first interview which was to be more conscious of the language I was using and to ensure that the interview was accessible to all. For example, I continued to ask participants how they "coped" with feelings, as opposed to how they "managed" their feelings. This was an example of the need for researchers to consciously avoid language which is jargon and to speak as naturally as possible. I have retained this aim in the write up of this thesis (Janesick, 2000). It was particularly important that my questions

were neutral rather than value-laden and that I avoided the assumption of shared knowledge (Oguntokun, 1998) in both the interviews and the analysis of the data. During the interview, it was again stated explicitly in person and in writing that participants were free to withdraw at any time.

3.9.5 Process of the interview

Participants were interviewed in their own home. It felt appropriate that I entered their space and that the interview took place where they were most comfortable. All participants were happy to be interviewed in their own home, but all made sure that we were out of earshot of anyone else in their home.

Each interview was approximately one hour in length (unless factors pertaining to the participant, required this to change, for example because of the need to attend to a child). Each interview began very similarly. An *Ethics Release* form had been completed through my university and in the form of my information sheet describing the aims, procedure and possible risks involved. I ascertained whether there were any questions or concerns stemming from any of the information given, regarding confidentiality and consent sheets, or simply from themselves. Participants were then asked to read and sign the consent form if they wished to do so. Informed consent was frequently re-established and reviewed regarding participants' right to stop the interview or withdraw at any time (McLeod, 2004). Participants were given details of counsellors and service provisions. These have not been included in the appendix for confidentiality reasons. Participants were also offered the researcher's email address as a future point of contact.

After checking that they were ready to begin, the recording device was switched on and the interview commenced either with the first question or according to the participant's train of thought and dialogue.

3.10 Analytic strategy

Reflective practice: The intention in the present study was to record a range of themes which might reflect being a daughter of a mother with EMHD in order to represent a diversity of viewpoints. Despite the researcher's potential expectations, it was hoped that where experience was of positive value that this would emerge alongside experiences which were deemed to be detrimental. In line with the idiographic nature of this approach, the researcher sought to reflect the uniqueness of experience of the personal world of the participants whilst recognising that access to that perception is the result of an interaction 'within' participants, one of whom is the researcher. It was therefore the researcher's responsibility in terms of ethical practice to do as much as possible to represent the participant's viewpoint as accurately and appropriately as possible. IPA as methodology was deemed to be both appropriate for the content of the current study and a responsible choice for the researcher.

Maximising validity: The two points in this research where ethics were most at risk and therefore most important to uphold (BPS, 1998, 2001) were in the interview process and subsequently in the analysis. During the weeks and months in which the analysis took place, I remained mindful that the participant was now not present. It is here where the skills and practice of Counselling Psychology contributed to the upholding of ethical responsibility as, just as a counsellor does not forget the thoughts and feelings of clients when they are not present, neither should I, as a counselling psychologist and researcher forget my respect for my participants at all points during the research process. I transcribed all interviews as advocated by Smith (1995) for rich analysis and annotated each with the intention of following Willig (2001) in her emphasis on the importance of analysing each transcript fully and separately to enable the process to remain descriptive and idiographic for as long as possible.

Transcription: The data were analysed according to recommendations clearly described in Smith (2003, chapter 4). IPA researchers continually expound that good IPA research requires a high level of transparency (Smith, 1996) about the process of analysis and therefore it is necessary for me to describe the analytic procedure systematically and inclusively.

Six stages of the analysis

The first stage of the analysis: This stage involved the division of four margins, incorporating the line number, my initial thoughts, the participant and my initial themes (see Appendix 7, for example). Each line of the transcript had a sequential number which would be used as an identifier for the subsequent reference of any piece of text. The analytic process began with the recording in the left-hand margin of anything which I as researcher thought was significant or interesting for any reason (regardless of the research question). This is known as free textual analysis (Smith, 2003; Willig, 2003). This was followed by looking for emerging themes and placing these in the right-hand margin. This process was conducted many times with the first transcript before both myself, as researcher, and my supervisor were satisfied that the themes were representative of the text. This involved making sure that the themes were grounded in the data (Elliot, Fisher & Rennie, 1999; Willig, 2001) by repeatedly going back to the text to ensure that the themes represented the context and meaning of what the participant had actually said. Willig (2001*)* states that it is important in good qualitative research for the researcher in working between the themes, to remain mindful of the original information which generated all themes.

The second stage of the analysis involved the documentation of themes with the aim of capturing the essential quality of what was said. The danger here as Smith (2003) cautions, is that because the analysis now moves to a 'higher level of abstraction' which may include psychological terminology the researcher may get side-tracked by this and lose track of the thread of what the participant actually said (Willig, 2001). This may be particularly likely if the researcher feels connected to the data by personal experience (Oguntokun, 1998). With this in mind, theme names were kept free of jargon and the themes were frequently taken back to the text to ensure that I was representing the data as accurately as possible.

The third stage of analysis involved listing the themes and looking for connections between them. I then began looking for clusters within the themes by which is meant the connecting of themes which appear to be related by an overarching, or 'superordinate', theme. This proved complex, as I continually deliberated over whether to provide the context of each

participant's childhood. I was concerned not to be drawn away too much from the emphasis in my research question upon participants' experience of motherhood. Smith discusses the process of establishing 'meaning making' (Smith, 1997) through IPA analysis and therefore I knew that I had to place the process of discovering what participants 'meant' before my research question and only then to look at this in the light of what I found. The participants had expressed and wanted to share so much of their childhood, and therefore I felt that it was appropriate to reflect this. I had to look deeply into the data, with as clear self-reflection as I could to see why the telling of their childhood had felt so important to participants and it became clear that this was a context without which they could not understand themselves or appreciate what being a mother meant to them. I concluded that I had to present this context.

The fourth stage of the analysis: As a result of this process and continual reflection, a structure to the analysis evolved. It became clear that I needed to present a timeline, which together with the sampling criteria (being a mother whose own mother experienced EMHD) eventually, after many versions of the analysis, became the overarching theme in that my analytic process suggested to me that participants understood the meaning of motherhood for them through a backward and forward and continuous process of connecting current experiences to their past experiences and re-evaluating from this their current experiences. Within each of the four main themes which reflected this time line there emerged strong themes reflecting participants' experience of being a mother in the light of their childhood experience with their own mother and their descriptions of many aspects of their identity as women and mothers.

Smith (2003) advises two possible ways to analyse more than one transcript. Either it is possible to use the themes from the first transcript to guide the analysis on subsequent ones or to conduct separate analyses on each. In the interest of maximising the opportunity for uniqueness as well as commonality to emerge, it was decided in the fourth stage to keep my intention to analyse each transcript separately, following which, all the themes I could extrapolate from the data within the timeframe were documented. It was not possible however, to utilise all observations and analyse these as themes.

Smith (2003) asserts that the number of emerging themes reflects the richness of the passage. It would seem that the transcripts were indeed rich, as in all transcripts there were many themes in each paragraph of speech. It proved difficult to limit the themes sufficiently for a thesis of this size. Eventually, I made the decision to take the themes from the first three interviews and source these in the other six transcripts whilst also taking account of any uniqueness and variation which felt important to bring to light.

The fifth stage of the analysis involved the isolation of representative quotes from the text and the collating of these with their numerical identifiers. Over many months, I sought to cross-validate the quotes and themes (Gaskell & Bauer, 2000).

In the sixth and final stage of analysis which involved writing up individual themes into a narrative account, the analysis becomes 'expansive again' (Smith, 2003). Here, there is further need for ethical consideration and care is needed to ensure the clear distinction between what participants actually said and the analyst's interpretation or account of it in their themes (Smith, 2003, p. 77). Every endeavour was made to ensure that the meanings which reflect the participants' experiences were clearly and unambiguously put forward. I devised approximately four models in various versions which it became evident were prematurely constructed and were subsequently discarded. In brief, these models involved several iterations of primarily two overviews.

First, 'Motherhood as a coping mechanism for healing from childhood', which contained five themes in which I had reduced the participants' interviews into aspects of what they were saying about how motherhood had developed them as individuals. Although I knew that this was evident within the data, I came to realise that I had been overly reductionist in developing this model. I recognised that the language I was utilising was increasingly removing me from the data and was threatening to produce a thesis which would not be readable for my participants and less relevant as a consequence. This model was completely written up and discussed with my supervisor on a number of occasions.

Second, I devised a model which incorporated six themes as stages of experience which I felt had been reflected by participants but which I came to realise were too broad and did not contain the data in a coherent framework. These themes were also completed and written up

and modified by myself. The last theme structure which I abandoned following write up contained the following themes:

A. Historical: About my mother's illness

B. Historical: My experiences as a child

C. The dynamics of my adult relationships

D. Adulthood before being a mother

E. The impact of my childhood

F. Looking back on my experience of being a mother

Eventually, I found the structure which I present here, the one that was most relevant and closest to the participants' accounts.

3.10.1 My personal challenges in the analytic process

I struggled to achieve a balance between 'thick description' (Geertz, 1983; Hauber, 1983; Harre, 1999) and selectivity and I have found it challenging initially to remove myself sufficiently during the process of the analysis to ensure that my participants were accurately represented. It was also initially difficult for me to ensure that I presented sufficiently whole themes which incorporated the entire sense of what was said. This was because I was making assumptions of the data and unconsciously thinking I knew what was there. Although I made every effort to consciously suspend my judgements and preconceptions, there were occasions when I thought that a theme was appropriate and obvious when it was not so to others. This meant that I had assumed meaning without realising that I had done this. My supervisor was invaluable in helping me to work with this difficulty, to try to ensure that themes incorporated the whole sense of what was said and that no theme had been extracted out of context.

There were many occasions when I realised that I was intellectualising the themes and labelling them too quickly with higher level labels. I wrote and re-wrote the analysis fully and many times and swayed between oversimplifying and overcomplicating its content.

3.10.2 The politics of the research

I have been throughout most of the research process one of the 'striving' mothers (see Analysis, Theme C.1. p.94) I was writing about and I have struggled with the anger and stress that the research process and my personal life has brought me. This process was painful, insightful, educational and humbling and I will always value the participants who brought this difficult but priceless experience to me.

3.10.3 Relationship with co-workers

It may be important to note here that discussions with colleagues who were also using IPA could have initially influenced the process of this research. It was felt that this was a positive influence for example by allowing cross-validation of themes in the early process and ongoing interpretations. Discussions were kept to a minimum in terms of number of colleagues and content and took place with others adhering to the same ethical guidelines (see BPS 2001, 'colleague', 11.1). However, for some time I have been working alone, apart from the support of my supervisor, at the university.

3.10.4 The positive influence of my own experience

I have openly reflected upon the difficulties which my own experiences brought to me as the researcher because this and the research process are entwined. However, I am aware that the difficulty I faced in being selective and in appropriately isolating theme clusters was far more a factor of the richness of these women's experience and accounts than it was about my internal and emotional processes, significant though they were. The themes emerged in layer upon layer of interwoven themes, making decisions about presentation and semantic structure highly complex, as will be discussed in the following Analysis. I believe that my own experience enabled me to see these themes with a sensitivity that I might not otherwise have been able to bring.

Chapter 4. The analysis

4.1 Introduction to the analysis

There were many themes in the accounts of these participants which echoed some of the feelings of mothers in general. In particular, a number of themes would support the wide literature which exists concerning the transition to motherhood (e.g. Smith, 1995; Nicolson, 2003). Some examples were, anxieties about the ability to conceive, or about being able to cope with the birth, or fears around their own mortality, or the health of the baby they were carrying. Any themes which could be said to represent these or the tendency of most mothers to revisit their childhood more generally when they become parents were discarded. Therefore, although further research may find this relevant, any discourse felt to be representative of motherhood in general was not discussed in the present study.

For context, the research question was:

> 'What might the impact be of having a mother with enduring mental health difficulties (EMHD) upon women's own experience of being a mother?'

I have presented the analysis in four themes pertaining to the timeline of the participant's journey as a mother. These themes are labelled 'A' to 'D'. My approach to this analysis is strongly outlined in the analytic strategy above. In addition, I have endeavoured to represent some diversity and also common themes. The themes described have been represented through various presentations. Where relevant, I have used some of the following approaches. Where I felt that this was most appropriate, I have expressed a common theme with one quote which I deemed most accurately represents the theme. Where dialogue between the participant and myself as researcher was helpful, I have used the abbreviations "I" and "R", for 'Interviewer' (for myself) and 'Respondent' (for the participant). When I have illustrated a divergence, I have used one or more quotes in its presentation. Alternatively, I have focused on an in-depth analysis of the processing of one participant to expand on a theme where I felt that best represented participants. Where I refer to *'Cross Themes'*, I am referring to a strong connection or association between themes. I did not analyse these connections into analysed clusters of themes, preferring at this stage to leave the potential connection in the thought of the reader and for the moment less analysed.

4.2 Theme A – Contextualising my experience of my mother in my childhood and growing years

List of themes

A.1 No-one explained (cross theme - D.2. Impact on relationships)

A.2 My Perceptions of normality as a child (cross theme – D.3.i Assuming difference

D.3.ii Distinguishing me from normal

A.3 How I experienced my mother in my childhood (cross theme - B3 The

complexity of bonding)

A.3.i Unable to care for me

A.3.ii Disconnected (cross theme - B3 The complexity of bonding)

A.3.iii Unpredictable

A.3.iv Cruel

A.3.v Suffering Empathy and pity

A.4 Other Significant relationships in childhood

A.4.i Father

A.4.ii Sisters

A.5 Social Comparison - Feeling Different (cross theme – D.3.i Assuming difference)

D.3.ii Distinguishing me from normal

Theme A, '**Contextualising my experience of my mother in my childhood and growing years',** offers a possible context to the current thoughts, feelings and experiences of the women in this study. I felt that detailed context was necessary in order to fully appreciate the

nature of the research question by giving a holistic picture of the women studied. However, this will necessarily be abbreviated to explore the research question.

All participants described how, or in fact whether, they came to know the details of their mothers' mental health. In general, they described not having any information about their mothers' illness when they were children. Participants' subjective views of the nature of their mothers' mental illness are described in Appendix 6 (p.261)

A.1 No-one explained (cross theme - D.2. The impact on relationships)

In general, participants described their feeling that as children, they had been left without explanation, and therefore the information to make sense themselves of their mothers' illness, absences and strange or extreme behaviour. In many cases, participants described that as far as they could recall, their mothers' mental illness was either not diagnosed, or the diagnosis was not made clear to the family, or perhaps just not to them as children:

> "No nothing was ever diagnosed. She spent some time in hospital - on and off. Really - she was in and out of there. But we were never told what was wrong with her." Elenor. Generally, it was the participants' experience that no-one spoke of their mothers' illness in their childhood, including their mothers. This continued for most participants into adulthood: "I was so young when it started and she would never … never ever … there was never any discussion of anything of a personal nature. She was very reserved. Yeah. Very, very closed." Caroline

> "I was never told anything, because she won't talk about it now either …and I can only go on what my experience was. I mean a child's perception when you're so little … it's difficult to say." Elenor

An exception was Melanie's account in which there was still a sense in which she felt that she (and not her mother) had to keep the boundary:

> "She talks about it more than I talk about it. She can't drop it and I always feel now, we've done it, we've talked about it now, I've talked about it with her so much, you know, she doesn't take any responsibility […] and I just said "Mother I can't keep doing this, you need to pull it together." Melanie

Many participants had come to a diagnosis themselves for their mothers; when adult and through their reflection on their childhood in hindsight, but also in reflecting upon their

current experiences as mothers. For many women, this reflection caused them to re-evaluate their childhood perspective:

> "As I came through my nursing, I came to the conclusion… that's what she was; she was a paranoid schizophrenic! … and only from the fact that my grandmother's sister said to me once when I was about 14 … 'she was having one of her turns'" […] Well, she used to tell the most frightful stories which she made up as she went along. Sometimes I even now found myself believing something and would suddenly realise it couldn't possibly be true because of something else, you know? It just dawns on you suddenly 'That couldn't have been right because of so and so." Paula

Paula's processing regarding her mother seems to be linking the past to current rationale, from which she takes stock and re-evaluates her childhood experiences. Participants' accounts suggest that lack of information as children, regarding their mothers' mental health suggests that their mothers' illness was either hidden or denied, or perhaps just not understood sufficiently to explain. There were many themes in which participants referred to the protective influence of other adults. This also alluded to the fact that even where adults were supportive, that little or no explanation of their mothers' illness was offered. Below are some examples, with regard for example to the protection felt from grandmothers:

> "… and I was very fortunate that I had my grandmother there, who was the kind of constant force in my life. She was like my dad, you know – 'mum, dad relationship', she was like the dad in the relationship. But it wouldn't have affected me as much as if I'd been on my own possibly with my mum." Della

Nevertheless, it was common to participants that no discussion took place with them regarding their mothers' illness:

> "But luckily Grandma, (paternal) my Gran, was a salt of the earth, no messing woman, but with the biggest heart you could imagine, stepped in… Although again, I have never spoken to my grandparents about it because, again, my Nan was a woman of few words really." Melanie.

> "Oh she was a lovely person; she was great (maternal grandmother). I always spent me summer holidays with her - couldn't wait to get down there […] No. No she never spoke about her." Caroline

Even where suggestions were made for grandparents to take over the care of their grandchildren for a while, no explanation was offered regarding the EMHD which affected

their mothers. Paula below describes a situation where she was encouraged to leave home but it was never explained to her why she should go:

> "Well at 17 I had to find a job …eventually it was suggested I took nursing to 'get way'…they didn't ever say anything about my mother. They said 'you'd be better away from home'. So I did nursing." Paula

Despite not having contributed to the explanations which might have helped participants to better understand their childhood with their mother, many participants spoke of grandmothers as a positive influence upon participants' lives.

> "My mum was an only child. Her mother was completely bonkers as well. […] you know I didn't have a relationship with her, or anyone on that side. So my Nan (Dad's mother) was great and she kept us safe. My Nan, she was very, very nice. And in summer my dad would take us up north to stay with my aunt. We'd stay up there. My mum just used to disappear. The minute we used to go - she'd be gone. You know it was like me and my little brother arriving home and she would just be gone." Elenor

However, not all participants had a grandmother or a father who was able to support them in any way.

Most women included themselves in those who did not speak of their mothers' illness when they were children. It could be assumed that this may have been partly because those around them had not encouraged this dialogue. Some of the women appeared to describe a 'received wisdom', in the sense that they knew as children what they should say and what they should not say and that they remembered behaving in line with what they came to know was expected of them. In this sense, they coped, as Elenor described:

> "You know, your mother goes away and you were supposed to not question it and not ask where she'd been, and not wonder what was going to happen next. And as kids we just did it, you know? I just did it!" Elenor

As Carmen describes, there seemed no choice but to cope:

> "She would shout and shout and slam doors and the whole house would shake. We just sort of accepted it – we just had to get on with it." Carmen

Some participants expressed their surprise in retrospect, and particularly as mothers, that the adults in the community surrounding them as children had not acted to protect them. Melanie

described how as a child. she persistently and frequently begged neighbours for help but she assumes that her mother's view of her as a 'difficult child' influenced those around her not to respond:

> "I was very vocal about hating my mum […] but the thing is, I was considered to be the 'child from hell' (by her mother) […] and I used to write to all the neighbours, I used to write notes saying "Please help me, I am really unhappy, I hate my mum…" Melanie

Unheard by the adults around her, including her church community, Melanie describes how she desperately sought spiritual help:

> "I used to pray a lot […] As a child I'd go in and say the rosary in church […] "Please, please will you help me." I was begging…"Please will you help me." Melanie

Carmen described the daily aggression and cruelty she and her sisters experienced from their mother in their childhood. Now, as a mother herself, Carmen, described finding it very difficult to understand how this could go unnoticed:

> "It was just constant – shouting and screaming in your face, beatings – just constant! […] But where were the adults? – where were the adults! […] Nobody questioned it." Carmen

However, Paula gave an example of actions and circumstances which might prevent knowledge or action. She spoke of how she believed that her mother and stepfather hid her mother's illness by moving home and area many times when she was a child. Paula explains this as an example that may have served to prevent others from discovering the cruelty she experienced:

> "I lived …everywhere… Well because of my mother's difficulty to some extent. Because if you're in a situation in one place… we moved a lot. We moved at least 25 times, so no-one picked up the cruelty. Then we were in York, […] Wales, and I've got to be now about three and a half. We went and lived in Eastbourne, […] Norwich, […] Manchester, […] Durham. […] Sometimes three months, four months. Sometimes six months. […] I think the number of moves until I was 10 was about 19!" Paula. (All place names have been substituted).

It might be assumed that there were many other ways in which the adults around these women when they were children were prevented from either knowing of the difficulties these

women faced as children or responding to them. Although this might be in part a product of the time, it nevertheless highlights the need for awareness today.

A.2 My perceptions of normality as a child (cross theme – D.3.i Assuming difference; D.5.ii Distinguishing me from normal)

The complexity of theme clusters made being selective extremely difficult. There were necessarily connections made between denial in childhood, expectations not to question the status quo and perceptions of normality for participants in their childhood. In particular, a strong theme connection emerged concerning low expectations and perceptions of normality:

> I: How would you have coped with being upset, being worried or being cross? How do you imagine? Can you remember how …?
>
> R: "I think I probably just worked it through. I can't honestly remember. I never Remember getting cross. I must have done mustn't I? … I would think I would just sort of sit and think it through and work it out. Don't think I would ever go to her when I was younger with a problem. I don't … don't think I had that choice. […] I think if I was called names, I mean I think I just rode with it you know […] so I had low expectations." Caroline

As in Melanie's account below, a role reversal was often described as normality for participants in their childhood, as these women took on the task not only of their own mothering, and for some women also, and often without question, that of their siblings:

> "We just did it all ourselves and I did most of it…I don't ever remember her not being drunk. You know we'd come through the door and she be rolling around on the floor, banging her head and throwing things at us the whole time." Melanie

There were many accounts of how participants coped alone as children, having had little choice but to take care of themselves as children, or early in their teenage lives. Della describes how she just expected to be alone with her care needs and how this continued as she grew:

> "[…] When I got to about 14 or 15 and went through that teenage stage, you know mum just completely stood back…And I don't know whether she was ill, or maybe she would have been like that…we'll never know … but she almost completely stood back and said "Right well you're off on your own now, off you go, make mistakes"…and I did, you know. I went off to college

> when I was… 16, just going on 17 … I applied to university on my own, I got into university, I found my digs, lived there. I left there, I came to (City name), I got married. And that's where … […] you know where the relationship kind of broke down from. I can see that." Della

The ability to have low expectations appeared to have been a way of coping which enabled participants as children to expect little of their mothers, thus enabling them to manage their day to day lives. To a certain extent, 'doing what was expected' appears to have constructed these women's perceptions of normality as children. Many participants spoke of their conceptions of normality in relation to themselves and social comparison and also surface normality (in other words the appearance of normality). They often described how they accepted their own situation as 'normal' and assumed this 'normality' to be shared:

> "I used to think all families were like that." Paula

Paula gave a more extreme example of how her perspective of normality was affected by becoming accustomed to bizarre and cruel behaviour which was happening routinely and which came to be evaluated in a comparative manner. For example, Paula described how being locked in a cupboard as a child was preferable to being beaten almost for her humanity. In this sense, she was learning to accept a level of cruelty as normal:

> "…she used to go out and she would lock me in a cupboard …That was all right as long as she wasn't gone for a very long time, and I wet my knickers on occasion. And she used to always beat me up when she came home and that happened." Paula

Paula was therefore learning to view her negative experiences hierarchically, with some even viewed relatively positively by comparison, as Paula further clarified:

> "So the problem was not being shut in a dark cupboard, but being afraid of what would happen when she came in, cos that was another thing that happened, she would beat me if I wet myself." Paula

There were many accounts of how surreal day-to-day life was for many participants as children and how to the outside world everything may have appeared usual to others:

> "'Who's afraid of Virginia Woolf' did you see that film? …How everything seemed very normal on the surface and then suddenly it was all turned, very bizarre?" Paula

Their mothers' absence was for many participants a poignant example of the surreal experiences they knew as children in which extreme or unusual occurrences were left unexplained or were treated as unimportant, as both Kye and Elenor describe below:

> "…she did get sectioned, sometimes for a few months at a time…I don't really remember much about that at all…I felt she was always there as a young child although I know that wasn't true and it feels strange. Maybe I am to some degree blanking out those times, I don't know." Kye

> "[…] home one day from school and she's not there, and then 18 months later you come home and she's sitting there, and you just carry on (laughs) just nobody says anything, like "Oh hello. How are you? Not seen you for a while."" Elenor

The experience of distortions in what is acceptable in a child's life, concerning the role of others around them and the roles they occupy themselves, seems likely to have not only led to accept unreasonable and even cruel situations as 'the way it is', but also, to some extent, to question their own 'normality' as Paula describes:

> "When I was 14, I remember asking someone on the bus whether I seemed normal to them." Paula

Paula speaks of appealing to a stranger for feedback. This suggests that she was not only in need of this feedback but also did not have anyone else to request this from.

A.3. How I experienced my mother in my childhood (cross theme- B.3. The complexity of bonding)

In the many themes and clusters produced, most of the women described a lack of maternal care in their lives. It was noteworthy that the women spoke far more about what they felt had been the negative experiences of their mothers than any positive memories.

A.3.i Unable to care for me

Most women described their mothers as having been unavailable to them emotionally as children. Many participants spoke of their mothers as being a 'mother' in name but not in warmth and behaviour or reliability. Some participants saw their mother's inability to be able to care for them as part of her illness and others as part of her character and disposition.

Kye described her mother as beaten down by her illness and struggling in her own life and therefore unable to be strong for Kye as a child:

> "I mean in my opinion my mum wasn't a bad mum but it's almost as if she was weak and stressed…that she was going up and down and depending on whether she was taking medication or not and whether it was working or not…she wasn't able to support me." Kye

For some participants, as was the case with Melanie, it was felt that their mother's inability to care for them had been almost total:

> "In dirty nappies, screaming, no care being taken of me. That was what I was born into …so all my life, from birth, she didn't even do the basic things. It's unbelievable, isn't it?" Melanie

Many participants spoke of feeling that their mothers' needs had submerged their own and spoke of having felt that they had to care for their mother rather than the other way around and were often burdened by role reversal due, they felt in retrospect, to their mothers' inability to care for them or their siblings:

> "Yeah and …she had become very dependent on me and I used to get frustrated with her because she needed me so much and then I would treat her in a way that was disrespectful. […] She just relied on me. Where was **my** mother?" Kye

> "…I mean it was like with my sister's periods. Her period started very early, she was still at junior school. And I got 'Well why didn't you tell her about them?' It wasn't my job! Excuse me! But I think all I got was a book thrust at me! I mean she would never talk about anything like that at all. Never discussed… I remember thinking, you know, that is not … I mean she (younger sister) was about 10, I was about 18 … and I thought "That is really not my job to do that. You should have done that!"" Caroline

A.3.ii Disconnected (cross theme- B.3. The complexity of bonding)

Some women felt that their mother may have actually unable to love them due to issues with their mother's own well-being**.** Women often expressed that they did not feel warmly connected to their mothers in their childhood. Many participants described their mothers as 'distant':

> "…to me in particular (the only girl amid two brothers) she was … she was never loving. She was very distant." Elenor

Sometimes the 'disconnection' felt physical:

> I: What about how she felt about you?
>
> R: " I don't know; I really don't know. As I said, because there was never this sort of contact, this physical contact… when you think about it…she was actually quite distant, quite distant […]. Yeah. She was very, very closed. […] because there was never this sort of contact, this physical contact…I don't know how mum felt about me." Caroline

Sometimes participants described the disconnection as a lack of support or involvement:

> "[…] or guide you in any emotional way yeah. And there wasn't any … there wasn't any emotional sort of guidance or anything. No emotional guidance, you know?" Della
>
> "I was always conscious I could not rely on her." Caroline

A.3.iii Unpredictable

Many participants described their mothers' lack of involvement in their lives as children. As stated, some women spoke of this as due to their mothers' personality or difficulties and some as a result of their mothers' illness, still others described that this was the result of their own avoidance of their mothers due to their fear of her. Many women described their mothers as changeable or unpredictable:

> "Yes, I was a very unhappy child. I couldn't invite my friends round as I never knew how my mother would be." Gabrielle
>
> "She would be just fine … and then for months, just nothing would bring her round. She didn't wash or eat. My mum was just gone." Sarah
>
> "You could never predict how she was going to behave." Carmen
>
> "My mother was very difficult. Even just a few words would set her off, […] you had to be very careful what you said. And you never knew when you walked through the door." Paula.

As Paula's account illustrates above, it was she who had to adapt her behaviour. The above quote paints a picture of a young girl whose identity one can only imagine might have been heavily influenced by her mother's complex erratic responses to her.

A.3.iv Cruel

Most women described their mothers as over reactive. However, some of the women experienced their mothers as actively cruel. Participants described a mixture of behaviours which they experienced as psychologically and physically cruel. Much of the psychological abuse involved strongly and critically expressed emotion, such as being shouted at or harshly criticised and some included what was felt by them in hindsight as more actively cruel behaviour, either physically or emotionally:

> "She would scream if we asked for anything… Everything was a huge problem. She was horrible …We all (3 sisters) described her as cruel rather than evil, because that would imply the supernatural." Carmen

> "I had no joy in clothes or makeup as my mother would make fun of me and tell me I was too fat or ugly." Gabrielle

> "…all the time she had a cane above the kitchen door, and I'd be caned and hit with a wooden spoon, mouth washed out with soap, hair pulled, shoved about and hit, all the time." Melanie

Paula described how she felt that her mother gained some satisfaction from the cruelty she experienced:

> "She was very psychologically cruel. Um … somebody might give her an invitation for me for a birthday and she would keep it. And when the birthday had gone by she would tell you it was this coming Saturday. She let me get all dressed for it, went to go, and I'd go, I'd be carrying a present. I usually had to look for something of my own to give because there was nothing, so I used to keep some things very carefully. It might be little box of handkerchiefs or a book I would read it, not opening pages … cos I was an avid reader. And …you knock on the door and they'd say it was last week. And she'd laugh all the way home 'You missed that party, didn't you?" Paula

> "Yeh yeah. She was fucking terrifying. She was absolutely terrifying. She was physically terrifying." Carmen

> "I used to try to keep away from my mother … as much as possible… because that was the best way to avoid traumas." Paula

Melanie described the anger she experienced as a child towards her mother:

> "…And I couldn't stand her, I absolutely hated her and when I was at school, I always remember there was this girl, and we were told we had to be so

> careful what we said because her mummy's dead, and it's a terrible, terrible thing, and I remember very clearly sitting in class, looking at her and thinking how lucky she was that her mum died and why couldn't my mum die because if I could swap with her, I felt like going up to her and saying "If I could swap, you know, my mum can die and your mum can live!" Melanie

A.3.v Suffering empathy and pity

Some participants described how as children, they had felt 'moved' by their mothers' distress. In some sense this could be viewed as role reversal, in that protectiveness, as an expectation is more usual as a maternal response. However, empathy is also a common exchange from child to mother. Although it could be seen as healthy for a child to feel protective, this probably depends upon the frequency of occurrence. Kye and Della describe below feeling protective and empathic towards their mothers, which Kye reflects that she felt continuously and Della reflects that she felt early in her life, which could therefore constitute role reversal.

> **"**I remember the times where I just wanted to protect her …when I think of my mum and my childhood I feel a lot of sadness. And my mum feeling so inadequate and in dilemma a lot of the time of "what do I do, where do I go?" and being tearful a lot." Kye.

> "I remember being very aware when I was six that she wasn't well, although I wasn't really aware of what was wrong with her obviously, but I remember being very upset because she was very upset. I can remember being dropped off at a friend's house and her picking me up in absolute floods of tears and sort of crying […] so I was aware there was a problem." Della

A.4 Other Significant relationships in childhood

There were three relationship strands which appeared high in focus in the participants' recollections of their childhoods and as having featured in, or as having been affected by, having a mother with EMHD. These were their relationship with their grandmothers (as discussed in Theme A1.p.68), their fathers and their female siblings as discussed below.

A.4.i Father

It was difficult to extract aspects which best reflected the thoughts and feelings of the participants in relation to their fathers' role in the lives they experienced with their mothers.

This was because there was often conflict for these women with regard to their relationship with their fathers.

Some women spoke of the role reversal which they felt occurred as a consequence of their mothers' illness. Some participants spoke of having enjoyed a sense that they were working in partnership with their father in coping with the family situation or, more specifically, their own situation with their mother:

> "We were working together but he died and I am kind of angry with him for leaving it all to Me." Sarah

Both Sarah and Melanie reflected upon this, as they expressed their loss of this 'partnership' when their fathers died. Melanie's quote below retains an unconscious acceptance of mutual support and omits that support for her should ideally have come from her father:

> "The trouble is my dad became ill when I was in my early teens […] he was the guiding ship, so when the guiding ship went? […] but we did used to support each other actually." Melanie

There were many references to their fathers as someone they revered as the person who enabled them to cope with their mothers' illness:

> "My dad was my hero. […] When I was little my dad was the one that kept us going, kept us sane." Elenor.

Some participants had come to evaluate this differently as adults, and in the light of being mothers, and seemed now to be highlighting issues of possible collusion on the part of their fathers. Some women felt that in retrospect their fathers were supportive but perhaps inadvertently (or helplessly) collusive. This caused many participants to struggle with mixed emotions in their memories of their fathers. As had been the case for many women with their grandmothers, there was a sense in which fathers were supportive but not, for one reason or another, able to be honest about their mothers' illness or the impact of it upon their children. One can imagine that this might have been difficult in the management of the situation which Melanie describes below. Melanie spoke of her frustration at her father's endeavour to change *her* behaviour as opposed to her mother's reactions:

> "I would be upstairs banned from moving from my room, my mum would be crying, saying "I can't cope with her" and he'd come up and I'd say "Look, you know what she's like" and he'd say "I know, but do you have to write notes? (to neighbours begging for help) Do you have to hit back? Can you not just be better?" and I'd say "No I can't, I'm affected too!" So even from when I was little, that was the only conversation I'd have with my dad, "can you not just be better?"!" Melanie

This is suggestive of how relatives, and in the case of this study, often fathers, seem to have found themselves utilising the strengths of their children in order to cope with the life that transpired. This necessarily may have encompassed collusion, role reversal and a distortion in their children's perceptions of what is normal, acceptable and healthy, and could also leave the child with anger, or a deep sense of loss concerning the relationship that could have been between them and their fathers, especially, but not only when their fathers were deceased:

> "I never really had a conversation with him basically about what he thought!" Melanie

Participants' accounts of both fathers and grandmothers reflect a lack of conversation or explanation about the difficulties these women experienced as children, as a result of their mothers' EMHD. The silence and/or the possible collusion of the adults surrounding these women as children may have both coerced their responses as children and informed their concepts of normality. These observations suggest the potential importance of an effective and positive relationship with fathers, for daughters where mothers suffering from mental ill-health, but also the need for a relationship in which helpful communication could best occur.

A.4.ii Sisters

Participants often spoke of their sibling in terms of evaluating their ability to help in their childhood situation, as opposed to their shared pain. This seemed to have distorted sibling relations. The effect upon sibling relationships was potentially greater than for any other relationship, bringing forth destructive dynamics, especially and for some enduringly, between sisters; such as competition over suffering, with lasting negative effect for some participants. Siblings were not spoken of in detail. It is therefore important to own for clarity and transparency that my analysis here may be skewed in terms of my interpretation from comparatively little but compelling information. It seemed to me that for many participants, the fact that they spoke little of but strongly about their siblings, was in itself potentially

indicative of the resentment in the relationship, or the poverty of the relationship, particularly, but not solely, when speaking of sisters:

> "I was closer to my brother, he was so sweet, he always helped me. My sister never helped. It was always worse for her. I felt so angry with her and we are still not close. We don't speak to this day." Melanie

Some participants spoke of the comparative closeness of their sister to their mother. This suggests the potential for splitting between sisters into the 'good' sister and the 'bad' sister or daughter, and the 'weak' and the 'strong' sister:

> "My youngest sister is like, it's a bit of another subject, I won't get into it too much or we'll go off track. I haven't spoken to her for six years. She is like our mother. She's like my mum. But they get on because they like therapy, I'm not looking for therapy. You know my sister needs my mum. Yes, they are each other's security blanket. They need each other. They are both depressed. So she had a, not a tragic life, but she just gets by." Melanie

As Melanie's account implies, there were often suggestions that childhood circumstances with their mother had decreased empathy between siblings:

> I: "Does she have children?"
>
> R: "Yes, one […] that is the only regret I have there, is that I feel terrible, you know I really really do, and I can almost feel my father looking down at me, because I think I should be helping that child."
>
> I: "That child?... Not your sister?"
>
> R: "Oh my god no. I'll tell you what, I have tried with her so many times!" Melanie

The suggestion below is that siblings may often blame each other for dynamics that are part of their circumstances, and, for the purposes of this research, their circumstances with their mothers. This may be even more poignant for sisters. In Melanie's account below, she does not see the possibility of a sister who is looking for a mother and therefore wanting Melanie to be that mother. Indeed, it certainly was not her job to see this as a child: a child who herself also needed a mother. Melanie's account is an example of how such feelings between siblings may persist, and perhaps without further analysis, into adulthood:

> "I think one thing, from my point of view, I had to carry the family. […] I had to do the housework, the ironing and she was like: 'Oh I can't'. It was all excuses, "Oh I've got a headache", you know, and so from the start that was friction, because it was like for me, 'This isn't fair!" My brother was like: "Oh I'll help you, don't worry I'll help you, Melanie". I used to run away from home all the time. He ran away with me once. He said: "I don't want you to be lonely, so I'll come with you." He was so sweet, and I remember I took an anorak and he took a duffle coat and I was freezing and he said: "Oh have my coat, it's warm"." Melanie

As Carmen expands, the focus for sisters can be competition not only for 'mother', but for pain and suffering. With regard to sisters, each sister is, for the purpose of this study, without parenting, and yet often it seems that their focus is about the fairness or not that exists between them concerning the impact of that lack of parenting. There can then be a tendency to blame each other for not alleviating their plight, rather than comforting each other, and their suffering as caused by the inability of the adult who would ideally be caring for them:

> "We (as sisters) have very different experiences of my mother – we were different ages. I think the younger one to an extent 'got away with' more. I think I had the worst time – but my sister thinks she had a worse time than me." Carmen

Even where the relationship was amicable, there was often a consequence for daughters of mothers with EMHD in terms of their sibling relationship:

> "Although I do talk to her about it, we do talk about it … but we're not phenomenally close either unfortunately […] Mum is more concerned about her, yeah more concerned about her. […] things are not equal." Della

Some participants did speak of an awareness of the effect of their mothers' illness upon them and their siblings, and the effect upon either their relationship with their sister, or their feelings about her. Caroline speaks of the impact of her mother's negative comparisons between her and her sister. Implicit within participants' accounts was often their feeling that their mother had caused a 'splitting' between siblings:

> "She (my mother) actually said to my aunt once […] 'I've got two daughters' – one's as hard as nails and the other one's as soft as shit.' (laughs) […] I'm the hard as nails one. […] Yeah". Caroline

As Caroline continues to say, there were many reasons why siblings had very different relationships with their mothers. There is a suggestion in Caroline's account that she was the child whom her mother, who had chronic agoraphobia, perhaps relied on practically, therefore her role reversal was 'errand-based' but her sister may have been the child that her mother perhaps invested in or relied on more emotionally. Such differences could have very different consequences for the development both of the child and its relationships with their mother and siblings:

> "After my sister was born when I was about 8 doing all the errands for her […] we just never went anywhere, never went out anywhere. […] My sister was much closer to her than I was. My sister is a different personality. […] I feel she relied on my mum a lot more. […] Whereas I think with me I've always sort of thought well you know I can manage. […] I think I was definitely more independent. My sister was very clingy. She always used to say … I mean I remember her saying "Oh when I grow up it'll just be you and me and mum and we'll get a house together" you know "I'm never going to leave home" and things like that. […]… I can't remember ever saying anything like that." Caroline

Competition about suffering, or irritation about unfairness of roles, is not the exclusive domain of female siblings, but is common in any event between siblings. Sarah's account below also hints at the positive identity that might be present in being her mother's carer and doing this better than a sibling, or being favoured through this role:

> "He (my brother) would never really look after her – it was always me. He's willing but he's much more "put her in hospital" and she doesn't really want him when she's not well, she wants me." Sarah

A.5 Social Comparison - Feeling Different (cross theme – D3i Assuming difference; D.3.ii Distinguishing me from normal)

Many participants made reference to comparisons between the family they knew and the families around them. Most of the women seemed to share the experience of having felt that they were 'not like other children'. For some this was related to a 'knowingness' that they believe came from having experiences which made play and ordinary conversation difficult for them. It was commonly expressed that other children seemed carefree by comparison. This feeling of difference was often a source of loneliness in childhood:

> "You know when I was at school I never, I didn't identify with other children, not at all. I always felt a bit lonely." Melanie

> "Friendships were difficult – other children had ordinary lives and no troubles – it's still like that – and it's difficult to have time." Sarah

For others, their experiences did not match those of the other children around them. In other words, they became aware of the fact that many experiences which they came to know as usual for other children were not afforded to them. Many described a lack of gaiety or general happiness in their childhood.

> "Can't really think. I certainly wouldn't say happiness and I wouldn't say sadness, I would just say mediocre really. Not really one or the other. Can't ever remember being really, really happy, and I can't ever remember being really, really sad." Caroline

Many participants remembered feeling embarrassed or ashamed either of themselves or of their mothers' illness and behaviour. Many felt that this had made it difficult for them to fit in as children:

> "I experienced my mother as […] I used to hate coming home from school as I never knew what she would be like […] Yes, I was a very unhappy child. I couldn't invite my friends round as I never knew how mother would be." Gabrielle

Some participants spoke of how they came to realise that others judged them by their mothers' behaviour or judged them according to their mothers' view of them as a child:

> "Others judged me by my mother […]. Well I felt that a lot of what happened with my mother was brushed off on me, people were wary of me because of her. Yeah." Paula

Most women spoke of the isolation they experienced as a result of their mothers' behaviour which had caused them embarrassment and shame, or which had caused others to judge or avoid them.

> "And we've only met up with my dad's … the families of my dad's siblings, at the funerals. And we've got on so well and my sister said to me … "why? … why weren't we socialising with these people years ago?" Because … I mean I know it sounds awful, you go to a funeral, but we really you know enjoyed their company. And I said "I honestly think, that mum," I said, "she sort of isolated us."" Caroline

For a child, having a mother with EMHD, means that the need for the support of other adults is increased. However, the accounts of participants suggest that having a mother with EMHD increases the likelihood of being more isolated:

> "There were no other adults. Dad went – mum had no connections – no friends." Carmen

Being isolated means that there was no-one to turn to as a child for the help needed in difficult life circumstances. Gabrielle encapsulated some of these very real experiences for participants in one sentence:

> "I experienced my mother as manic, depressed, needy, personally insulting, scary, embarrassing, unpredictable and sad." Gabrielle

4.3 Theme B - Beginning the motherhood journey - pre-pregnancy to birth and adjustment to becoming a mother

List of themes:

B.1 Maternal Feeling

B.1.i Lack of maternal feelings

B.1.ii Strong maternal feelings

B.2 Fear of Harming (cross theme- C.2.iii. Waiting to fail)

B.2.i. Self-protection and Selfishness (cross theme- C.2.iii. Waiting to fail)

B.2. ii. Fear of becoming 'her' (cross theme- C.2.iii. Waiting to fail)

B.3 The Complexity of Bonding

B 3.i Connecting my mothering with my mother (cross theme - D overall. Making sense of my journey)

B 3. ii Not a 'natural' mother

B3. iii Bonding and Fear

B 3. iv Bonding above all else

Theme B '**Beginning the motherhood journey'** is pivotal and integral to all the emergent themes and endeavours to capture the recollections of participants concerning how they felt about both the idea and the fact of becoming mothers. This involved their thoughts, feelings and processing pre-pregnancy; throughout pregnancy; giving birth and initially becoming a mother, as well as their adaptation to all. It was poignant for me as the researcher that the women in this study rarely spoke of their 'birth experience' experientially or physiologically, but rather their emotional experience concerning pre-conception, pregnancy and post-birth; this included what they considered to be early motherhood (or a heightened period of adapting to motherhood), which for some women spanned their children's infancy and for

others was described as continuous. Theme B, therefore, encompasses participants' varied narratives on three conceptual themes: Pre-pregnancy, Pregnancy and Post birth adjustment to motherhood. Since all participants explored this through extensive backwards and forwards reflection, it was difficult to present these themes in isolation, or as a current experience. As will be seen, there is considerable overlap, with the same themes occurring for different participants at differing stages of their reflections and their experience of being a mother.

B.1 Maternal Feeling

Although opinions were varied, many participants held strong views about even the thought of having children prior to becoming mothers. Heightened feelings of desperation either to have or not to have children were common.

B.1.i Lack of maternal feelings

Some women described themselves as not having experienced maternal feelings prior to the birth of their children. Gabrielle describes her response to pregnancy as one of shock which is perhaps particularly relevant to this study in that she had also never envisaged herself being a mother prior to pregnancy:

> "I felt surprised and quite shocked – I had never thought of being a mother and until I gave birth, did not have strong maternal feelings." Gabrielle

Gabrielle connected her childhood experience of her mother's EMHD with the absence of maternal feeling prior to expecting her first child. Gabrielle described that her expectations were of never having children and of a potential negative outcome if she did:

> "That's (my mother) probably why I didn't think much about having children until I became pregnant. I was always terrified I would have post-natal depression." Gabrielle

Melanie described herself as both determined not to have children and, like Gabrielle, she had never imagined herself as a mother:

> "You know I thought I'd grow up, I'd leave home, I'd have a boyfriend, I'd travel, but never ever in my life did I think that I'd have a baby. I never went down that route, I didn't even start to go down that route, that that might happen […] I never wanted children, I was dead against it! Oh my God! And I

> had some friends that got really funny with me, because there's like a club of women who don't want children […] And I was the leader!" Melanie

For transparency, it is important to mention that Melanie had believed both that she would never have children (due to her history of anorexia nervosa) and that she did not want to have children.

> "[…] I always thought I couldn't have children, I was anorexic, what a surprise, in my teens! […] Yes, I think because I didn't want it and thought I wasn't going to have it. I was in control now and I wasn't going to have it! […] didn't want it, didn't think about it, and it was never an issue. […] and I fell pregnant so you can imagine the shock of that!" Melanie

For Melanie, her presumed infertility could have affected her acknowledgement of maternal feelings. However, later quotes illustrate her subsequent fears during pregnancy which could not have reflected her view of her fertility as she was by then a mother.

> "Sometimes I wake up and I think I'm pregnant and I get a great fear in me, I do sometimes get that now. I think "Oh my god, oh my god" you know, I do, I actually wake up covered in sweat, I do actually wake up frightened." Melanie

Sarah's narrative suggests that historically, her extensive caring role, which was essentially maternal role reversal, had affected the potential for her to experience excitement at the thought of becoming a mother herself. In addition, the pre-existing, extensive and long-standing caring role that she knew, and, in Sarah's case, its unpredictability due to the nature of her mother's illness, seemed for Sarah to have had significant impact upon her ability to enjoy *anything* spontaneously.

> "I didn't feel that maternal. I felt I had been a mum a long time before I was a real one. I suppose I had always looked after Mum and although she's great when she's well, I never knew when she'd turn but I knew the signs and it was always a worry – in the back of my mind – and when she's not well, well I just never knew how long it would be. I could never plan - all my life - for me really." Sarah

For those women who could not see themselves as mothers, it seemed that fears surrounding mental health issues and difficulties in identifying with the mother role were at the heart of this.

B.1.ii Strong maternal feelings

Whilst some participants had not envisaged themselves ever becoming mothers, and some had been determined that they should never become mothers, for others there was a strong drive to have children, as Della describes:

> "Um … before I had the children? […] I was desperate to have children, you know? Definitely wanted to have children … got married to start having children. […] I worked in travel industry. I was the general manager […] it was a great job […] It was important to me at the time, but becoming a mother was much more important to me." Della

Della spoke of having been strongly driven to create her own 'normal family' having spent her childhood coping by connecting with other families:

> "Finding these families that were normal, that were happy to kind of take me in as part of their family." Della

Della spoke of how her joy in her pregnancy was part of this specific need for 'normal'. Della spoke also of a second need, which was her deep desire to experience a mother-daughter relationship:

> "Yeah. Took a long time to become pregnant. Took about a year to conceive Liz […] When I found out I was pregnant, I was delighted, absolutely delighted. […] but I desperately needed a girl, I desperately wanted a daughter, I really did …if I didn't get my daughter (laughs). So no … I didn't, I didn't have anything. […] So … no I didn't have any feelings because of my relationship with my mother - about being a mum, but I wanted to create my own family." Della

Carmen had endured many miscarriages in her endeavour to become a mother. This is in itself a testimony to her strong desire to have a child. This was further emphasised by Carmen in relation to the happiness she felt she would experience if, in turn, her daughter became a mother, which feeling she also connects with the possible impact of her childhood:

> "If she was pregnant with four kids I'd be delighted, because for me that would have broken the cycle because my sisters haven't got children (nervous laughter) – one's a lesbian – other one doesn't know how to form relationships – her whole sexuality has been destroyed." Carmen.

The reasons for wanting children or not wanting them were varied, as of course they are for all women. However, where women connected their feelings about having children with their own experience of being 'mothered' in their own childhoods, this distinguished their narrative from that of mothers in general. The conscious presence or not of maternal feelings might therefore be less important in this research than the underlying reasoning.

Kye shared that she had always had strong maternal feelings and that having a child was a response to a drive to heal and support herself in the light of her own childhood experiences:

> "I was very keen to have my kids, so part of me was, it was quite a selfish move, I was thinking I want something that's mine and that will love me and need me, even more I will be needed […]. I suppose that was where my value system was, as long as I'm needed then I'm valuable. So yeah I wanted to have my kids, I was delighted to have them […] There wasn't any valuable relationships, I mean I loved my mum but she was in and out of hospital … so I didn't have any strong connections with anyone, and I needed that, so when I had a child, I had it." Kye

Kye refers overtly to a relationship between needing to feel needed in order to feel valuable. This was less specifically referred to by other participants but was potentially evident in many of the behaviours and thoughts and feelings which participants will describe in Theme C, concerning the mother they saw themselves to be currently. Kye also referred to her needs as 'selfish', which was further explored by participants when referring to their fears about themselves as mothers.

B.2 Fear of harming (cross theme - C.2. Waiting to fail)

Many participants spoke of aspects of themselves and their motivations, which made them fearful about being a mother. Some participants revealed how they had felt about the thought of motherhood, by describing their fears around harming their child due to their inability to sufficiently care for them. A number of themes emerged which connected this fear with the effects of their childhood experiences.

B.2.i. Self-protection and Selfishness (cross theme - C.2. Waiting to fail)

For most participants, there was a recognition that for them surviving their childhood was dependent upon their ability to protect themselves both as children and as adults and there were many references to this:

> "I got to the point where I just thought you know you're not going to rule my life. And it was that sort of thing … and I did put the phone down on her once. This is why she thought I was hard. But I'm not having it, you know." Caroline

> "No I think I would have been very self-destructive if I'd stayed. (inaudible) where I was with my mother […] I would have no relationship with her. I am a long way away, you know she and I don't confront one another." Della

Participants often described their own needs as 'selfish', as was the case with Kye above, in Theme B2.i:

> "[…] it was quite a selfish move, I was thinking I want something that's mine."

There were many accounts in Theme A which echo this, as there were many situations in which, as children, there was a need for participants to protect themselves either from their mother, or from others, or other situations from which their mother was unable to protect them.

Melanie described having felt fearful that she might protect herself above a child. She explained that she felt that she had always used self-protection in order to cope in her childhood. Melanie did not experience maternal feelings prior to the birth of her first child. However, the level of her anxiety and her determination to avoid pregnancy may suggest that her maternal feelings were submerged by a fear that she would not bond with her child, as her narrative below intimates:

> "I never wanted children, I was dead against it because I thought: "Trouble, I'm not going to be able to deal with it, I'm not going to be able to love them." I thought: "I won't love them and they won't be part of me." We'd been together for thirteen years before I had my son, married for ten, I thought: "What if I don't even like this baby, what if it's horrible?" and he (my husband) would go: "But you will." And that used to annoy me because I'd say: "No it's not a given, it's not a given that that will happen." […] but you

> see that's why I worried so much when I was pregnant, because I thought it would be my bubble round me, and kids on the outside, but they are so much in my bubble, they are me. I was truly afraid and worried about it." Melanie

Both Melanie and Carmen's accounts reflect a fear of not being able to protect both themselves and a child. Carmen described her self-protection, though necessary to her survival given her childhood, as 'selfishness'. Given this, she too experienced anxiety about her abilities as a prospective mother:

> "I worried I would be too selfish. I would not have survived if I wasn't quite selfish." Carmen.

Carmen expressed strongly her belief that she had to put everything possible in place currently as a mother to protect her child from the negative experiences that she, as her mother, might inflict upon her daughter if she herself were under stress. She did this by giving herself sufficient breaks, by utilising childcare to alleviate her stress:

> "I am the only one to have children and it took me so long to get her. […]. I am quite selfish really and I can be quite unkind…. No I can really… I am not unkind really, and I do care but it comes out when I'm stressed. When I have to protect myself. I have to be careful. […] It (childcare) will give me that space to do all the things I can't do since I had her. And I can't do any of this when she's here without getting cross with her, so I think that I am very wary of not getting cross with her when it's not her fault. I was always in that situation." Carmen

Della however, spoke of how self-protection had been beneficial to her in her role in her own family as a mother. She described how she felt that this was something which was not conscious, and which she came to realise as a mother but in retrospect. It may be that such accounts could allay the fears of daughters of mothers with EMHDs, who would like to become mothers but are fearful:

> I: Have you made any conscious decisions to protect yourself?
>
> R: "Yeah I think probably. Or an unconscious decision. […] I mean I think as you get older things change and get a bit more sort of … I don't know, you kind of realise a bit more. And then as I had my family … it was an unconscious decision, it wasn't conscious. Della

It would seem that complex feelings towards motherhood, often lay beneath participants' feelings of the joy or dread of having a child.

B.2. ii. Fear of 'becoming her' (cross theme - C.2.iii Waiting to fail)

For many participants, a fear of harming their child appeared to be deeply rooted in their anxiety that they might suddenly behave as their mothers had behaved towards them, as Carmen expressed above. It is important to acknowledge the immense trust these participants showed in sharing this with me. I felt strongly that it might only have been the fact that I had shared my own experience with them that enabled this trust.

This common fear of 'becoming her' seemed to be rooted in participants' experiences as children and was not stemming from any behaviour they had ever actually witnessed in themselves. In addition, none of the participants knowingly suffered from any obsessional disorder and therefore their concerns were not knowingly attributed to obsessional thinking, but for some women they were often strongly present and disturbing. Some participants expressed having experienced this 'fear of harming' not only in connection with pregnancy and motherhood but also at the mere thought of having a child, as Elenor and Melanie describe:

> R: I had been terrified before.
>
> I: The idea of having children?
>
> R: "The idea terrified me. The idea of looking after them also […] yeah, terrified me. […] And all I was doing was thinking about the one person that had bloody terrified me and was terrifying me even now. Terrifying me that I was going to turn into her." Elenor

Many of the women studied feared that it was only a matter of time before the 'bad mother' emerged. They feared becoming mentally ill and helpless to avoid their mothers' mistakes and behaviours.

> "I couldn't even try to have kids for ten years. I was just so terrified I would repeat it all […]and my husband kept saying "you'll be fine, just look at how you are with the cats!" But I was terrified I would be a terrible mother or I would repeat the pain." Melanie

Elenor spoke of being preoccupied by thoughts that she could somehow helplessly harm their children:

> "All the time when they were tiny I was so scared "…what am I going to do if that happened to me?" I was so terrified, I told no-one… I was terrified that it would creep up on me and I wouldn't know." Elenor

Fears were often expressed regarding their own mental wellbeing and that of their children, mostly in terms of their fears for future outcomes. For some women, these fears included concerns that their children might develop behaviours or an illness that would reflect a possible genetic connection, passing their mother's EMHD through them and on to their children. There were also fears that they may themselves develop behaviours that would affect their children's lives adversely, as Melanie describes:

> "[…] All the way through my pregnancy I was really, really anxious – would he be ok? Would I cope? Would I be a dreadful mother? […] You know I spent the first few years of my son's life scouring the text books waiting for him to have a syndrome." Melanie

It is easy to imagine how difficult it might have been for participants to have a positive internal image inside that they could be good mothers. Elenor spoke of how she had feared in the early years of her experience of mothering that she might in the future not have the ability to control her behaviour towards her children.

> "When I first found out I was pregnant I was so frightened […] and I was just so frightened, so, so frightened …that I wouldn't be able to help myself. That it didn't matter how hard I tried that something would happen when you had this baby, some kind of hormone would kick in that turns you into that monster. You know what are you going to do? What am I going to do if that happened to me?" Elenor

Many participants felt pre-occupied by their dread of developing mental ill-health, as will be further explored in Theme C. As adults, this was the over-riding factor which they felt had caused their own suffering and/or neglect in childhood, and they greatly feared being ultimately responsible for repeating the pain they had known. This common anxiety appeared at different stages of their motherhood journey and regardless of whether their desire to have children had been strong. Anxiety was therefore common in pregnancy and in motherhood and while this is to be expected to a certain extent in all women, for these women this was primarily centred around participants' own mental health anxiety and the potentially negative consequences of being 'their mothers' daughter', for their children.

It is as important to reflect divergence as well as convergence and not all participants felt fearful at the prospect of becoming a mother. However, Caroline expressed a possible distancing of herself, in that she may not have thought very deeply about motherhood before giving birth and that therefore, her 'delight' at pregnancy, was at that time in ignorance and perhaps did not yet reflect her feelings about the idea of becoming a mother:

> "Um, well I was thrilled to bits […] Um … and I don't know … I was never worried about being … pregnant or giving birth. Or anything … I must have been extremely naïve. […] And I can't even remember thinking "how am I going to cope? I've got two in nappies. How am I going to do it?"." Caroline

However, it was notable that Caroline described herself more generally as finding it difficult to get in touch with her own feelings. She spoke much more about the practicalities of her adaptation to motherhood:

> "I'm not one of these that sits and thinks … internalises and thinks about how I feel. Perhaps I should, I don't know. I mean I've considered counselling over the years but I've always sort of muddled through. Probably cos I am quite embarrassed about talking about my feelings […] cos we weren't a family that discussed things like that, you know, just weren't." Caroline

Caroline's account echoes the thoughts above of participants in Theme A1 'No-one explained', in that many participants grew up in homes where very important feelings and occurrences were unlikely to be discussed.

B.3 The complexity of bonding

It is not necessarily unique to daughters of mothers who have EMHDs, to experience powerful emotions connected with bonding when they become mothers. However, the mothers in this study often connected the complexity of bonding for them with their childhood experiences with their own mothers.

B.3.i. Connecting my mothering with my mother (cross theme – D- overall: Making sense of my journey)

In different ways for each participant, the experience of becoming and being a mother had surprised them, in view of the mothering that they had known. Most made connections between their own bonding experience and their bond with their mother regardless of the

unique nature of this experience. Melanie describes the sudden fierce emotions she experienced, not during pregnancy or during the birth, but quite unexpectedly for her (given her childhood) upon her first physical contact with her son. She describes the opposite experience in her bonding to one she believed for many years that her childhood has prescribed to her. As can be seen below, her feelings about herself as a mother changed in an instant upon her actual contact with her baby:

> "When I had my child - after all that and all my childhood and all the worry, I remember while I was pregnant thinking "well I'm only going to have one baby." I had a caesarean […] and they cut me open and said: "Do you want your son on your chest?" I said, "Ooh no, give him a wash first!" That's so me, "switch on the light!" But when they gave me my son it was like a thunder of maternal instinct that I never knew I possessed or had, and I felt like – "No one is going to come near my son, hurt my son!" and that's what I've been like ever since really, and I said to my husband – "I want another baby" and he said: "But Melanie, I've been saying for ten years I wanted children and now you want another one?" and I said: "Yes I want another one, I want another baby!"" Melanie

Some women expressed surprise at how well they responded to becoming a mother, which, in itself, suggests that they had an expectation that they would fail as mothers, which may in turn for some participants have been likely to have affected their experiences pre-pregnancy, during pregnancy and also their adjustment to motherhood. Melanie had previously discussed her fears in pregnancy about being too selfish to be a good mother. Her account below expresses her surprise that she could adjust well to being a mother given her childhood experience. It is clear in her account that she expected to fail as a mother:

> I: Did you experience anything connected to that loss of control? That fear of loss of control when you were first a mother?
>
> R: No…actually again, as weird as this may sound, it all came to me quite naturally, I felt very happy being a mum. I didn't really think about myself at all, all the kind of selfishness, you know, I always thought I was selfish, […] but when I actually had my son all I felt was happy, I was very, very happy and I didn't think really about lack of control. Melanie

In Melanie's quote below there is the suggestion that Melanie's anxieties and her vehement opposition to motherhood prior to her experience of being a mother, suggested a deep-rooted

knowledge and care (unbeknown to her at the time) regarding the welfare of children. This may be particularly relevant to counselling psychologists in therapy pre-birth and post birth:

> "No, but you see that's why I worried so much when I was pregnant, because I thought it would be my bubble round me, and kids on the outside, but they are so much in my bubble, they are me." Melanie

This close look at Melanie's processing pre- and post-birth exemplifies the sudden transference that occurred, although in differing ways, for other participants. Although some of the women had described that self-protection had been an effective strategy pre-motherhood, this was rarely expressed once participants became mothers. Melanie describes her instant transference of strong self-protection towards herself to the fierce protection of her son:

> "But when I had my son, the minute they gave him to me, even though I never wanted children - I was dead against it (using child minders), […] because I thought "I won't love them and they won't be part of me. I won't let them into my bubble" […] but when I had him and I looked at child minders, nurseries, I would just get tears start dripping down my face." Melanie

It was notable that participants made the connection between their own response to their children and what they assumed had been their mothers' very different responses towards them as children, as Elenor describes below. Elenor also alludes to what she feels should be the uniqueness of a mother's love for their child, when she expresses that although she felt care from her father, this, in her opinion, does not equate with what she experienced in herself to be a mother's love for her child:

> "You know having that first baby and just thinking … and just being so totally overwhelmed. I don't think I've ever experienced love like that in my whole life until I had that baby. Cos I hadn't … I mean my mum … my mum, there was nothing there. My dad, it was different, you know it was my dad. But not that kind of… just totally focussed on one person." Elenor

Caroline spoke of how she realised through her behaviour as a mother herself, that her own mother's responses towards her in childhood had been lacking in comparison:

> "She's not like me. You know when I compare her role with the way I am with my children, I mean she was just no help at all really. […] I was always

> conscious I don't think I could ever rely on her to be there if I needed her." Caroline.

B 3. ii Not a 'natural' mother

When considering the bonding between themselves and their child or children, there were a number of accounts of women describing that their mothering was not a 'natural' process. Whilst the assumptions around concept of 'natural mothering' are widely debated and impact all women who are mothers in terms of assumptions around gender, the mothers in this study related this to their own experiences of having been 'mothered' by a woman who was suffering from EMHD. Many felt that mothering was natural for others but not for them. It could be assumed (and perhaps was assumed by participants themselves) that what they perceived as 'unnaturalness' in their mothering was rooted specifically in their childhood experiences and the nurturing which they felt that they lacked. However, it may well be that processing back and forth between their current experiences and childhood experiences in itself contributed to the lack of naturalness described. Elenor seems to be suggesting below how her conscious effort to be unlike her mother and the energy involved in this process both constructed her maternal identity and obstructed it:

> "And that stops like natural things just happening sometimes, just interrupts, because I was obsessive. I just so didn't want it to be like my childhood I really didn't. And I hadn't told anyone. I didn't tell my husband till two years ago when I broke down, well …… about three years ago. He knew something was strange, he knew that my mum and I didn't get on. He knew that she wasn't quite right but ... and my brothers never spoke about it either." Elenor

Carmen's explanation of how she feels she has to protect herself and protect her child from how she might behave when stressed also exemplifies the effort that accounts suggested that these women put into being a mother, often because of their fears of causing harm to their children:

> "I wouldn't say mothering came naturally to me. I don't have that much patience with children. I am not a gushy Mum. I love her, of course I love her! But it's not instinct with me. I have to put everything in place to make sure I don't become her (her mother) [...] I don't think I could ever hurt a child but I have to have it all planned out." *Carmen*

Carmen described the benefit for her in the slow introduction to pregnancy and birth which the complications she experienced in pregnancy afforded her in allowing a gentle bonding process between herself and her daughter:

> "I was very ill after the birth and I didn't see her for a while and the nurse was encouraging me to see her cos "it's good for you and it's good for the baby", but in some ways it was good – because I was wheeled down and she was wheeled up and it gave me some space. It can often be very stressful – oh she's doing this and not doing that – but that two weeks they looked after her and it was all very gradual." Carmen

Some women explained how in the absence of a model for mothering, that they had relied on observation and copying others as a way of coping as a mother:

> "And I suppose maybe a lot of my stuff I just copied things from others I saw … copying friends and family, you know. It was never quite natural. And I suppose I just got on and did it. That was how it was to be." Elenor

> "I watched what other people did, how they went about things in various circumstances and thought that must be the right way to do it." Paula

B.3.iii Bonding and fear

For some participants, separation at birth had compounded their sense of failure as a mother. Sarah seemed to be expressing how in retrospect she felt that she had been destined to fail given her already extensive caring responsibilities. Whereas some participants had expressed expecting to fail as mothers in their future role, Sarah felt that she experienced depression after the birth of her first child upon the realisation of the burden that had been already placed upon her in childhood and felt overwhelmed by responsibility and fear when her daughter was born:

I felt so sad for my daughter. I just felt she would go through so much and then I will die – (pause). I felt overwhelmed. Before she arrived, I already knew the enormity of having to care for someone all the time. I suppose I was connected but I felt guilty. I didn't feel connected. I was already so responsible – and this was even more scary." Sarah

For Sarah, motherhood had suddenly become a frightening experience which may in itself have impacted upon the bonding she experienced with her daughter, her first child. The first line of her quote above suggests trauma. The last line above suggests that Sarah already

knows bonding as ‘scary’. This may reflect being overburdened as a child or currently, as she has remained her mother’s carer since she was eleven years of age. It is poignant that although in her early experience of being a mother, her memory is of a lack of feeling for her child, that further dialogue represents her commitment to her child as being highly evident in the sadness she felt, both at the time post birth and the later harsh self-criticism she expressed at this memory. This in turn seems connected to her own experiences as a daughter of a mother with EMHD:

> “I’ve seen videos and she looks like she’s reacting to me – so I must have been doing something right – but I know how I felt […] I imagine others would feel wonderful. I so wanted to feel happy – to feel connected (to my baby). I felt so jealous of others. I was in touch with the heaviness of it. It was all just not what I expected. […] I tried to compensate. She got every toy and I never shouted at her.” Sarah

Some participants spoke of not having experienced maternal feelings pre-conception and in pregnancy until the birth of their children. Some women described themselves as feeling strongly maternal once their children were born and others described needing time to bond or having struggled to bond with their child. Sarah, whose mother had suffered unexplained but sudden (without pattern) and severe bouts of completely incapacitating depression throughout Sarah’s childhood and also currently, had assumed she might have children but did not plan them. Sarah’s account reflects two themes that emerged, which appeared to affect maternal feelings and bonding: namely, the perception of control in their own lives and the experience of already feeling that they had long already been a ‘carer’.

The extract below from Sarah suggests a fatalistic approach to her life, as she perceives that she has little control or choice in her life due to her childhood role and continued role as a carer for her mother. Although, as she spoke, her love for her children was clear, Sarah struggled with her early maternal feelings.

> “It wasn’t like I thought it would be – the first one. I was very depressed and low and didn’t bond. I didn’t feel how I thought I would. I felt disappointed in me, in motherhood. Maybe I had already been a mother too long. I was always her mother. I always looked after her when she was ill.” Sarah

For Sarah, motherhood came as a responsibility on top of being a child carer and now an adult carer of her mother and she described a struggle with bonding in the early weeks of first being a mother and the ongoing anxieties this has left her with:

> "It's better since I had more children […], but she was my first and maybe I just didn't have that motherliness. I did all the right things and I cooed at her and she cooed back at me but I resented her in a way and she'd wake up every hour […] and it took a while […] and I still worry that maybe she thinks I didn't have that feeling." Sarah

Feelings of joy and love were often tinged with fear or caution for many of the women who often felt that such responses were more prevalent or deep-rooted for them in comparison with 'other' mothers:

> "I loved her from the moment I saw her – there was no problem there – but I would say I have more fear." Carmen

B.3.iv Bonding above all else

For some participants, bonding was instant and all-consuming regardless of whether they had wanted to have children, that it overshadowed all else. Some women described very clearly how when they became a mother, their interest in their partners diminished. This of course is not exclusive to daughters of mothers with EMHD. However, in their case, their childhood with their mothers may in their view underpin their relationships. Kye felt that in retrospect she had been so determined to have her children that she had little consideration for their father, her then partner, and, as both Kye and Melanie explain, other relationships diminished in comparison to their mother-child relationship:

> "Initially it was like, yeah you know a very selfish feeling because I was doting on my son when he was born and I couldn't care less about his father, that's how I felt. "You can go away because I've got my little treasure now"." Kye

> "I would say that before I had children I had a fantastic relationship with him. You know after knowing him for 13 years, I used to run home from work […] But from having that, our relationship just went […] But although it has come up it will never be, I mean I know this sounds bad but I'm being brutally honest, it will never be the same. I mean I don't know how a relationship could be that bad for that long?" Melanie

For most women, becoming a mother took precedence over all, including their care of themselves:

> “I didn’t exist.” Elenor

4.4 Theme C – The mother I am today

List of themes:

C.1 The concept of Striving

C.2 The mother I am (and the mother I fear I could become)

C.2.i The importance of being a mother

C.2.ii My empathy with my children

C.2.iii Waiting to fail **(**cross theme - B.2 Fear of harming, B.2.i. Self-protection and selfishness); B.2. ii. Fear of becoming 'her')

C.2.iv Being a mother being my 'self'

C.2.v Self-doubt and mistrust (cross theme - D.2.iii confidence in relationships)

C.2.vi Needing approval (cross theme - D.2.iii confidence in relationships)

C.3. Guarding against failure

C.3.i Overcompensating

C.3.ii Doing it for them but not for me

C.4 My mother-daughter relationship

C.4.i My daughter-my 'self'

C.5 Taking it all on

C.6 The mother I fear I could become

C.6.i Avoiding mental illness (cross theme - B.2 Fear of Harming, B.2.i. Self-protection and selfishness); B.2. ii. Fear of becoming 'her')

C. 6.ii Depression and identity

C.6.iii Avoiding all aspects of my mother

C.7. Some consequences of striving

C.7.i Avoidance and overload

C.7.ii Lack of enjoyment

C.7.iii Suicidal ideation

In Theme C, '**The mother I am today'** participants described how they experienced themselves as mothers today. On the day that they were interviewed, each woman was in a different stage of motherhood, in terms of the age/ages of her children, her own age, or the place in which she felt herself to be in her own individual journey as a mother. There were many shared experiences, as well as unique references.

Many quotes contained layers of themes, which made for some further difficult decisions concerning where best to present these. A consideration for me concerned the decision as to whether aspects of these themes would be more appropriately placed in Theme D. The fact that all narrative incorporated reflection rendered it complex to distinguish these women's feelings about the mother they believed themselves to be today and their reflections upon their journeys as mothers, since their current frame of reference incorporated the mothering they had known, their own experience as a mother and their fears for the future, all of which had reflection at its heart. Therefore, it felt difficult to capture from these women the themes which reflected the mother that they felt themselves to be today as a significant part of this was the mother they feared they could become.

C.1 The concept of striving

In terms of how these women viewed themselves currently as mothers, my overwhelming and unexpected finding was that of the conceptual theme of 'striving' as being integral to these women's daily functioning. The concept of striving refers more generally to persistent effort. To me, these women's behaviours reflected more than simply 'trying'. Through more than a

year of analysis, I struggled to know whether the theme of 'striving' was legitimately reflective of what I experienced with all the participants. I was concerned that it might be my own projection as a daughter myself of EMHD. However, I was often aware of how tired I felt both during the interviews and later upon reading through transcripts and I felt that I needed to reflect what I felt to be present in the ambience of the interview space and in the transcripts. Eventually, I felt sure that the most relevant theme in order to try to capture the energy all participants put into being a mother seemed to be 'striving':

> "I was, I think, bionic in my efforts to get him in there. I know that seems pitiful but again you have to do, what you have to do. Well I had to. I became on the pre-school committee, I ran the toddler group […] I volunteered for everything, I made cakes! And when he started school, even though it was a brilliant school, I cried for two weeks because my little baby boy was having to find his own way." Melanie

> "Absolutely totally always. Always. Especially when they were young. It was always I am not going to do that because that's what she did, it was that way for us and I would do the opposite (pause) even though sometimes it was you know not the rational thing to do." Elenor

> "[…] and I want them to have a totally different recollection of their childhood. I do overwork, I'm ridiculous." Della

Inherent in the quotes above are descriptive linguistic references to 'effort', which gave rise to the concept of striving. I was conscious of the choice of adjectives which participants tended to utilise, such as those stated above: 'bionic', 'totally', 'overwork' and 'ridiculous'. My aim here is not to switch methodology but to alert the reader to this concept. The concept of 'striving' seemed to be persistent and prevalent in these women's narratives about their experience of themselves as mothers. However, rather than run the risk of forcing this through each theme, striving is presented here as a conceptual theme of significance for the reader's awareness throughout Theme C.

C.2 The Mother I am (and the mother I fear I could become)

After much deliberation, and in addition to the concept of 'striving', I established two further themes within participants' views of themselves as a mother. The main themes emerging were: 'The mother I am' and 'The mother I fear I could become'. The theme 'The mother I am' incorporated themes in which participants described their feelings and behaviours as

mothers currently, within which was the sub-theme, of equal importance and relevance, of 'The mother I fear I will become'. These two themes necessarily overlapped to describe how participants felt about themselves as mothers today.

C.2.i The importance to me of being a mother

Striving appeared to represent first and foremost the meaning of motherhood for all participants. Many stated overtly, but in different ways, that being a mother was of the highest importance to them. Melanie described motherhood as the role she put most effort into:

> "I think my main role is a mother and I (pause for thought) for me, that role, I just do the absolute best that I can do every day. It almost does overshadow everything." Melanie

Della described being a mother as being prioritised above all else in her life:

> "Like a mother, the first thing is a mother. Yeah that is my most important role, I make sure everything (work, friends) revolves around it […]." Della

Carmen described her child as taking up most of her emotional life:

> "Most of my life is my child. There's a little bit of my life that goes out to work […] I give the impression of being laid back. I don't think they would have any idea how much I analyse it and the planning and the processes I go through." Carmen

C.2.ii My empathy with children

Many themes reflected the general empathy participants felt towards children.

> "I think my past has made me very compassionate, […] but I am very, very compassionate, especially with children." Melanie

Elenor spoke of how her childhood had drawn her towards children and caring occupational roles:

> "You know all the jobs I've had, loads of jobs, all with people, loads of young people. […] And I suppose I have that empathy with those kids because my mum was shit as well, so … not that I ever told them, but there was that level of understanding. […] I was good at it and I could do it, because I know exactly where they're coming from." Elenor

Participants were often strongly affected by what they saw as an adult's failure to take care of a child, even in relatively minor or commonly occurring ways, as Caroline describes:

> "And they're absolutely blanking them, and I'm thinking for goodness sake, just bend down and say: "Yes, dear, all right, mum's talking", just acknowledge them. And that I really could not bear." Caroline

It seemed that participants felt that their empathy with children had developed from their own childhood experiences. In this sense, the mother in them was also extended more widely beyond their own children:

> "And I always think about like other people's children as well. You know if I've seen another person's child in tears (pause) if they cried it would make me cry." Della

> "I can give all I can to her but I get quite irritated quite easily with other children…but I would never hurt a child. Never." Carmen

It was interesting for me to note that none of the participants mentioned that their empathy might predispose them to being a 'good' mother.

C.2.iii Waiting to fail (cross themes – B2 Fear of harming; B.2.i. Self-protection and selfishness; B.2.ii Fear of becoming 'her'.

For many participants, as explored in Theme B.2, there seemed to be a strongly held belief that given their own childhoods and the model of mothering which they knew, that they had a predisposition to fail as mothers themselves.

Carmen described her surprise at the mothering ability she experienced in herself:

> "Having been through what I have been through I should have been crap." Carmen

Elenor spoke as if for her failing as a mother was a foregone conclusion, for which she had to make amends:

> "I worry about things…I say things like, "Look I've probably screwed up somewhere." because you know you never find out until it's too late. […] So I kind of apologise in advance in case I've screwed their lives up. And if any of them has a problem, I mean I worry I caused it." Eleanor

Melanie spoke of her continued fear of failure, despite the many aspects of her life which had been successful:

> I have been married for 18 years, my children are happy children and they are doing well, I have done well in life - and it worries me." Melanie

C. 2 iv Being a mother and being my 'self'

The following themes seemed to relate to the persistent questioning which many women spoke of concerning their insecurity in themselves as 'fit' for the role of mother to their children.

C.2.v Self-doubt and mistrust (cross theme - D2 iii. Confidence in relationships)

Continual self-doubt and self-criticism was common to participants, and many spoke of an interplay between their individual identity and their maternal identity. Sarah spoke of finding it difficult to respect and trust herself as a mother and generally:

> "I analyse myself as a mother - "Should I feel this? Should I not?" And I think, "Why can't you just stand up for myself?" I question – "Should I be upset? Should I not be upset?" – always questioning. I struggle with communication. Maybe that's just me being silly again." Sarah

It is possible that Sarah's linguistic 'mistake' underlined above, may suggest the presence of frequent internal dialogue which berates her from inside in the third person as well as the first: the third person dialogue being an even more critical voice because it represents the view of others in addition to herself.

Self-doubt for Carmen appeared to manifest not only in her questioning her abilities as a mother but also questioning her motives as a mother:

> "I think I think about things much more – I always question myself – even when my husband gives her (my daughter) a bath. I question, "Am I giving her enough?" Is that because I have had enough of her? Do you know what I mean? Am I dumping her? – erm (pause) and whenever she goes into any form of childcare - so I can go into work if I have to." Carmen

Paula spoke of herself as lacking certain human qualities which would allow her to relate well to others. She attributed this perceived deficit to her childhood and saw it as bringing

difficult situations towards her both in general and as a mother. It was Paula's experience that others doubted her. She in turn doubted her own ability to convey her integrity. She doubted that I would understand her:

> "[…] So I think that … when I say something …I don't look honest […] It doesn't come over honestly. Can you understand? […] I think I don't appear to have the right (pause) you know (pause) how people have a sort of facial expression in life about things. The things that you should learn and how you respond of which you're unconscious. And I don't think I have those (pause) or I've got some of them missing. […] I've had trouble with all three children." Paula

C.2.vi Needing approval (cross theme – D.2.iii Confidence in relationships)

It seemed that for these mothers who struggled to trust themselves and felt destined to fail, the approval of others was vital, particularly from their children. For some participants, recognition of their own need for approval currently as a mother themselves, created feelings of guilt and remorse in them regarding their own mothers.

Elenor also expressed her regret that as a child she had favoured her father above her mother. Although she understood the reasons behind her childhood feelings, her awareness of her fear of failure as a mother currently and her need for her children's approval was connected to feelings of guilt towards her mother

> "But I do feel … I do feel bad that I preferred my Dad to my Mum now I am a mum. I favoured my dad so much - because I don't think you should. And I do feel bad. And then when I'm objective about my Dad he was good in comparison." Elenor

Della reflected that her effort to meet her children's every need may be rooted in her fear of being disapproved of and side-lined by them in ways that she had come to realise in retrospect that she had done with her own mother:

> "I was with my husband's mum on my wedding morning – […] she came with me to choose my dress […] my mum felt very much that that wasn't how it should be … you know? - which it actually wasn't, you know? […] my husband was farmed out to our house, and that's what really hurt my mum. But I think even that is symptomatic of the fact that I didn't have that relationship with her. […] I mean I'm older and wiser now. I mean if I was getting married again, I wouldn't let that happen […] If Yaz (her daughter, not

> her real name) did that to me I would be devastated. […] Yeah but I'm worried that I'm overly attentive to her, and to him as well, overly … you know because I'm so worried that that would happen". Della

Gabrielle spoke of how she was only able to feel happy about her ability as a mother through her children's approval. She had waited a long time for this affirmation:

> "[…] as soon as my children were old enough they assured me I was not a bad mother!" Gabrielle

Elenor spoke of looking outside of herself generally in order to know how to be a mother. She too described how she saw her children as a direct reflection of her mothering and of Herself. They were therefore the main guiding force in her model for being their mother and the main source of approval:

> I You had no real sense of yourself then?
>
> R "Not really".
>
> I It was governed by whether they were happy?
>
> R "Yeah. Yeah I'd have to go on the kind of things they'd say - feedback I'd get from them. […] Yeah, I'd just be guided by them, really. My kids and other mothers". Elenor

Elenor also spoke of her concern about the potential negative impact that her need for approval could have on her relationship with her children:

> "Oh I just sit and … I just worry … especially with my kids, I worry that I put them off me… I know I do it too much and then I check it out with them and I apologise to them." Elenor

There was a strong consciousness amongst participants that their own needs, particularly for approval or support, had the potential for overburdening their children, as Carmen's experience illustrates:

> "I could easily become immersed in her, but I feel it's not right to use her in that way." Carmen

C.3. Guarding against failure

Although the avoidance of repeating negative patterns of behaviour is largely presented under the theme 'The Mother I fear I will become', some themes in which participants were concerned with actively ensuring particular positive patterns of behaviour are included here under the theme 'The Mother I am' because this reflects what the participants currently do. Della's main concern was to protect the communication in her relationship with her children, in the light of her sadness at the lack of a relationship she experienced with her own mother:

> "I'd like to be able to phone up and say: "Hey Mum.". […] I'd like to, but I wouldn't and I didn't. […] I mean you know the more I thought about them yeah it has, it really makes me worried that I will have that relationship with them. […] Yes, maybe. Or it's made me very aware of keeping the lines of communication open, being there for them." Della

C.3.i Overcompensating

Many participants spoke of ways in which they overcompensated in their parenting in order to guard against overburdening. Participants' primary preoccupation seemed to be to strive to ensure that their children's experiences differed from those of their own childhood. They frequently described overcompensating in their parenting:

> "I am desperate for my daughter and son to have a completely different experience – I praise them constantly and if I hate their clothes or music I hide it so they won't feel criticised. I allow them to have as many friends over as they like and make them feel very welcome." Gabrielle

> **"**I had this thing as a child that I would have to eat the same thing every day of the week. […] Every Wednesday there would be sausages, you know. And even though I said "I don't like sausages" they would still appear on my plate and I would have to eat them. And if I didn't eat them then she would go mad… So, if I'd ask for fish fingers she would have had a bloody breakdown, so you just don't, you eat the sausages. And… I would say to my kids "What do you want for your dinner?" and if one of them said roast dinner and the other one said fish and chips that's what they would have. And my daughter said it was like a café sometimes in my house." Elenor

> "[…] Yeah, and you know I really over-compensate when the children come here. I'm dreadful when the children come here but I have this thing that I want other children to want to come home for tea, and I want them to have a good time […] I want them to look back and see that they've had a lovely childhood." Della

However, not all participants necessarily made automatic connections between their feelings and behaviours as a mother and their own childhood experience. Caroline describes as very much 'conscious' her efforts not to overburden her daughter through role reversal. However, although she acknowledged the possibility that this may relate to her own role reversal with her mother, I felt that this was not overly 'conscious' and not stated overtly:

> "What I was quite conscious of was after my husband died, as I said my eldest daughter was 12 and … I was very conscious that I did not want her to take over my role. I mean she did look after them; I'm not saying she didn't but I didn't want her to be burdened with it." Caroline
>
> I So maybe you were a bit conscious that you were a little bit burdened in that way?
>
> R "Possibly yeah, yeah. I just thought it's not fair, she's far too young to take on that Responsibility" . Caroline

C.3. ii. Doing it for them but not for me

There were also many accounts in which participants spoke of the difference between how they would care for their children and how they would care for themselves. Paula described leaving her first husband, not upon his continually emotionally abusive behaviour towards her but upon the first realisation that he could harm her child:

> "Very obsessive. Obsessive compulsive, extremely so. Everything had to be his way he didn't like me listening to Woman's Hour, so he took the valve out of the radio. I left the baby with him. And he put a pair of speakers either side of my baby's head and turned them as loud as they could go. […] And that was the last straw really. I didn't leave him alone with him again, but I was desperate." Paula

I recalled Paula's recollection of herself locked in a dark cupboard (see Theme A.2) and stating that this was in a way acceptable compared with the beating she would receive when her mother came home because she had wet herself. There was a clear connection here for me and an understanding as to why she could only leave her husband because her child needed her protection but not on account of her own needs.

Carmen, who described herself as panicky around emotional closeness, spoke of how she would completely over-ride these strong aversive feelings in order to be with her daughter (currently aged 5) at the birth of a child she might have in future should she want this. This

suggests that Carmen would change herself in order to meet her daughter's needs but not to support herself:

> "Maybe come to the hospital etc. (if having a baby). I mean it's quite strange how people do that – I am not sure about the delivery – I can't understand that level of closeness but if she said I want you there – I'd be there. […] I would do it for her, but I won't do it for me. I am going to find a different me through motherhood." Carmen

Carmen reflects a common theme above in that she speaks of almost reconstructing herself as a mother to her daughter through her endeavour to be whatever her child might come to need.

C.4. My mother-daughter relationship

The concept of striving was particularly evident in mother-daughter relationships and especially with reference to fearing disconnection and wanting to ensure that the relationship with their daughters, did not reflect their childhood relationship with their own mother. Many participants were fearful of their daughters' potential to reject them. Carmen spoke of how this fear might be causing her to keep her distance in some ways from her daughter.

Carmen also suggests that that her relationship with her daughter relies on her ability to overcome her own childhood:

> "I don't throw myself into her as much as other mothers do. I suppose I think "what do I do if she rejects me?" – also knowing, if I don't sort this out, she will reject me! It's a self-fulfilling prophesy." Carmen

Several themes suggested a preoccupation with maintaining good communication and connection with their children. The need to protect their own mother-daughter relationship was often expressed in the light of the poverty of relationship they knew as daughters themselves in their own childhoods:

> "Mm, yeah. And I really don't want to have this relationship with Yaz (her daughter) that my mum's got now (with me). I want my daughter … I don't know why I want it so much with Yaz but I do … I want her to be able to phone up and tell me things. You know I've had medical problems in the past, and I never told my mum that. Quite major things that she should know about but I didn't tell her …I would hate Yaz to go through a problem and not tell me about it […] We had no relationship, you know - where the relationship

> kind of broke down. I can see that. I mean there's no way I'm going to let that happen with my children." Della

Carmen spoke of her need to adapt her behaviour as a mother to maximise positive communication between herself and her daughter in the light of her fear that she has a predisposition to harm as a mother given her childhood:

> "Taking into account what I might do, I am much more into negotiation as a mother. […].My communication with her is so important – it is." Carmen

Kye, who, on the other hand, did experience a strong connection with her mother in childhood, despite her mother's EMHD, and whose mother was now deceased, spoke of the pain of experiencing disconnection from her daughter even briefly. It is important to note that Kye felt emotionally close but not emotionally held, as she was always aware of her mother's vulnerability and experienced frequent absences from her mother due to her mother's hospitalisation. Her fear of both separation and emotional disconnection are clear in the quote below:

> "I suppose it's that same thing with me and my mum (crying), we were very close in a way and now with my daughter I am very close to her, but every time she goes off and we have had a row, or parted company on a bad way, that leaves me feeling pretty crap until I see her and we sort it out. And then that brings up, it's all about what I had with my mum, because my mum died you know?" Kye

Kye, unlike other participants, shared a warm and attentive relationship with her mother; particularly she described in comparison to her father, whom she described as "evil really". However, she also experienced many absences from her mother. It is easy to imagine the unique factors impacting Kye in terms of disconnection with her daughter. This highlights the importance of also presenting unique accounts in IPA research.

C.4.i My daughter - my 'self'

Many themes reflected the impact of the daughters of participants upon their own self-concept. There was a sense in which participants judged themselves as mothers by their relationship with their daughters and the qualitative difference between their daughters' lives and the lives they had known as daughters of mothers with EMHD. For transparency, it is important to note that all participants were mothers to female children, however, all but one

(Carmen) were mothers also to children of each gender. For Gabrielle, who frequently experienced humiliation in her childhood from her mother, particularly about her appearance, her daughter's ability to enjoy and value herself was reaffirming as a mother:

> "My daughter will tell me she likes herself or she thinks she's pretty and my heart sings – I feel I have been successful." Gabrielle

Elenor spoke of blaming herself and evaluating her self-worth negatively through her daughter's faults or mistakes:

> "I was apologising for something … something she'd done … she said "For God's sake mum, some of these things are me. Not everything I do is down to you." You know "Stop beating yourself up. There is other people in my life." I said, "Mm?" (questioning tone). So I'm kind of … all of their faults I will take on as being my fault." Elenor

It was common amongst participants for there to be a preoccupation with the potential for their daughters to view them negatively:

> "I keep thinking she is punishing me. […] I think she judges me – my daughter – I wonder what she thinks of me. Another person might just see the baby and not feel the pressure. Only a daughter brings this up to a mother." Sarah

For some participants, relationships with their daughters were particularly complex. Paula spoke of the fear she felt at the thought of what her daughter's view might be of her and could evoke in her:

> I don't think she sees me as a bad mother, but I think she sees me as an odd person. Perhaps I'm afraid to look at that […] Afraid to look at why my daughter thinks I am odd." Paula

Paula suggests that what she sees as her daughter's negative view of her concerns her overall character and not just herself as a mother, in the sense that her daughter may see her as strange in her inherent personality. This is very painful for Paula.

The fear of losing connection is featured in the descriptions given by many participants of their behaviour with their children. Many themes suggested participants' anxiety about mother-daughter relationships. Paula's accounts below are an example of the complexity that might exist for a daughter of EMHD in her own mother-daughter relationship. I have

included this for its many relevant strands to all the themes discussed above. Paula's continual efforts to maintain connections in general but specifically with her daughter are evident below. Her self-doubt and insecurity as a mother are notable, as is her tendency to take on blame. Her effort to create positive boundaries for her daughter is clear, though perhaps misread in intention by her daughter due to a number of circumstances. Her sadness at the age of 74 at the lack of closeness currently and the loss of past closeness are poignant and her continued effort to connect, despite rejection, illustrates the importance to her of this mother-daughter connection and her general fear of losing connection. Regardless of the close relationships she has with her sons, Paula clearly longs for a positive mother-daughter relationship.

In the first quote, Paula's description of her second marriage, (a marriage about which she stated "we were never unhappy"), it can be seen that her expectations for herself were low, her overwhelming concern was for her children and she had little ability to speak up for herself. We also see her continuing to work at this relationship after its breakup and despite having been hurt by infidelity and we see the effort she puts into trying to maintain connection:

> "I know he had three or four one night stands. […] I said 'All right, put up with it last time, I suppose I can put up with it this time […] And um … I felt the first thing was the children … I had to think about them. […] Uh … we never rowed because I was just so happy if he wanted to do something I was happy to do it cos he wanted to do it, you know […] When he'd left, I didn't fight with him, I just … I was desperately upset. I begged him not to go. […] And I was trying to work you know with my own depression. I was on my own, three children. […] And when he was having all this trouble with this woman I rang him up and I said "I am concerned."." Paula

As Paula speaks of the sadness she feels about her relationship with her daughter we see very similar behaviours and responses in Paula but as a mother. Paula's default position appears to be one of self-blame. Paula accepts issues of betrayal and keeps trying:

> "[…] … you see we went through a long period of time when he (second husband) was saying I was like my mother. And I think gave her (daughter) that impression, that I wasn't reliable, I was difficult. […] At 17 my daughter went off with her father […] and didn't speak to me for 8 years. […] She had got into university. […] said look go to university and when you've finished then you can move in with him […]. I mean I wasn't keen for her to live with

> somebody at 17. But her father gave her £35,000 to buy a flat with him […] and she was supposed to be coming home […] I thought something awful had happened, and … it was Christmas … and I then discovered […] she's gone down to her father's […] I said "Well why didn't you let me know?" She said: "I can go where I like, I'm 17, I can do what I like." But we are … we were back together again. I don't think the relationship was ever re-made. I've tried my hardest but it doesn't re-make […] Well obviously, there's something that I'm lacking which is not… you know I mean […] She doesn't get something from me. […] I go past the end of her road several times a week to go to my various friends. […], I've called in […] but always feel I'm not really wanted there, you know." Paula

Melanie and Della both touched upon an aspect of the importance to participants of a positive mother-daughter relationship, in that it is a woman-to-woman relationship for these women, whose most fundamental woman-to-woman relationship with their mothers had been fraught, or in some cases actively cruel:

> "She can't wait to have a baby but… if you've got a close relationship with mummy then you're going to want to be mummy aren't you? […] She says: "Oh mummy I'm going to have a baby and you can look after him, we can go shopping together."" Gabrielle

> "I mean it's funny I suppose maybe cos I'm a girl and maybe as a girl I feel different to her as to how strongly I feel about it with my son […] or it's a female thing." Della

Many themes seemed to suggest that participants' own need to maintain connection and communication with their children was a key feature in the effort they put into being a mother.

C.5. Taking it all on

The concept of 'striving' (Theme C1 above) was very much evident in this theme as is the theme of 'overcompensating' (Theme C3i). Being a 'good' mother was often connected by participants with being a 'strong' mother. There was a sense in which participants were striving to be what they saw as the 'perfect' mother. Della who was working and also happily married and did not feel alone in her caring, nevertheless described herself as her children's "primary carer", and equated 'being a strong mother' with seeing to all her children's needs:

> "[…] I'm a strong mother because I'm the one that does everything for them, does their homework with them, puts them to bed, gets them up, washes and

> feeds them. Does everything, advises them, watching out for their teachers… you know making sure." Della

Being strong as a mother was often related to being solely responsible for their children's well-being and outcomes. Elenor spoke of how her daughter had highlighted to her what she felt was her difficulty in maintaining perspective as a mother regarding what she could reasonably expect of herself:

> "[…] And she's right, it isn't all down to me is it? But I do, I take ownership of everything. Just everything, it's all down to me. […] To the point where it was silly. […] if they lost … mobile phone I just buy another … you know? You're never going to learn if someone fixes everything …you know I get another one out of the cupboard, you know?" Elenor

There was a strong theme of rescuing running through the dialogue in general. Melanie's instinctive response when asked to describe herself as a mother was:

> "A saviour […] it's like my children cannot be upset about anything, they cannot be hurt about anything." Melanie

For some women 'being all things' to their child represented ensuring that their children knew that they were strong mothers. Kye also spoke of feeling totally and solely responsible. For transparency, Kye is a single parent, but with her children's father active in theirs and her life. However, her sense is of her sole responsibility in that if she is not strong, her children's' lives will suffer, because no-one else would take over, yet her self-doubt is evident as she speaks. Her anxiety about maintaining her mental health is also intimated below:

> "Not a very good job of it (mothering) either. […] I guess that's why I'm always pressuring myself to be strong because if I'm not strong everything will fall apart, that's what I think because my children to some degree do dictate in this house and it's hard for me to get them to see, well you know I'm here and I'm sane and I'm not going to break." Kye

Kye also highlights a common theme concerning the fear for participants that their children would view them as weak or mentally unstable and as will be seen further into this theme, many participants equated depression with weakness. Being strong, therefore equated with 'not being mentally ill', as Kye describes above.

C.6. The mother I fear I could become

It is poignant that participants spoke much less about the mother they felt themselves to be currently and much more about the mother they were striving to be or striving not to be. In striving to be a certain kind of mother and striving not to be a certain kind of mother, participants appeared to be endeavouring to cover all aspects of representing being a mother who was opposite to their own. It seemed that much of their mothering was constructed via the avoidance of a model of mothering they had known and which they feared repeating. Elenor's account suggests an impulsive and perhaps compulsive process which she experienced as unnatural:

> "You know I didn't want any repetition at all of my childhood … anything that could be compared […] and at times it didn't feel natural, because it was like I was kicking against something. It wasn't something conscious … it wasn't a thought out thing but I made a conscious effort not to be the way she'd been." Elenor

For most participants, this research constituted the first time that they had ever shared in any depth with anyone the details of the childhood that underpinned their fears as a mother. Therefore, to illustrate this, some of the current thoughts and feelings of participants about their mothers' illness and how this relates to them today as a mother are included here.

C.6.i Avoiding mental illness (cross theme – B.2. Fear of harming; B.2.i. Self-protection and selfishness; B.2.ii. Fear of becoming 'her'.

In striving not to be like the mother they knew, all participants expressed being determined as mothers to be the opposite of their own mothers and integral to this was their determination to avoid mental illness. Specifically, their focus was to avoid depression, perhaps in the belief that their mothers' unhappiness had caused their behaviour towards them, or in a way that had affected their lives negatively as children. There was a sense in which these women felt a pressure to be happy.

> "But I just won't do it (say I can't cope). I really … I try to be an optimist got one life, every second counts. You know I will not sit and dwell and you know worry about it." Della

Many women spoke of contradictory thoughts in connection with their feelings about their mothers and about depression. For example, although participants often saw their mother's EMHD as a weakness at some level, they also struggled with the dissonance of two opposing thoughts that their mothers were either *weak* and therefore responsible, or *ill* and therefore, not responsible for the negative aspects of the mothering they experienced.

This was often applied both to their childhood experience of their mothers and currently. Della spoke of her determination to avoid depression, which mostly she related to her mother's inadequacy, and which she did not want to repeat, as she explains:

> "I'd be absolutely … I'd be more distraught myself. I know depression is an illness, and it's something you can't help and if you get it you get it, and it happens … something can happen in life that can bring it on … but I think I'd be distraught. Because I see it as … I do see it as weak … even though I know and I know it's not right, because I do know and I say you know my mum's very ill, you know, and I do know it's an illness I still see it as weak." Della

In Della's narrative, there is a contradiction in terms with the idea of being 'distraught' at the realization of being affected by depression or in other words 'sad' at the idea of being 'sad'. This may reflect an aspect of the internal conflict that being determined to be the opposite of their mother presents. Elenor presents several conflicting emotions below in which she struggles with her thoughts and feelings about her view of her own mother from the perspective of being a mother herself, and also her view of herself:

> "Um, to me in particular she was … sometimes she was cruel, she was never loving. She was very distant, cruel and aggressive as well. But now I know now she did the best she could […] "But I do feel … I do feel bad that I preferred my Dad to my Mum now I am a mum." […] I worried that I'd turn into her but I never thought of it as an illness." Elenor

As Elenor continues to describe below, participants frequently connected being depressed with being 'self-absorbed'. There were many accounts of how women felt that their relationship with their mother in childhood and currently was all about her":

> "I mean she just didn't have any idea of what it was like (in childhood). You know what I mean? And it was all about her… All about her. And that's one thing that infuriates me. I mean she still does it now, […] my daughter's getting married in August and my mother's not well (not serious). So where are we now … April? And she's already emailed me to say "I don't think I'll

> be able to see the wedding cos I've got this virus…" […] She's got no perception of how that must feel for my daughter. You know her eldest granddaughter getting married, first marriage. And that's the way it was, you know. And when I told my daughter she was quite hurt. And I just dismiss it, cos it's always been like that." Elenor

Most felt that their mothers' EMHD caused them to continue to be self-absorbed in their adult lives, and they described many ways in which this still affected them and also their children:

> "She can only think about herself and that is the route of my mum's problems. Yes, because she cannot see anyone or anything that goes on around her. […] I have so given up there, that is the thing to do, when you've got a mum like that I tell you what advice I would give as a counsellor – give up. Don't have any expectations of her, because while you've got expectations you will be upset and hurt, when you've got no expectations, if you expect nothing from anybody their power over you is gone, so that's how I treat her." Melanie

> "I don't feel she shows any interest in anything that I do … or anything the children do either […] And when she comes here I always feel that she comes here for a break from my grandmother to get away […]." Della

> "I mean I'll give you an example. I had a small lump removed from my breast and a couple of weeks later I went […]to get the results. And it was benign fortunately. And I phoned my sister … and I said will you phone mum and tell her everything's okay. So she phoned mum she said "Oh Caroline has just phoned, she's okay, the lump's not … it's not cancer". Mum went "Oh that's good, do you know what I had for dinner?" Caroline

C. 6.ii. Depression and identity

In the light of the narratives which connected depression with weakness, it is easy to imagine how these women might be compelled to be 'strong' mothers; which was also represented in the dialogues. In view of the fact that depression was considered by many participants as a weakness, in avoiding depression participants seemed to be trying to preserve a positive identity for themselves as mothers by endeavouring to prevent themselves from developing the 'self-preoccupation' that many shared that they had experienced in their own mothers. Many women believed that they avoided depression as a way of coping and even perhaps compensating through their own mothering experience for the effects of their childhood experience with their mothers' EMHD. This also maximised their current propensity towards happiness. This avoidance of depression also emerged as a way of coping with their feelings

about their memories of childhood with their own mothers and their lack of, or loss of a positive relationship with her. This was a way of seeing themselves in a positive light as a mother themselves in comparison with their experience of their own mothers:

> "I received a certain type of mothering from the person she is and received the … "I can't cope" and "I can't do this" and … "This has happened and therefore my life's like that", you know I won't do that. And I don't know whether … I possibly won't do that because that's what I watched her doing. But I just won't do it." Della

Participants often spoke of checking their own mental wellbeing. This seemed also to be rooted in their fear and preoccupation that they might begin to behave towards their children in the way that their own mothers had behaved with them. Some participants spoke of enlisting the help of others to ensure their sanity:

> "I often worry about becoming my mother and have to do a lot of sanity checks. […] If I am starting to get a bit paranoid about something I have to ask my husband to help me calm down. […] If I start to get a bit emotional for no reason at all I have to spend some time analysing it and ensuring that it is normal mood swings and not manic depression (her mother's EMHD)." Gabrielle

C.6.iii. Avoiding all aspects of my mother

For some participants, even simple behavioural aspects of everyday life that reflected their concept of their mothers' illness, but which would not necessarily indicate the adversity in childhood in themselves, were avoided if these had previously been witnessed in their mothers, as Caroline explains:

> […] And I think she found it very difficult to get herself up and going in the morning. And quite often at the weekend she'd be cooking the Sunday dinner in her dressing gown. And this … I cannot … even if I am dying, I get up and I get dressed. Now whether that's a reaction to mum or not I don't know, but I can never … I can't bear not being dressed, you know. The less like her I was, the better." Caroline

There was a sense, as the quote above suggests, that in striving not to be like their own mothers that a great deal of pressure was put upon them by themselves. The above extract

suggests that Caroline would not let herself stay in her dressing gown even if she were ill, simply because this would remind her of her mother, showing that there was an almost phobic quality to her efforts not to be even reminded of her mother. The following extract from Elenor is an example of how the determination not to behave like their mothers was so strong that this manifested as superstitious and almost phobic in nature:

> "Now I am totally the opposite …totally bizarre… to the extent that if me mum kept the porridge on the top shelf, I'd keep it on the bottom!" Elenor

Again it can be seen that so strong was the determination *not* to be like their own mothers that participants were often striving *not to* do what their mothers did in any form, even when this was irrational.

In the extract below, Della explains a common theme in her strong desire for her children to have a completely different childhood experience to her own, even in the aspect of their memories. There was a sense in which she was very much conscious, that in the light of her own experiences, that she was 'mothering for today and mothering for tomorrow', in order to maximise the possibility that she and 'childhood' would be remembered positively by her children in their future. Again, I could feel the concept of 'striving' in Della's approach to herself and her mothering:

> "I want them to have a totally different recollection of their childhood […] I want them to look back and see that they've had a lovely childhood, their friends come over and they want their friends over, and nice things to eat and nice memory of having nice times, and normality, just normality … and be normal, look back, you know […] I always feel I don't want to be like my mum." Della

Therefore, featuring strongly in the image of the mother they believed themselves to be today were participants' accounts of the type of mother they did not want to be and the kind of mother they feared they could become. All participants spoke of striving to be very different from their own mothers and most participants spoke of wanting to express a mother who was diametrically opposed to the mother they had experienced. For many, their biggest fear was that their mothers may lie dormant within them and might one day emerge unexpectedly and affect their children negatively. This was best described by Eleanor, as also quoted in Theme B2 ii, as she explores 'what if':

> "[…] some kind of hormone would kick in that turns you into that monster. You know what are you going to do? What am I going to do if that happened to me? […] was terrified that it would creep up on me and I wouldn't know." Elenor

For many women, this fear continuously affected their confidence as a mother because anything they did that was positive could suddenly be overridden or undone by the 'bad mother' lying in wait inside them. This is echoed across the relevant cross Theme C.2.iii 'Waiting to fail'.

Some participants quoted specific aspects of their mothers' character, which they felt corresponded directly to their mothers' EMHD. For example, Caroline described her mother's agoraphobia/OCD (Obsessive Compulsive Disorder) as resulting in her being controlling of others in order to create circumstances that her own anxiety could cope with, which often meant that she persistently interfered with what others were doing. This Caroline felt had made her interfering and selfish, which Caroline strove to avoid. The extract below describes well Caroline's effort to avoid repeating as a mother herself, what she experienced with her mother. In this sense, she was avoiding a mother she feared she could become.

> "As I said, this is why I feel that she was basically selfish, though I didn't realise that until quite late on. […] No, certainly didn't, no. Didn't want to interfere. But I am very conscious of the fact that I don't interfere. […]. And I think I have physically made the decision not to interfere. I mean with my eldest daughter and her husband, they don't want to have children, and I have never ever made any comment … I've always said "It's up to you, it's your own decision." … my daughter has actually said she appreciates … they both appreciate the fact that I have not commented, just accepted. I have physically made the decision not to interfere." Caroline

Caroline's language best describes the intentions and effort of many participants to construct a maternal identity as much opposed to their experiences of their own mothers as possible. The above quote from Caroline suggests a process of active identity construction in response to her experience of motherhood as an event and to the subsequent revisiting of childhood, as Caroline describes looking back at her childhood and deciding how to behave as a mother. In linguistic terms below, the use of the word "conscious" suggests a deliberate and thought out action and the use of the word "physically" suggests effort or 'striving', as Caroline still determines how to behave, even as a grandmother, in response to her childhood experience.

Caroline reflected that her mother's behaviour often created a role reversal (as was described in Theme C.6.i). Role reversal occurred for Caroline not least because she did all her mother's errands but also because her mother was the person in their relationship who needed carrying and supporting, and Caroline was often the carer rather than the child. Caroline strove to avoid this as is represented in the quote below. All participants spoke of the effort they put in to destroy (what they saw as) the tendencies of their own mothers in themselves as mothers. The language used in Caroline's quote below is an example of this effort or striving:

> "[…] when I was thinking about you coming, the two main things I thought about was, 1) I was determined my children were not going to be housebound, and 2) … and I was going to give them the opportunity […] I gave them all the opportunities I could. And the other that I was going to make a conscious effort not to give my daughter too much responsibility for the younger children when I was on my own. Though like I said I can't honestly say that I succeeded 100% with that. But I think I was conscious of it, this is the point, I was conscious of it. And that's about it." Caroline

Caroline describes herself as *determined* and *conscious* and *therefore* she is hard working, deliberate and aware in her processing of the decisions she wishes to make with regard to her behaviour as a mother. Hence her maternal identity seems constructed as a response to her childhood experience, but triggered by her own experience of being a mother herself and continually reconstructed in opposition to her experience of the way that she experienced being mothered.

This identity construction in turn reflects participants' 'striving' not to be the mother they don't want to be and how any part of themselves which seemed to reflect their mothers' identity are actively rejected. Kye reflected this theme again most strongly in the following quote in which she assesses her 'real self' to be like her mother and therefore she rejects her 'real' self:

> "Well sometimes I don't like it being the real me, it reminds me of my mum." Kye

C7. Some consequences of striving

In many themes, striving to be and striving not to be as concepts appeared to suggest an insecurity in identity, as participants' endeavour was not only to be the kind of mother to

their children which they felt to be desirable, but equally their striving was to not be the kind of mother that they felt that their own mother had been. Many participants viewed their positive traits as mothers as perhaps somehow temporary, or as not fixed in their personality, in the sense that, as described in Theme B2 ii, there may be a 'bad mother inside them' who would one day harm her children.

C.7.i. Avoidance and overload

In their effort to be a mother who was opposite to their own, many women as has been illustrated above, expressed overload and often a lack of joy in their experience of being a mother. For some women, so great was their fear that a 'bad' mother lay within, that this led to some avoidance of their role as mother, for fear of bringing harm. Carmen, for example, spoke of the great efforts she went to in order to employ every help she could to enable her to give the best of herself to her daughter in the time that she had available to her. She spoke of how she hoped that others would make up for what she saw as her own shortfalls and weaknesses. This meant that she worked literally to employ others (child minders, cleaners, gardeners) and spent less time with her daughter than she might do but felt safer about her daughter's care than if she herself were to undertake any more than she did. This, in itself, presented as overload. However, she reflected on the greater overload there might have been if she was unable to provide this. This was very frightening for Carmen.

Carmen's motivation was shared amongst participants; in that she was striving to be a mother that was opposite to the mother she had known and her maternal identity seemed to be constructed to avoid becoming the mother she feared she might become. However, the consequence for Carmen was that she feared that she might be distancing herself too much from her child. In other words, she feared that she might be going too far the other way and was becoming removed due to under involvement. Carmen did not describe having experienced the need for connection owned by many of the other participants but in a sense her maternal identity was also constructed around not being good enough. In fact, in her effort to avoid being the mother she feared she might become – the aggressive, invasive, unyielding and stressed mother she described - she feared that she might be creating another mother she feared she might become, which was a mother that was too removed as she explains below:

> "Sometimes I think …am I avoiding her, but then I think no…no I am not, I love her. I would never, never harm her […], but I can't get stressed – I mustn't get stressed. I am an older parent and she's got to survive without me. Her needs come first and she's got to have the best and I might not be the best for everything. I have got that in me to bully…I really have and I can control it if I don't get stressed…and I have got to for her." Carmen

Financial and occupational factors necessarily come into the picture here. However, it was also less usual among participants to put effort into avoiding stress, but rather participants were often overloaded themselves by trying too hard to be all things to their children and described being worn down by stress.

> "Yeah. Yeah I mean I know the other day. Like… moving my daughter. I was absolutely dead on my feet and still trying to put things away, and my eldest daughter, when my other daughter asked me something and she just turned to her and said "Look you know she'd sleep in the hall standing up if you ask her, so leave her alone." Elenor

In addition, such was their fear of being a destructive mother that their efforts seemed justified to them. As Elenor explains below, she would have done anything to avoid becoming the mother she feared:

> "I made a conscious decision not to do things simply because she'd done it. I mean I didn't want three children because I felt … in my mind then I thought that was the problem, it was that number. You know I didn't want any repetition at all of my childhood … anything that could be compared. So … and the fact that I had three children you know … why did that happen? … but then I could equate that because I had two girls and a boy and not the same order that me and my brothers were. So that was okay, that was all right then. Otherwise I would have done anything to change it." Elenor

C.7.ii. Lack of enjoyment

> "I try to keep her life as stress-free as possible and I suppose that I have not enjoyed her as much as I want to." Carmen

> "I had to try, I really had to try. […] So it was hard work, and I didn't enjoy it And it took me a long while to enjoy it. […] I don't think I enjoyed it … I don't know maybe […] It took over my life." Elenor

C.7.iii. Suicidal ideation

So vital was it for these women to overcome their childhoods in their mothering, that some described desperation at the idea of not achieving this. At its worst this was expressed as suicidal ideation.

> "In a sense that happened for me but it was because I was wanting to give up then and for me I can remember it being a point where I thought "I'll let it take me over", it was almost like I think I'm going to lose my mind and I just don't care now, let it happen because I want to die anyway, I don't want to be responsible for all this crap that I'm producing in my life.". Kye

I was struck by what I felt was the terror underneath their assessments of themselves: terror of not coping in life and in the context of this research, not coping as a mother.

4.5 Theme D – Making sense of my journey – contextualising the impact of having a mother with EMHD

D.1 Realisation of the impact (cross theme- A.1 No-one explained)

D.1.i Anger

D.2 Impact on my relationships – (cross themes - C.2.v Self-doubt and C.2.vi. Needing approval)

D.2.i Parallel lives

D.2.ii Being the me that others see, the complexity of friendships

D.2.iii Confidence in relationships

D.2.iv My adult relationship with my mother

a) Conflicting emotions and dual roles

b) Still fearing her

c) Mothering my mother

a) Role Reversal

D.3 Looking back on my motherhood journey

D.3.i Assuming difference – (cross theme - A.5 Social Comparison - Feeling different)

D.3.ii Distinguishing me from normal – (cross theme - A.2 My perceptions of normality as a child)

D.4 What I have learnt

D.4.i I don't know how I did it

D.4.ii Low expectations

D.5 Regrets

D.6 Healing

D.6.i Healing through motherhood

D.6.ii The Value of interview

D.7 Thanking my children

Theme D '**Making sense of my journey'** describes women's reflections about their experiences both as children and adults and the meanings they made. All participants spoke of re-evaluating their childhood through becoming a mother and also re-evaluating in retrospect their experiences as a mother. This involved them looking back upon themselves as mothers and also their analysis of the impact of their childhood upon this experience. In this layered analysis, there will necessarily be some overlap between the mother they see themselves to be today in Theme C (in which their experiences are described) and their perspectives of themselves in hindsight as mothers. There will also inevitably be some overlap in how they saw themselves as individuals and as mothers. It seemed artificial for the most part to sever these aspects of the participants' dialogue too much in the interest of my research question but I have endeavoured to strike a balance here.

As part of making sense of their journey, accounts of participants' current relationships with their own mothers emerged. Theme D, therefore, presents a broader overview which reflects the women's views of the impact of their childhood upon their experience of motherhood, and how they make sense of who they are today. As will be seen in discussion of the impact of the interview for this research, for some participants, the impact of their childhood with their own mothers and their view of its effect upon themselves as mothers was significantly realised during this interview process as they reflected on the emotional experiences they described to me. Participants' understandings of themselves in their close relationships are explored below to give context to their experiences as individuals who are mothers. The focus is their experience of being a mother, as the individuals and women that they are, and not an evaluation of their 'mothering', or their mothers' 'mothering'.

D.1 Realisation of the impact (cross theme – A1 No-one explained)

This theme concerned participants' experiences of having denied or buried their feelings about their childhood and the negative impact of their mothers' illness and of a time when, as mother themselves, they could no longer do this.

D.1.i Anger

Many themes expressed anger and some expressed this as rage and/or highly charged emotion.

> "I think that was the final straw, that was just I can't forgive her. […] Anger. Totally angry, absolute anger. Complete rage. […] it was I hate her and stuff like that. […] So you had these sort of conversations with yourself. But that's the way it was, you know, that's the way it was, and I ain't going to change it. […] I think all the time I was ignoring it or forgetting it and never thinking about it. It got to the stage you know I couldn't keep it in. I just exploded!" Elenor

For some participants, their emotions became heightened when they finally told someone else; which was often their partner.

> "The thing is you tell your husband and he's like "Oh My God!" and you think "Oh no!" Melanie

> "He (my husband) said: "I can't believe you never told me". I mean I just went into a complete breakdown. A complete breakdown. It had to come out. I suppose you know I'd never spoke about it. Very careful to keep her away from my kids - never babysat them." Elenor

For others, realisation of the impact of their childhood came to them through a particularly upsetting memory of their mothers' specific treatment of them or an event. In the quotes below, Della speaks of how she felt that her mother just left her to cope from her early teens and Caroline speaks of a traumatic event through which her realisation that her mother had never supported her occurred:

> "[…] first she was just mummy, she was my mummy when I was younger. […] you know I can't think of anything that comes to mind at all. […] But then I do blame her, because she is the one who let me go, she let me do all these things and I look back now and think I did some quite hard things on my own without her support. It's horrible isn't it?" Della

Caroline, whose children were grown up and whose mother was deceased, spoke of how she was very uncomfortable with holding onto any anger towards her mother:

> ” I mean I’ve got her pictures all over, you know I still look at her pictures […] I don’t sort of brood over it. That’s all well over and done, and there’s nothing you can do about it.” Caroline

However, she spoke of the distress that she still experiences at the memory of her mother’s failure (due to her agoraphobia) to come to her at a time of extreme need, when as a mother herself of three young children, she found her husband dead at their home:

> “I don’t think I thought at the time, “Oh this is mum doing it again”, cos obviously at that time you’re not thinking straight anyway. […] And the other thing which I think I won’t ever forgive her for is the day that my husband died. I found him at 5 o’clock in the morning and mum and dad turned up at 1 o’clock. And that is something I cannot forgive. I was left on my own with three children. And if it hadn’t been for our local vicar I don’t know what I would have done. Probably found three of us in the river! […] And that is just unbelievable. That is the first example I ever had of that side of her […] that was when I really needed her most.” Caroline

Some women spoke of how they felt that their anger towards their mother would not subside until their mothers’ death. This illustrates not only the strength of feeling that participants retained but also the continuing effect upon their lives:

> “Cos I mean now I’m thinking all the time about my mother. I mean there’s times when I wish she’d just drop down dead you know. Just stuff like that. And if I hear of someone that died … big train crashes […] that’s what I thought about my Mum, and that’s what’d be going on in my head.” Elenor

> “And you know, it sounds evil, but my mum has got a skin cancer scare at the moment and my husband said “Are you really upset about that?” and I said: “No” and he said “Well what if she dies, how will you feel?” and do you know I said: ‘If she dies I am just going to think thank God, it’s over, it’s over, it’s over.”” Melanie

In general, many women described the ongoing influence of their childhood upon their lives and saw themselves as living with the aftermath of their childhood:

> I’m still struggling to move forward with my life and to try and I keep saying in some way, it feels like you’re trying to hold it together and not lose it and because I am well aware that ‘that’ (my mother’s mental illness) was a focal point in my life. […] I am feeling quite emotional at the moment anyway but

> erm (pause) at this stage I'm just (pause) because I'm doing counselling and it's something I've been building up for years […] I am familiar with hurt and pain and fear and heartache and all those things sort of club together so, yeah it feels like an irony to be starting work in that area and your own life still feels like a mess […] even today it feels like "God can I keep things together?"" Kye

The enormity of the impact as described by these women's responses constitutes in itself a rationale for the current study.

D.2 The impact on my relationships (cross theme – C.2.v Self-doubt and mistrust; C.2.vi Needing approval)

Many participants described the impact that their childhood had upon them in terms of their adult relationships and their own relating, both to themselves and others. This is presented as essentially descriptive and offers important context for how participants made sense of their experiences as mothers.

D.2.i. Parallel lives

Generally, participants seemed to feel that they could not talk to others about their childhoods. They often spoke as if they were used to 'leading a double life', in the sense that they felt that they were portraying the image of themselves that they felt others wanted to see. There was a sense in which they were carrying their past around but with current impact; a past which they often hid from others, or made more palatable to preserve their relationships.

Participants often spoke of having been used to denying their childhood experiences and/or its impact. Both Elenor and Melanie described as adults a time in their lives when they had tried to completely separate themselves from their childhood. This involved strong denial of their childhood experience with their own mothers.

Elenor spoke of how as a young woman and as mother, for a long time she had pretended that her childhood did not exist:

> "And I hadn't told anyone. I didn't tell my husband till two years ago (pause) three years ago! […] I think the thing is that I always felt like I had two lives going on. I had this one that everyone saw but then I had this dark secret that nobody knew about, nobody realised and I was pretending that the two … that

> I wasn't that person and that I was someone else. But I'd never spoken about anything like that at all .... ever. Really, really strange you know. It's like you started your life, as a friend's said you are, you know - at 16 when I left home.*"* Elenor

> "All my school friends, I used to think they were silly and stupid, I used to go through the motions of playing […] I'd get into lots of fights; I was very naughty in school. In fact, my life is really two roles, there's before marriage and after marriage. […] And you know before marriage I could never sleep and now I sleep for England." Melanie

Often women spoke of their hidden pain, as Kye and Melanie describe:

> "You know I'll go out on the street and people wouldn't necessarily see what I was like on the inside." Kye

> "Yes (pause) well, I on the outside am happy." Melanie

D.2.ii Being the 'me' that others see; the complexity of friendships

Friendships were highly valued by participants. However, although friendship was often seen as vital, many women saw friendship as difficult to maintain. Some felt that issues in their own lives would be too complex for relationships, especially friendships. For others, there was an element of not being able to be what participants felt that other people needed them to be in a friendship and therefore, some participants behaved with friends according to what they felt was expected of them. Sarah, who continued to be both a mother and her mother's live-in carer, described how friendship had always been complex for her:

> "It's hard to keep up with friends. It's hard to talk about the stuff I do. I don't have the energy to explain really. […] Wouldn't want to bother them really. I have friends but my life is full and just (pause) can't predict it really. When Mum's bad, I have to drop everything else." Sarah

Many participants were fearful in their relationships. Carmen spoke of her fear of closeness and its impact upon friendships and relationships generally:

> I mean a lot of my relationships are fleeting and quite (pause) – it's about safety. It's not even a conscious thing. I can just look back on it." Carmen

Carmen's description above suggests an almost unconscious quality to her avoidance of emotional closeness.

In general participants felt afraid to disclose too much about their childhoods, for fear that it might affect their friendships negatively. This seemed also to be connected to a feeling that others would not understand their lives, both current and past, but also their own desire to separate themselves from their past, as Melanie explains:

> "Well, to be honest I rarely talk about her (my mother) because to be honest friends don't really want to know. I mean even good friends, because usually, they have had good childhoods and I seem a happy person who is coping well and they don't really want to know any different. It's not that they don't care, it's just that they don't know what to say. They can't understand how you could have that childhood and be ok and I think it scares them a bit. Maybe it doesn't make sense that I could be normal. They want me to be normal and I guess I do really." Melanie

Carmen and Elenor highlight the need for this research, in that they describe how, as daughters of maternal mental illness, they feel unheard or not believed:

> "I find that people are bored by it (pause) I think lots of people just don't believe you (pause) they think how awful to be mentally ill but they just don't see the other side and how truly awful that can be." Carmen

Elenor spoke of how she still fears being disbelieved in her adult life; which echoes her childhood experiences with her mother:

> "Yeah. So you know … but that still happens, that still happens. Scary but I am still scared no-one will (pause) they don't believe me; you know? Making all this up. My mum always used to say that I made the story up. But I never ever related my childhood to the childhood she told me I had." Elenor

In behaving in the ways that made others in their lives feel more comfortable, participants recognised that they continued to live the parallel lives of childhood with their mother and in their early adjustment to moving away from home, and as Melanie acknowledges, this could be both facilitative in their lives and sometimes a source of irritation:

> I'm quite thrown actually because people look at me and my friends, they (pause) and it annoys me actually, if ever I talk about childhood or anything like that, they have no idea, they think "Melanie, she's strong, she's athletic, she's successful, she's happy, she's sociable, she's funny [...] and cheeky" […] That's how my friends would describe me and if I said something about having a bad childhood, they'd probably just think…they just can't imagine it." Melanie

Leading a double life meant having a different internal life to the one those around them routinely knew of them. This parallel existence was also reminiscent of life as a child, as described throughout Theme A.1, in which no-one explained the many surreal situations which occurred.

Despite the fact that most women stated that they did not want to burden friendships or spoil them by sharing too much of the truth about their childhood, most spoke passionately of the value of friendship for them.

> "[…] I've several friends, friends are very important to me because of my family situation, friends are my self-development (?) and I cherish my friends, love my friends, I might go up and give them a cuddle. You know at the school gates the other day I saw one of my friends and I went up said "Oh I'm so glad I saw you today" and gave her a cuddle and she said "Oh isn't that nice!" But I really appreciate friends. I would do anything for my friends. They are my family." Melanie

Kye spoke of the value of friendship and also her desire to protect her friendships and to not overburden others in the light of her own experiences with her mother:

> "And my friends are important to me. […] I think one of the things I have noticed and I connect this to my mum, I believe it is connected, when someone has a mental health problem, a depressive nature can be very demanding […] I know that being depressive you can be self-absorbed and not much good to other people so there's an element of trying to keep balance with that. But I do have some good strong friendships now and I'm well aware that when I'm in that friendship I don't want it all to be about me. I want there to be some balance of this is both of us and we've equally got something to give and take from this." Kye

One could only imagine how difficult it must have been for these women to share aspects of their lives – their childhood in particular - with others. This made them fearful of judgement, even in friendship.

D.2.iii Confidence in relationships

Many themes reflected that participants struggled regarding their confidence, particularly in their relationships. Several theme clusters connected women's concerns about how others viewed them. In Theme C, it was clear that participants agonised about how their daughters

viewed them as mothers. Some participants spoke of finding it hard to relate to any positive image of themselves that others described:

> "Friends see me as fun, creative, loving, […] but I still struggle with how people perceive me." Gabrielle

Participants' own self-criticism seemed to make it difficult for them to accept compliments.

> "I don't talk that much to people. I never feel that important. I do feel that I am insignificant at times. I will put myself down before anyone else does." Sarah

> "I did not have that kind of confidence you know? I always looked to other people." Paula

Paula, Sarah and Carmen speak more specifically about the belief that they lacked the appropriate skills to relate well or sufficient easily:

> "I think sometimes I think I don't communicate well at all (inaudible) […]. I think: "Do other people think that I'm not truthful?"" Paula

> "Maybe I judge people too quickly and I think they won't listen. I am my own worst enemy. I just feel why would they be interested in me anyway? I just watch. I am very self-conscious." Sarah

> "I'm not very good with friendships. I lack the skills for long-term maintenance." Carmen

Many women described how they had always found it difficult to ask for their own needs to be met and were afraid of burdening others in any way. Some spoke of not wanting to 'bother' or 'bore' others, as Caroline and Sarah explain:

> "I won't … yeah I will not bore them. No, I'm very conscious … I'm a very good listener. I will listen, […] I wouldn't sort of walk up and start talking." Caroline

> "Not used to thinking about my needs – not sure really (laughs nervously), Somehow I don't try to express them – people switch off – or maybe it's just me – I think they will. Maybe I don't try hard enough. I don't really feel valued. […] But no-one ever asks. I would discuss it – I would, but no–one asks. […] feel I am a bad person if I am selfish and it would be selfish just to make sure I was ok." Sarah

Accounts suggest that there was little space for these women in their own childhoods with which to consider themselves uniquely, or to ask to be considered and that this persists into their adult lives.

D.2.iv My adult relationship with my mother

In exploring participants' current relationships with their mothers, an enmeshment of themes emerged which reflected both the long-term consequences of their mothers' EMHD for their relationship with their own mother and also their own adult lives as mothers. This was a particularly difficult theme for me to reflect upon and to bracket in terms of my own experiences. My sense was that my difficulty also reflected that participants found the boundaries represented in this theme complex for them in their lives as adults and mothers. Through several versions of the analysis, I omitted and included this theme alternately, however, ultimately I felt that this was highly relevant to the participants' experiences as mothers.

Many themes reflected the conflicting emotions of participants as well as the continued feelings of fear and protectiveness that they felt towards their mothers, or the memory of her.

Conflicting emotions and dual roles

Many themes concerned conflicting emotions or dual roles, some of which are included here for context. It proved complex at times to separate aspects of conflicting emotions from those themes which were more about dual roles, for all participants from certain viewpoints, but especially for those participants whose mothers were living with them. For all participants, the impact of their mothers remained active.

There were many themes in Caroline's accounts below which reflected her discomfort at seeming critical of her deceased mother. Although this would be common to many when speaking of someone who is no longer living, Caroline's words describe her conflicting emotions towards her relationship with and the memory of her mother, that reflect the impact of her mother's mental health. In particular, Caroline struggles with distinguishing feelings of love and feelings of duty towards her mother:

> "[…] but then I must have loved her, I mean I broke down at the funeral. I must have loved her, I cried at her funeral […] if you say well she's my mother … does it sound it's only duty or … I don't know. But no I mean we certainly weren't as grief-stricken (as with my father) with that it was such a relief because we knew she wasn't happy and she was making us unhappy." Caroline

Kye, remembered with fondness some closeness with her mother:

> "She was loving, I felt that I had much more of a relationship with her than I ever did with my dad." Kye

However, she held some more conflicting memories of her mother "losing her rag and giving us hidings" and of her mother's inability to support her:

> "She wasn't someone I could lean on. Well, I say she wasn't someone I could lean on but at times she was but she wasn't always able to support me." Kye

There was a sense in which participants felt a continued sense of their powerlessness in their relationship with their mothers, in that to complain felt futile:

> "It's very difficult to know who to kind of blame […] I feel stops you saying all sorts of things that you would do […] because you know she's ill, or she's had these … she's been somebody vulnerable in your life […] I mean she was ill at the time, and that's what I mean about her being … she can be this completely fragile person that can't lose anything without breaking down to tears (pause) or she can also be this real nasty person … you know." Della

> "What's the point, what would be the point? Confront her about what? She can't help it and I would never, ever tell her the full story of what she is like when it's bad. She doesn't wash, oh all sorts of things." Sarah

For most participants, there was continued impact from their mother's criticism or judgement of them:

> "When I get ready to go out on a Saturday night and she says "let me look at you" I still feel physically sick and it brings it all flooding back." Gabrielle

> "I really agonise over […] what she thinks of me, you know, I don't even think my mother really likes me (crying)." Della

It is easy to see how these accounts might resonate with participants more general experiences in relationships, including as a mother:

Still fearing her

As Carmen suggests, there was a continued conflict for many participants, who having grown used to their ability to accommodate keeping certain aspects of their characters hidden in certain situations, still feared or could be affected by their mothers' negative behaviour towards them:

> "What I might do is shut the windows. […] It's hard to know what it is – how it feels (carries on shutting everything and whispering) – I don't know if it is betrayal. Me and my sisters talk about it a lot – an awful lot. When we were kids, we never talked about it. I will talk about it to my older sister and to my younger sister – they won't talk about it together – whenever we meet. As kids we never did. I don't know if it's betrayal – it's probably fear of her reaction. Even though she's a 70-year-old woman! (nervous laughter). She was fucking terrifying!" Carmen

As can be seen above for Carmen, conflict concerning what constituted remaining fear or confusion stemming from childhood and what reflected empathy or feelings of protection towards their mothers:

> "Mm. I spend my whole life being terrified of her. Terrified I was going to be her. And it's only now, you know, the past three or four years, that I can actually feel some sympathy for her. I do feel sorry for her. […] goes through my mind all the time, and I feel bad towards my mother, now I am a mother - my mother all the time. Lots and lots … still now." Elenor.

Mothering my mother

Being afraid of and fearing the response of their mothers were common theme clusters, which were often also connected with strong empathy or perhaps feelings of responsibility for their mothers, which are expressed in some detail through extracts from Della:

> "[…] No I think that (fearing criticism) probably comes back to my mother too […] she doesn't know what I do with my life, […] But I do think also that comes from the fact that I don't tell her about me […] I do blame her, because she is the one who let me go, she let me do all these things and I look back now and think I did some quite hard things on my own without her support." Della

Some participants expressed empathy that had developed over time towards their mothers and many spoke as if they were mothers to their mothers:

> "I blame her […] but I feel that she almost can't express herself. She almost can't express love, she's almost kind of numb, you know. […] I do think now I'm older I think it's … I mean certainly from the drugs she's on […] they keep her; I don't know in a kind of nowhere… rather than having some of the strong emotions that she should have had. […] Although you know again you do feel guilty saying that because I am very aware that it wasn't all my mum's fault. You know my dad left, she didn't cope." Della

For Paula, who regarded her mother as extremely psychologically and physically abusive, it was clear that there was little internal conflict regarding her feelings about her mother. There was no question of loving her mother, either in her mother's lifetime or since her death. Paula looked after her mother in her later years with the objective of inheriting from her. She undertook this on a completely practical level:

> "That if I looked after her, she had Alzheimer's badly, I would then inherit that which I needed to inherit. At that time, I'd been diagnosed with my back problem. So, I did have a secondary thing." Paula

It is easy, given Paula's accounts in Theme A.2., where, as a child, cruelty was a day-to-day normality for Paula, to appreciate the view expressed above.

Role Reversal

There remained an underlying theme of the continued experience of role reversal for many participants in their adult lives:

> "And one of the things that her counsellor said […] "You need to get interests; you need to have interests away from your mother. You need to go and stay with your daughter." … and that's almost what she does, I mean she comes and stays with us four times a year and it feels quite controlling. So it's almost like she comes here because she's been told she must do it a couple of times a year to make sure that you know that she's ok, but it's a really odd kind of relationship." Della

As Melanie describes below, her adult experience as a daughter is not one of having the wisdom of her mother to turn to, but one in which she takes a motherly role on top of her own role as a mother to her own children. This has been a concept which has been difficult for her to explain to her own primary school children, who do not realise what the impact would be upon their mother and their time with their mother, if Melanie did not put this boundary in place:

> "[…] And to this day, whenever she rings up I know it's going to be half an hour to an hour all about her, while I just sit and listen." […] and my daughter says can I ring Grandma? And I say no because Mummy is going to have to talk to her for hours after you." Melanie

Further to Melanie's account, other participants referred overtly to how they felt it necessary to conduct a guarded relationship with their mothers, much of which relationship constituted continued role reversal. Sometimes this was in being their mother's carer or emotional support and for some this was in keeping a boundary, which they felt that their mothers could not keep:

> "I have a turbulent relationship with her – even though she lives with us I can't touch her or demonstrate love to her because of how I feel. As she doesn't know how I feel she simply thinks I am a bad and emotionally retarded daughter so it is hard. However, I have been so badly hurt in the past that I cannot put myself at risk again and so operate the relationship from a purely practical state – i.e. keep her safe and look after her but no deeper into the relationship." Gabrielle

> "But even now I mean my older sister won't tell her anything and I do tell her things but I am very wary of what I tell her. I mean she didn't even know I was pregnant for ages. Everyone at my church knew." Carmen

Many women spoke of having been young carers in their childhood years, often only realising this through motherhood and in their adulthood. It has been clear that participants reflected only later upon the fact that they had been responsible for meeting the needs of an adult in their mother, more often, although to differing degrees, than that adult was able to support them. In hindsight, many participants came to realise that the role reversal that had occurred in their childhood had often continued for them in adulthood:

> "I realise that I was more her mother." Kye

One can imagine how many participants might have felt that there was no helpful model of mothering for them to internalise.

D.3 Looking back on my journey as a mother

In making sense of their experiences as mothers, participants made strong connections between their childhood experiences of their mothers, their adult experiences of their mothers and their own experience of motherhood, which they expressed throughout all themes.

D.3.i Assuming difference (cross theme – A5 Social Comparison – Feeling Different)

The meanings which participants made of the impact of their childhood upon them, often seemed to be derived through comparison between themselves and other mothers whom they felt had not shared their childhood experiences. This appeared to be the case beyond what might reflect mothers in general, or the content of the interview schedule. There was often an assumption of difference and the nature of that difference appeared to be a simple 'them and us'. In other words, many participants compared themselves with all 'other' mothers, whose subjective experiences of motherhood will necessarily have been affected by other experiences. Indeed, their subjective accounts of their experiences may not solely reflect their childhood with their mothers. However, in phenomenological terms and therefore subjectively, this was the experience for these daughters of mothers with EMHD.

Carmen makes direct reference to the impact of her childhood upon her as she describes the tension she feels upon physical and emotional closeness with others, even with her own child and in comparison with another adult who welcomes closeness by comparison. She also highlights the difference between herself and others by making this comparison. Carmen infers that she finds it difficult to be close to others, even those she considers non-threatening:

> "How it's affected me? Oh hugely. I mean I think I have done well at sorting myself out…but I think my relationships – it's about closeness – I get panicky. (pause) I mean I think, I mean she's my child and I think she's brilliant and I said that to her but I think she'd actually prefer the child minder (laughter) I mean that actually suits me, whereas I think Gale (friend pseudonym) is much gushier and I can feel myself panicky near Gale – I like her, I really do – she's lovely – but I don't (pause) – there is this thing – I am not sure how close I want to get to you. I know a lot about relationships but there is this 'thing' (that stops closeness)." Carmen

Sometimes participants assumed that other women (who did not have mothers who suffered EMHDs) were better mothers because they had better childhoods.

> "I had to try, […] check things out with her (my daughter). I don't know, I just always think … when they were younger I just used to think that everybody else would just do it, you know. It's just effortless." Elenor

In general participants expressed the belief that daughters who had good relationships with their mothers would find the motherhood journey easier than them. Della described this with reference to her fears regarding maintaining good communication with her children:

> "About their children … I do think that they probably don't worry so much about communication with their children as they grow up. But it's my biggest worry. Because… so yeah I don't think they probably worry about it at all. I mean people that have got a great relationship with their mum …have a very good relationship." Della.

Paula spoke of how she felt that she would worry more than the 'other' mothers:

> "Well sometimes it seems that other mothers don't really seem so bothered by their children." Paula

Many women stated that the effort (see Theme C.1 Striving) they felt they had to put into mothering made it difficult for them to enjoy being a mother and that this 'joy' of motherhood (as also explored in Theme C.7. ii) in some sense was the property of 'other' mothers:

> "I suppose other people just did it, thought it was easy. […] I don't know, maybe I thought other people weren't burdened with all that stuff as well, they could just get on and enjoy it. And it took me a long while to enjoy it. […] I don't think I enjoyed it … I don't know maybe … I can't think when I started to enjoy it really, when I just thought I think it has just kind of crept up on me." Elenor

The theme of 'assuming difference' was strongly connected to the concept of not being 'a natural mother' in which both Elenor and Gabrielle spoke of the emotional backdrop against which they strove to be 'good' mothers.

Paula explained how fundamental this feeling of difference was for participants, in her thoughts below:

> "It has affected me […] I think things happen to me that don't happen to other people." Paula

D.3.ii Distinguishing me from 'normal people' (cross theme - A2 My perceptions of normality as a child)

Participants appeared to feel that they were quite 'different' to mothers in general and that their worries were unique to them and to mothers with their childhood experience. This concept of separating themselves from others by assuming that other mothers were 'normal' and by inference that they themselves were somehow not 'normal', was strongly related to the theme of 'assuming difference'. Gabrielle's narrative reflects the way in which many women distinguished others (as in those who had not experienced a mother with EMHD) from themselves:

> "If I told 'normal' people about me, and there's some of the things that happened when I was a child, I don't think they would believe me, so if I talk about it, I talk in a joking way." Gabrielle

Gabrielle refers above to how, if and when she shares her past with others, she makes this palatable for them, perhaps by minimising the content. This enduring sense of difference seemed to cause many women to need to collude with the image that they felt others wanted them to have in adult life. This is also intimated in the theme 'being the me that others see' (Theme D.2.ii) above, in how women often protected their friends and their friendships and to a certain extent themselves from much of the internal sadness they carried. They did so in order to cope with their lives and their relationships of which motherhood was their most important one.

> "I only feel supported when I speak to people who have truly had the same experiences." Gabrielle

Colluding with the view of others was commonly a way of preserving an outward appearance of normality for women who, as previously described, saw themselves as different to others and saw others as 'normal' in comparison to themselves:

> "They all had normal childhoods. They just don't want me to have that terrible, unbelievable stuff behind the happy me." Melanie

For these women, who, as Paula states below, saw themselves to have grown up: "in a strange world" (as explored in Theme A2) *questioning* their own normality was frequent in

childhood, and this also remained with them underpinning their sense of themselves as adults and mothers.

> "Yeah there would be some row or outburst… I had to hide things really […] Yes - with a strange world and I copied other people." Paula

Kye speaks below as if she feels that her childhood has sabotaged her as a mother:

> "One thing that affects me is when I lose my rag I think, not every mum, but I think mums that have got it together, never do what I do, in the sense of screaming and ranting and raving and it's in the same way that I'm dealing with a child - down on their level, I imagine they keep it together and they don't lose their rag and that's where I feel sort of self-condemned that I lose my parent role." Kye

Della spoke of how as a child she had sought normality by attaching herself to the families of friends:

> "[…] finding these families that were normal, that were happy to kind of take me in. […] Um… what did I think of mums […] a kind of normal family environment. And I think that was quite indicative that my life wasn't that, particularly when I went to secondary school and left home. And then latched onto my friend and practically moved in with her and her family, you know." Della

Interestingly, there were no actual accounts of having ever met another mother with similar 'experiences'. Women seem to feel quite isolated in their experience and although they were very aware of the effect of other childhood situations in which neglect or cruelty might occur, they often minimised the impact of their own experiences, perhaps in part because they lacked a benchmark from which to assess this:

> I: Have you ever met anyone else who you felt really understood your experience?
>
> R: No not … well I mean yourself (laughs). No, not really, because I've met … I have met people whose mothers have been mentally ill and in fact I had two friends whose mothers (pause) one's mother was very similar to me mother. So, I think yes that is yeah, yeah. But neither of those have gone on to be mums themselves. Della

It is possible that Della may be highlighting a possible reluctance for some daughters of mothers with EMHD to be mothers (Nathiel, 2007).

D.4 What I have learnt

In general, the accounts of participants contained a great deal of reference to hindsight.

D.4.i I don't know how I did it

Many participants expressed that they could not understand how they were able to 'mother'. As has been evident throughout the analysis, most women struggled to believe, or to understand how they could be 'good' mothers. All felt determined to be the best mothers possible and most expressed that they wondered how they managed to parent as well as they did, given the model of mothering they had received. A common theme depicted how they felt that whilst other mothers may wish to be good mothers, they had to be 'the best mother' and by any means:

> R: "I had to be a great mother. I had to do it right. […] I pushed myself not to be the mother I had."
>
> I: So you felt very different to her?
>
> R: "Very. Very. You know it's weird, I just don't know how it has happened. […] I think I am actually a deep person, a kind of thinking, logical person. I do have a lot of love and I don't know where it comes from really." Melanie

Some participants explained their ability to mother through social circumstances or fate. Carmen describes her spiritual belief about what helped her to be a good mother:

> "My view is that God gave me time to watch other mothers – She took eight years to get and I kept thinking and people kept saying you will be a good mother and I started off thinking I will be good at this, whereas having been through what I have been through – I should be crap. I took what I want." Carmen

Most participants found it impossible to find a way of explaining their commitment to their role as a mother:

> "I looked at child minders, nurseries, I would just get tears start dripping down my face. […] Very, very. You know it's weird, I just don't know how it has happened, maybe it's a past life." Melanie

There were frequent references to the disbelief that they had managed to be positively different as a mother to the mother they knew as a child themselves:

> "All the time. (laughs) I don't know. I don't know where that's come from. I don't know where any of this has come from. Why I'm so different. I don't know. And that's one of the things that continually baffles me. Really me childhood was garbage." Elenor

Many women expressed bewilderment about their attachment to their children and the maternal bond they experienced.

> "No it's not a primary role (work) […] but I gave up a job last year cos it was too much with the children, I needed to spend more time […] I mean you know the being here for the kids in the morning and the afternoon is really important […] But I don't know whether that's my very strong feeling that I want to be here and when I had my daughter I couldn't go back to work, I just couldn't. […] I couldn't … you know […] in the morning worrying about leaving her in a nursery. I don't know where those really strong feelings come from." Della

Some narratives questioned the value of their determination to give their children such positive experiences. As they reflected on what they were giving their children despite the difficulties they experienced in their own childhoods:

> "I wonder if it really matters what childhood you have, I have spent all this time trying to be perfect. Well I didn't have that did I? […] Yeah cos […] … me mum being shit, I turned out okay." Elenor

D.4.ii Low expectations

Many participants described how they coped alone as children; often recalling experiences from which they learnt not to ask for help and support. For many, this had then become their normality. Participants often reflected on the ways in which they had realised they had been coping, on how low their expectations of help had been for themselves in their own lives, and how this had been a way of coping in itself.

Gabrielle described how she distracted herself from the reality of a painful childhood life, and how unconscious she could occasionally make herself of how painful her childhood life had been:

> "I used to spend a lot of time on my own dreaming about the future when I was older and listening to music. Sometimes I used to write. I didn't feel it was that hard to cope then." Gabrielle

Although for all the participants, early independence was familiar, many felt that this had been the case prematurely in their lives. Often they described how this carried on into their growing lives. Della expands on how this caused her not to seek support in the ways that most of her peers and people of her age would have done:

> "I just tried to be too independent because she let me go at such some young age…or I, you know when I look back at it, I feel that she let me go at such a young age, in terms of the fact that I did make my own decisions and do my own thing (pause) I had to move out of my house, I had to move out of the house at the end … you know on April or whatever it was. And I didn't have a job, (pause) home, I didn't know where I could go, I didn't have any money. But it didn't really occur to me at that age to turn round and say "Can I come back?" Della

Della reflects a common theme above, of not seeking the ordinary help from their mothers that they witnessed in their peers; a theme which participants described as continuous in their adult lives, as Caroline confirms:

> I: And what about now, are you finding it hard to ask for help?
>
> R: "I do, very hard yeah. I find it very hard to ask for help now".
>
> I: So that's stayed with you.
>
> R: "Yeah definitely yeah. Even with things like round the house and things. (inaudible) sounds awful, but no I found it very difficult. I like to think I'm self-reliant … self-sufficient. I mean I do, if I have to, I will." Caroline

Most women spoke of how they had come to realise that they had developed independence due to the lack of support they had experienced in childhood and in order to adapt to their circumstances as children. This they realised, they had carried with them into adult life. This was often connected with the low expectation which many women expressed concerning the possibility of support coming towards them in their adult lives.

A common theme cluster amongst the women reflected having learnt to get on with things themselves early on in their lives. In this sense, they had learnt to have low expectations of their mothers and in their lives more generally. Some narratives reflected the value of their childhood**.** The following extracts from Caroline expand upon this:

> "But then again I can remember when I was about 11 or 12 going up to London on my own, trying to find Charles Dickens' house and failing miserably […] but I mean …and now I can go on holiday on my own. So, I suppose … cos someone actually said that […] "you go on holiday on your own!" Lots of people couldn't do that." Caroline

As the quote above also exemplifies, some participants did feel that there was positive outcomes related to their childhood. Caroline felt that the enforced independence in her childhood seems to have enabled her to cope with later loss (having lost her husband when young), helping her to travel alone as an adult, and also possibly had helped her to cope with such an early loss in her adult life. Caroline relates how she has no recollection of ever contemplating how she would cope, or in fact whether she had the choice not to cope:

> "And I can't even remember questioning - how am I going to cope, […] how am I going to do it. And […] I never thought about not coping." Caroline

Caroline describes how as an adult she stopped trying to receive her mother's support as she felt that even though her expectations were low, her mother's own preoccupation with herself always superseded Caroline's needs as indeed she had felt that it had done in her childhood.

> "[…] What was the point you know. I mean I used to phone up quite often and I used to moan about my life … I did used to moan. You know I was stuck in here with three kids, no transport, no husband (died young, leaving three young children) … you know. […] But whatever I moaned about, my mum had it worse. And in the end I stopped moaning. Because […] whatever I was experiencing or was happening to me, my mum … it was worse for my mum. […] all I wanted her was to say "Yeah life's a bitch" "Yeah, yeah I understand completely, yeah." Nothing anybody could do about it. But just to talk about it. But no she always had to … and I sort of thought well really … you know you've still got dad, how can your life be that bad? But no it was always … would always moan back. And in the end I stopped saying anything to her because I thought I'm just not getting anywhere." Caroline

Caroline's experience was that even in extreme circumstances her mother had continued to be more concerned with herself.

> "And the other thing which I think I won't ever forgive her for is the day that Derek (her husband, not his real name) died. I found him at 5 o'clock in the morning and mum and dad turned up at 1 o'clock. And that is something I cannot forgive. I was left on my own with three children. And if it hadn't been for our local vicar I don't know what I would have done. Probably found three of us in the river. You know. Cos dad had been at work, but there's nothing

> wrong with getting a taxi. Cos dad couldn't get up. And that is just unbelievable […] don't think I even got a hug then!" Caroline

As can be seen below, low expectation has been maintained in Caroline's adult life as a mother. Often, it was in examining the difference in the relationship between themselves and their mothers, and other women and their mothers, and also the difference between their own behaviours as mothers and that of their mothers (as can be seen below), that participants came to fully appreciate the lack of support they had experienced from their mothers:

> "I suppose I didn't really expect any more of her than that. […] When I think of what my daughter in law's mother does. […] I mean I wouldn't have expected her to baby sit. She wouldn't … no she wouldn't have been around to baby sit very often or offer. […] She's not like me. You know when I compare her role with the way I am with [my son], I mean she was just no help at all really. […] Oh well […] they only have to phone up and say she (granddaughter) is not well and I'm down there, I'd be down there, you know, and that's my granddaughter. With any of them, I would be there straight away." Caroline

Caroline appears to dismiss or minimise her own experience as a young mother, when she states above: "Oh well". This appears to reflect the low expectations in her life she recalls as a young mother:

> "Yeah. Yeah probably if I'd have met you when my children were young I probably would have said "Oh no there's no problem." I mean I would have known about the agoraphobia but I wouldn't have said it was a problem, you know. I think I got from my mum what I expected from her." Caroline

Caroline's narrative reflects how many women spoke of how they had learnt to have low expectations for the quality of their life experience, which often meant that they realised that as mothers they had not sought the support they needed.

Many participants recalled that they had been so used to the situation of their lives as children that it would not have occurred to them to question this (as was discussed throughout Theme A). This was often also reflected in their account of their journey as mothers. Elenor speaks below of how she viewed motherhood when her three children were young:

> "Yeah I think so. Yeah maybe. But I don't think I ever … I don't think I ever reflected on stuff too much then, I was just kind of getting on with it, in the moment you know." Elenor

Melanie's account of herself, aged she believes at about three years, how early in her life she felt the burden of her mother's EMHD:

> R: In fact, when he was born I remember thinking "Oh god I can't believe she's had
>
> another baby, how is she going to cope with him and me?
>
> I: How old were you then?
>
> R: About three. I was very young. Melanie

Melanie's account also exemplifies just how early in life a child's role reversal can begin in the thought.

D.5 Regrets

I have included some quotes below which give the opportunity for participants to express their sadness without my interpretation. I endeavoured to shape these quotes into narrative and each time felt unhappy with my intrusion. I have therefore left them as descriptive for the readers' reflection:

> "With my mum, see a mixed bag again, in later life my mum, because she was more settled, you know we could have good times, it's not like everything was low moments, but her overall life was pretty sad and I don't want to be that, that's what I project, you know that I'm sad, predominantly. I don't know what people would say about me if they were asked that, I don't think they would say that. I think it's more balanced than that, although years ago probably that would have been the truth. That brings up, it's all about what I had with my mum, because my mum died you know […] Yeah I am I'm just feeling very emotional, I'm just feeling like, I guess I am feeling isolated again, that's what it's bringing up, I feel lonely." Kye

> "Yeah. It doesn't matter anymore if people believe me or not, because I believe in that […] I spent all those years wanting things to be so different. I wanted to have a childhood like the one my kids had. That's what I wanted, and I never got it. And I'm never going to get it." Elenor

> "I think that's … that's why I feel sad. I feel sad now, that our relationship now (pause) your relationship with your mum now I think should be a friendship, an equal relationship and a wonderful exchange of two mature women. And my friends who've got that relationship with their mum you know I mean passing on their experience and their knowledge and … and the love and support, you know. And I think that's sad." Della

Elenor spoke of how she wished she could have trusted herself. She also revealed another layer of regret in sharing that she wished that she could have trusted herself as a mother and trusted her children's truth and not coloured this with her own childhood experience and fears. She regretted that she had not been able to trust that her children loved her and by inference that she was lovable:

> […] I didn't value myself […] I was very suspicious about them as children. Because it didn't matter what they said … I would wonder what was going on in their head […] but I doubted that I'd got it right. […] I didn't value myself as a mother. […] Yeah yeah I'm getting better at that, I am getting better at that. But when they were younger I'd love to have had that, when they were younger to have that level of confidence and trust their lives (?). That it would be ok, that they had a part to play but (inaudible) I couldn't, I couldn't. I Couldn't trust it because [...] No for me to trust theirs. Because in my eyes mothers let you down you know. […] That was the thing … but I doubted that I'd got it right. Even though I knew that I was doing the best I could (inaudible) I still really doubted that it would work." Elenor

Lack of trust in these women's childhoods with their own mothers was often connected with a lack of trust in themselves as mothers.

As the quotes above suggest, there were many references from participants to their sadness and regrets, with many feeling that they were denied the joy of childhood and in different ways, the joy of motherhood. Although all participants valued their role as a mother extremely highly, it was a common theme for all participants that they felt that their childhood had made being a mother very difficult for them:

> "I feel sadness that it couldn't have been more fun, and confusion over my identity. I feel angry that I couldn't have had a normal mother." Gabrielle

D.6 Healing

Participants highlighted three main aspects of healing in their adult lives, with different participants referring to different aspects of healing through motherhood, therapy and also the interviewing process.

Many participants described the importance of what they had learnt through being a mother:

> "It (motherhood) did take it away but you can't ever, although I have cast it off, I don't want to ever completely cast it off because in some way I think it has made me a better person, although I hate to say it. I think it has given me compassion, and humility and understanding, you know and would I have been those things? … Maybe." Melanie

There were many accounts which reflecting a healing process through motherhood, with some participants actually utilising the word 'healing' in connection with what being a mother had given to their lives, as Melanie and Gabrielle explain:

> "All the way through my pregnancy I was really, really anxious […] would I cope? would I be a dreadful mother? But I have to say that I have done a lot of healing as a result of being a mother." Melanie

> "Similarly, I think before I used to get caught up in trivialities and concerned about things which didn't matter so much. Having children means that I put things in perspective although I do get emotional if the children are upset." Gabrielle

Some spoke of having pieced together their childhood self and their adult self through being a mother themselves:

> "Now I just feel that the two people are one, that I'm complete now. That I am who I am. And I'm quite happy … I haven't got this fight going on any more." Elenor

Some participants spoke of how motherhood had helped them in relation to their feelings towards their own mothers and for some this effect, of having become a mother themselves, was so marked that they now felt unaffected by encounters with their mothers as adults, in situations that had previously caused them acute distress:

> "I have not cried over her (my mother) since I had the children. But you know it can't bite me on the bum anymore, that's what I say to my mum now. I used

> to be, you know when I was five and she let me down I would be like (crying noise). That hasn't happened, I haven't cried over my mum since I had the children, but up until having children she could still do something that would floor me. And I would think… I remember at Christmas once I was ill and I said "Can I come round and get some trifle because I haven't been able to make any at home because I'd had flu?", and she said: "No." … and I was like (crying noises). It's so stupid now, I'd probably just slam the phone down on her, I don't know what I'd do, but it wouldn't even touch me now although I could still be touched by it before." Melanie

Many described immense changes for the better as a result of being mothers, particularly in terms of their confidence. Elenor spoke of how she has come to feel that her children may understand her and also some of her behaviour that she is less comfortable with. She reflected that she is now better able to cope with discussion with her children about their experiences of her as a mother:

> "Um … but then thinking about it, yeah they (her children) have said a few things. Initially I get quite hurt, quite sad, but then after I've reasoned it out, thought about it, I'm okay with it. But I think my initial reaction (pause) But then … yeah. And a couple of things I've actually … especially with my middle daughter I've actually sort of said to her "I wasn't too happy" (pause) cos like …I think I'm able to talk to her about it. (pause) And my son as well, there's stuff I did to him that I wasn't too proud of (pause)and explained really why I did what I did. All I can do is apologise now "I'm sorry I did that." Elenor

Many women described how being a mother had increased their confidence as it had provided evidence of their worth. For some this was especially the case in hindsight as they looked back upon this journey:

> I: Do you think you would be sitting here today describing yourself in the same way if you hadn't gone through motherhood yourself?
>
> R: I don't think I would have been so confident. You know I think I might have been … I wouldn't have been quite so self-confident. Because I think the thing is you know you look back and you think well I've done this - you know I brought them up. Caroline

All participants were given information regarding counselling, including free and low-cost options. They were also left with my research email, although not for counselling purposes. I spent time speaking with participants where necessary about ongoing support. Paula, at 74

years of age, had considered but feared counselling and following the interview and discussion, she expressed that she may reconsider:

> R: Well I feel a bit upset because I've dragged up a lot of things which I don't usually talk to people about […]
>
> I: Do you think that you would benefit then from counselling? Would you want to go…?
>
> R: I'm not sure. Would it make anything worse? It would depend who it was. It might not be good. I'd probably like to try it now. Paula

Elenor described having healed a great deal through therapy:

> "Yeah. But I mean I had a good sort of 18 months of therapy and it really did help, you know, it really did. I kind of worked through it all there." Elenor

Elenor expanded upon this healing process describing how she had found the confidence to share her childhood with close friends and family following therapy. She spoke of how she had also shared her childhood with her children. Elenor's consciousness and care regarding her children is evident in the quote below but so too is the confidence to own her own feelings, which was gained through a therapy:

> "Since I think … like the past four or five years I've changed so much. Since I've stopped … just acknowledged what my life is about. And since you know I've sort of worked through all that stuff with my families, told everyone how I feel. Like my best friend knows - my children know now. Whether it was right to tell them or not I don't know, I feel maybe I shouldn't have done it, but I did it. But then I think they've got a right to know, you know. So … and I've changed an awful lot." Elenor

Some participants expressed that they had felt drawn into and at the mercy of their mothers' counselling. For this reason, I have repeated a previous quote but with a different emphasis:

> "That was what they said: "You need to get interests; you need to have interests away from **your** mother. You need to go and stay with your daughter."" Della

Through the counsellor's comment, Della now feels that she has been recommended as 'therapy' for her mother, which incorporates further role reversal through a probable lack of understanding on the part of the counsellor of the impact of this advice. This is a

consideration for counselling psychologists, as the outcome for Della is potentially that she is an 'unseen child' in the therapeutic process, which could undermine the healing for daughters of mothers experiencing EMHDs.

In her account below, Melanie speaks of not wanting to be compared to her mother and sister, who are drawn together in an attempt to heal from the past. This may have enabled them to have a mutually, potentially co-dependent relationship. For Melanie, the consequence could be that she denied herself appropriate support, which could include counselling, if needed, in order to differentiate herself from her mother:

> "They need each other (her mother and younger sister) and they need therapy. I am not like them." Melanie

For most participants, their healing was expressed as ongoing. Elenor describes below how echoes from her childhood still persist in adulthood:

> "[…] but that still happens, that still happens. Scary but I am still scared no-one will … they don't believe me, you know. Making all this up. My mum always used to say that I made the story up. But I never, ever related my childhood to the childhood she told me I had." Elenor

Elenor further described how seeking proof of her worth and a positive identity as a mother, through her own mothering experience, seemed to have been very much ongoing and incomplete:

> "I've still got this voice going on "I'm not sure, I'm not so sure."" Elenor

All participants spoke of the therapeutic value of the interview as an experience in itself:

> "It's not that I want to bring it up, if it makes me feel this way then I think that it needs to come up, and in some ways I'm surprised that there's still that much in there, and all these areas, because of the nature of what I'm involved I've done a load of processing already, it's been roughly twelve years and I've cried loads but it's obviously still there, stuff that needs to come out, but yeah it has been therapeutic, and making me look at it from another angle, because you're looking at it from a mental health issue, which I've never done before in therapy or anything like that, and even though I'm going to my own therapist it was never looked at in that way and maybe I do possibly need to do that a bit more. Because it's almost like, even though going to the therapy is ok, I'm not sure how much I've really changed, it's kind of just nice, but if it's nice maybe there's no real work going on." Kye

> "Well I feel fine, I feel quite animated, I feel quite passionate and strong about what I'm talking about even though it's an awfully long time ago, I mean I'm forty now, I've been married nearly fifteen years. It's a long time ago, yet it can still make me, you know. But I don't ever mind talking about it, and it's funny that I remember, in my memory, I remember everything. And I do still remember it clear as if it was yesterday." Melanie

> "This is the most I have ever spoken. This has been space for me." Sarah

Kye, who was currently seeing a therapist, compared the interview process to her therapy and explained what she felt was the increased value of the interview for her as a daughter of a mother with EMHD:

> "Yeah I've got a couple of good solid friends, they've got family life and so on and pressures. But I mean I haven't cried like this in quite a while so it's probably just as well, it's probably what I needed. I mean it is useful talking about, especially the whole mental health thing and my mum and my relationship with her. Even though I have been to therapy it's not talked about in the same way so I know it's not tapping-in in the same way. It's not the same sort of question." Kye

Caroline spoke of how she felt that the interview had enlightened her. Caroline also felt that the interview encouraged her to feel that counselling could be a supportive process for her. Caroline also felt able to reflect on what might be helpful aspect for her to look at with a counsellor:

> "I mean in some ways it's sort of opened my eyes. Perhaps some things I didn't really see clearly before […]. Perhaps I should, I don't know. I mean I've considered counselling over the years but I've always sort of muddled through. Probably cos I am quite embarrassed about talking about my feelings (inaudible) cos we weren't a family that discussed things like that, you know, just weren't." Caroline

D.7 Thanking my children

Many women expressed gratitude towards their children, and expressed that they believed that believing that being a mother was responsible for turning their lives around in a way that made them very much appreciate their children's positive impact upon them. Many were grateful to the learning their children and being a mother had afforded them. Often the role of their children in their healing had been realised by these women in retrospect. All spoke of their children with appreciation and gratitude as can be seen in the examples below:

> "And then as I had my family … and it was an unconscious decision it wasn't conscious that they were my priority but that probably saved me." Della.
>
> "I don't know where I would be without them." Gabrielle
>
> "It's given me everything, the best things in my life. Totally. It's given me everything. I just wouldn't want to do anything else than be a mum." Elenor

At least for the participants in this research, their accounts would suggest that healing through mothering was their most poignant and moving process of healing.

4.6 Complete list of themes

Theme A – Contextualising my experience of my mother in my childhood and growing years

List of themes

A.1 No-one explained (cross theme - D.2. Impact on relationships)

A.2 My Perceptions of normality as a child (cross theme – D.3.i Assuming difference; D.3.ii Distinguishing me from normal

A.3 How I experienced my mother in my childhood (cross theme - B3 The complexity of bonding)

A.3.i Unable to care for me

A.3.ii Disconnected (cross theme - B3 The complexity of bonding)

A.3.iii Unpredictable

A.3.iv Cruel

A.3.v Suffering Empathy and pity

A.4 Other Significant relationships in childhood

A.4.i Father

A.4.ii Sisters

A.5 Social Comparison - Feeling Different (cross theme – D.3.i Assuming difference D.3.ii Distinguishing me from normal)

Theme B – Beginning the motherhood journey - pre-pregnancy to birth and adjustment to becoming a mother

List of themes

B.1 Maternal Feeling

B.1.i Lack of maternal feelings

B.1.ii Strong maternal feelings

B.2 Fear of Harming (cross theme- C.2.iii. Waiting to fail)

B.2.i. Self-protection and Selfishness (cross theme- C.2.iii. Waiting to fail)

B.2. ii. Fear of becoming 'her' (cross theme- C.2.iii. Waiting to fail)

B.3 The Complexity of Bonding

B 3.i Connecting my mothering with my mother (cross theme - D overall.

Making sense of my journey)

B 3. ii Not a 'natural' mother

B3. iii Bonding and Fear

B 3. iv Bonding above all else

Theme C - The mother I am today

List of themes

C.1 The concept of Striving

C.2 The mother I am (and the mother I fear I could become)

C.2.i The importance of being a mother

C.2.ii My empathy with my children

C.2.iii Waiting to fail **(**cross theme - B.2 Fear of harming; B.2.i. Self-protection and selfishness); B.2. ii. Fear of becoming 'her')

C.2.iv Being a mother being my 'self'

C.2.v Self-doubt and mistrust (cross theme - D.2.iii confidence in relationships)

C.2.vi Needing approval (cross theme - D.2.iii confidence in relationships)

C.3. Guarding against failure

C.3.i Overcompensating

C.3.ii Doing it for them but not for me

C.4 My mother-daughter relationship

C.4.i My daughter-my 'self'

C.5 Taking it all on

C.6 The mother I fear I could become

C.6.i Avoiding mental illness (cross theme - B.2 Fear of harming) B.2.i. Self-protection and selfishness (B.2. ii. Fear of becoming 'her')

C. 6.ii Depression and identity

C.6.iii Avoiding all aspects of my mother

C.7. Some consequences of striving

C.7.i Avoidance and overload

C.7.ii Lack of enjoyment

C.7.iii Suicidal ideation

Theme D - Making sense of my journey - Contextualising the impact of having a mother with EMHD

D.1 Realisation of the impact (cross theme- A.1 No-one explained)

D.1.i Anger

D.2 Impact on my relationships – (cross themes - C.2.v Self-doubt and C.2.vi. Needing approval)

D.2.i Parallel lives

D.2.ii Being the 'me' that others see, the complexity of friendships

D.2.iii Confidence in relationships

D.2.iv My adult relationship with my mother

a) Conflicting emotions and dual roles
b) Still fearing her
c) Mothering my mother
d) Role Reversal

D.3 Looking back on my motherhood journey

D.3.i Assuming difference – (cross theme - A.5 Social Comparison - Feeling different)

D.3.ii Distinguishing me from normal – (cross theme - A.2 My Perceptions of normality as a child)

D.4 What I have learnt

D.4.i I don't know how I did it

D.4.ii Low expectations

D.5 Regrets

D.6 Healing

D.6.i Healing through motherhood

D.6.ii The Value of interview

D.7 Thanking my children

Chapter 5. Overview

This phenomenological study of motherhood in women whose own mothers experienced long-term mental health difficulties has highlighted that at least for the participants studied there exist multi-layered processes in which women are experiencing motherhood and childhood trauma as inter-related phenomena. While there was some overlap between the experiences of these mothers and those of mothers in general (Hanson, Hanson & Pollycove, 2002; Porter & Hsu, 2003) what distinguishes the mothers in this study is the nature of the process of re-evaluating themselves and constructing motherhood concurrently. This process concerned the construction of a maternal experience out of their daughterhood which was not straightforward in its evolution. Where I refer to the term 'maternal identity', I am referring to the participants' view and evaluation of themselves as mothers. This suggestion of fluid identity is not completely novel (Breakwell, 1986/1996), however, for these mothers, the ability to have the experience of motherhood first and then to evaluate this was hampered by assumptions of failure and in some cases, quite extreme fear that they held inside themselves a model of mothering derived from their childhood that could be psychologically destructive for their children. These women appeared to not only re-experience painful memories from their childhood through being a mother themselves but also to persistently re-evaluate these and the likely impact on their mothering ability from a starting point of the assumption and the fear that they may cause harm to their children via the helpless repetition of the mothering they had known.

The women in this study appeared to carry with them into adulthood and then motherhood a sense of difference and in particular the tendency towards, a negative sense of themselves as mothers, which drove their mothering in a manner which potentially threatened their own wellbeing. As parents, the women in this study seemed prone to overcompensate in their desperate endeavour to avoid inflicting psychological harm upon their children and yet their every word was a testament to their dedication and strength in their role as mothers. The fears expressed therefore concerning their inadequacy as mothers seem unfounded but deeply rooted and influential upon the quality of their life experience. Participants' evaluations of themselves as mothers were expressed through their comparison with their own experiences of their mothers in childhood. This meant that phenomenologically their self-worth in terms

of their role as a mother appeared to be shaped almost entirely by their experience of having been mothered, and that their view of themselves as mothers impacted heavily upon their global self-concept.

This research suggests that early support from counselling psychologists in terms of developing positive distinctiveness for women growing up with mothers who are living with mental health difficulties is necessary to circumvent distress and anxiety impacting upon them as adult mothers. The impact upon their psychological well-being as mothers will be discussed and implications for future research and counselling practice will be explored.

5.1 Perspective upon the potential limitations of this research

The 'daughters' in this study cannot be said to represent all mothers whose childhood was affected by the mental health of their mothers and this study can only offer thoughts for exploration in relation to the role of fathers and the experience of sons who become fathers. Therefore, any conclusions must be contextual and tentative. It was also originally felt that interviewing women whose mothers were deceased might confound the research in a way that could threaten its validity. However, availability dictated the sampling outcome which was valuable nonetheless. Qualitative research also values the insights which emerge through uniqueness rather than homogeneity and the particular insights that these three outlier participants, whose mothers were deceased brought, provided much food for thought. particularly for further research as to the longevity of the impact of having a mother with EMHD.

As a result of the experience of interviewing it was considered that the interview guide could have contained fewer questions about the participants' experience of childhood or perhaps have initiated earlier the questions relevant to their experience of motherhood. It could also be said that I did not stay sufficiently closely to the semi-structured interview schedule with each participant and therefore that there was a lack of uniformity in interviewing examples. However, as a researcher, my intention was to conduct unique existential meetings (*Batthyány,* 2014; Cohn. 1997) with each participant and for the quality of that interview to render them as close as possible to 'co-researcher' in that instant (Smith, 1994), and so to facilitate their interview in the way that was helpful to each of them and not helpful to a

cohort. It was felt also that longer could have been spent on discussing participants' experience of their transition to motherhood (Smith,1995). It should also be noted that there might be methodological effects of simultaneously analysing the accounts of mothers of young children and mothers whose children are adults, in that the former cannot speak about the long-term experience and the latter may not remember and therefore emphasise less the experience of the transition to motherhood. Nevertheless, this research focused on the existential experience (Cohn, 1997) of each mother studied and in that regard the construct validity was evaluated as strong.

It could also be argued that a criticism of this study is that the mental health difficulties of the mothers of the daughters in this study were defined by these daughters and that there is no evidence that their mothers had the problems which their daughters reported. However, I would argue that in this phenomenological study, the inclusion criteria were the subjective view of daughters, and that it was only their view of their mothers' EMHD which was of concern to this research. Further, little attention was officially paid to the mental health status of the participants. However, my assessment that participants were able to give informed consent was continually revisited in the procedure and I would argue that this is probably the only aspect of mental health that would have been a consideration for this phenomenological study.

In addition, regarding the sample, this study consisted of retrospective and current accounts of adult women. The sample was purposive but with few variables taken as distinctive and desirable to the sample. The participants were mixed in terms of social background and cultural background as well as the nature of their mothers' mental health difficulties but were generally of a similar racial (although not cultural) background. In retrospect, it seems that a breadth of sample could have been beneficial to the study in that it may be more representative of a diversity of perspectives (Smith, 2004). However, despite fairly varied circumstances, the women in this study appear to have experienced some considerable similarity in processing about and responses to motherhood.

It is important also to take into account the possible difficulties with retrospective accounts as to whether they are an accurate representation of experience. A body of literature has

discussed the errors which can be present in retrospective memory. Historically, memory was described by Bartlett, as an *imaginative reconstruction* (Bartlett, 1932) and a number of studies (particularly in eyewitness testimony) have pointed to the ease with which details of retrieval can be interfered with (e.g. Baddeley, 1995) as well as the effect of social and cultural contexts (Mistry & Rogoff, 1994). However, research also suggests that retrospective memory for emotional experience may be more reliable than previously thought (Brewin, Andrews and Gotlib, 1993), especially in comparison to memory for detail such as in events, or the sequence of events (Loftus & Palmer, 1974). Research has put forward arguments to challenge the accepted belief that autobiographical memory is inaccurate (e.g. Blane, 1996; Brewin, Andrews & Gotlib, 1993; Neisser, 1994; Ross & Conway, 1986; Rubin, Wetzler & Nebes, 1986; Wagenaar, 1986). Retrospective data is integral to psychological research and in any event, the minute a 'tale is told', it is arguably retrospective. What is likely to be accurate and in phenomenological terms of the only value, is not so much accuracy, but rather the nature of what participants say that they feel and think.

The limitations discussed here are most relevant to a quantitative methodology and the centrality to it of reliability. However, they are discussed above in terms of their relevance to the access of subjective meaning making in an IPA study and the need to encase IPA in rigour, a research ethos that stems from good quantitative research practice and is relevant to all methodologies.

5.2 Evaluation of this research

The detailed method section in this research contains much personal and methodological reflexivity concerning the potential weaknesses and strengths, that both became strengths throughout the IPA process. The sensitivity of the method in this research has given rise to some important implications for conducting IPA research. For example, the value of the 'insider perspective' (Conrad, 1987/2010) has been shown in my processes to be of inherent and significant value if conducted alongside heightened and extensive reflection. It is evident within my study that participants confided in me some of their deepest and most disturbing fears because they felt that I would understand and not judge their processes. This is likely to have impacted positively on the richness of participants' accounts. Additionally, despite my

continued concerns that my interviewing style was too deeply placed in a counselling role, the depth of the analysis presented here supports the need for relevance on the part of the researcher. In this sense, the researcher is part of the sampling procedure. I believe that if I were not a counselling psychologist, I could have found it difficult to contain participants sufficiently in order to guide them through such painful admissions in terms of their perceptions of their experiences and perceived identities as mothers. I was critical of my tendency to reassure and empathise in my interview technique. However, through the process of my analysis, I came to see that the level of person centred validation which I offered was helpful to the participants themselves and came instinctively from surrendering myself to the unique relationship each encounter presented. My own personal experience meant that I was truly 'there' with participants on this part of their journey. This transparency and authenticity is a vital part of IPA research and potentially maximises the wellbeing of participants post interview. I was conscious of the interview process as being another part of the experiences of these daughters and mothers, and of my need to approach this sensitively, and to view their "subjectivity as arising in and through embodied experience, as the struggle to make sense of that experience, and the struggle to communicate it to oneself and to others (myself as researcher)" (Murray & Holmes,2014. p.5). In the examples presented here, my approach went some way towards promoting the maintenance and growth of a positive maternal identity in women who struggled.

Further, the trust engendered from my belief in them and their integrity as women and mothers enabled them to share very difficult feelings with me. Their feedback (see Theme D6 'Healing') suggests that this had been an open encounter with a therapeutic outcome. This study has identified a number of factors which could underpin difficulties in the adjustment to motherhood in women whose own mothers suffered in terms of their mental health. It is important to mention here that the transcripts analysed in this study may only represent one construction of the participants' experiences (Willig, 2001). However, a brief summary of some important insights will follow in order to situate these within the practice of Counselling Psychology as information for practitioners.

5.3 The salient findings

The current research focuses upon women's views of themselves from within a specific role and with a particular childhood, that is from within their roles as mothers: mothers - who themselves, as children, experienced being parented by a mother who had enduring mental health difficulties (EMHD). This is not to undermine any other childhood situation that may affect the experience of parenting, or indeed any other parental role than that of mother. Central to this research are these women's subjective experiences of their identities as mothers.

The research question was:

> 'What might the impact be of having a mother with enduring mental health difficulties (EMHD) upon women's own experience of being a mother?'

The emphasis therefore was primarily upon the participants' experience of becoming and being a mother in the light also of their views of the relevance of their childhood to their experiences as a mother.

The emergent themes were presented across a timeline which best reflected the nature of the identity processing (Breakwell 1986/1996) which the participants in this study seemed to illustrate in their accounts of motherhood. By the term 'identity processing', I am referring to the way in which participants seemed to have constructed their view of themselves as mothers and the sense that I also had of this process during the interview space. Counter to the timeline, which could suggest straightforward contemporary processing, participants displayed a model of processing which seemed to be multi-layered and multi-directional in their continued backward and forward processing, but unusually appeared to place memory before experience in a way that suggested that their maternal identity (self-concept as a mother) was constructed rather as a phobia might be constructed with sensitisation and fear pre-empting onward experience (Beck, Emery, & Greenberg, 2005). An overview of participants' identity processing is inherent in the analytic structure.

5.4 The detailed findings

Several themes relating to the impact of motherhood upon identity were extrapolated from the accounts. Participants shared a feeling that they were somehow vulnerable to mental health difficulties which would ultimately lead them to fail their children. They were often disappointed in and highly critical of their ability as mothers. However, some themes reflected the positive impact also experienced by many participants.

In Theme A, **'Contextualising childhood experience',** there were many accounts of distressing situations in the childhoods of the participants. At the end of this theme, we see the first theme which exemplifies the potential for participants to develop a deep-seated negative identity, that is, that they are somehow different in social and negative comparison. The quality of that difference is further clarified by some participants as 'different' means 'odd' and 'difference' means 'failure', or predisposition to failure. For some participants, this was stated overtly and for others, this was implied. This meant that participants grew as children alongside feeling the judgement of others around them and the isolation that this caused. Paula described this as "my mother brushed off on me". In this way, the suggestion is that participants started life with a merged identity with a symbiotic quality (White, (1997), which, more importantly held a 'negative identity'. This identity seemed to them to have been forged helplessly and without their involvement. This finding may reflect the shame which many researchers have discussed for children and families experiencing the mental illness of a parent (e.g. Corrigan & Miller, 2004)

In Theme B, the **'Beginning the motherhood journey',** we see the women beginning a journey which seemed to be constructed in reaction to their childhood with many participants fearful of having children. What typified many participants was the fear which preceded pregnancy and most importantly the content of that fear. Many participants shared not just a fear, but a 'terror' of inflicting psychological harm upon their children. What is unique in this presentation is that their fear was not set in any evidenced part of their own personality, nor had it developed because they had come to know their own extreme unpredictability or aggression or cruelty, but simply because they feared that their childhood predisposed them to turning into a 'bad person', or specific to this study a 'bad mother', without their volition.

The early themes in Theme B.1., seem to suggest that many women with relevant backgrounds might suppress their maternal feelings in order to prevent inflicting harm and also that anxiety, perhaps suppressed, would be common in their pregnancies and adjustment to becoming and being a mother. Further, in this theme, arguably, participants seemed prone to assume selfishness of themselves rather than fearfulness in this process. This is not in any way to connect a non-desire to have children with selfishness; it is simply to explain what might underpin such decisions in daughters of mothers with EMHD. In her 2007 book *Daughters of Madness,* Susan Nathiel interviewed women who had grown up with mothers experiencing EMHD, some of whom had not become mothers (Nathiel, 2007). This may in itself suggest fearfulness on the part of daughters. In general, the participants in the current research confirm that they too did not know other daughters of EMHD who had children. This, of course, could represent either fear or lack of disclosure. In Theme B, we start to see the backward and forward processing which participants appeared to rely on in order to endeavour to construct positive maternal behaviour. Their experience of fearfulness prior to and during pregnancy described in Theme B clearly stemmed in their view from their childhoods and these fears also move forward and are reflected in Theme C, 'the mother I am today'.

In Theme C, **'The mother I am today',** themes represent the reaction of participants to their childhood as they construct their image of themselves as mothers, that is, their maternal identity from the standpoint of the mother they fear becoming and the mother they do not want to be. These reactions and constructions are continuous in deriving their subjective maternal experiences, how they view themselves as mothers in terms of this aspect of their identity and how they think that others view them in terms of this identity. As participants' accounts move further into motherhood, reactions are split, but with many participants describing still being fearful of causing harm - and specifically psychological harm - to their children. Such fears fuelled the need for approval particularly from their children and most pertinently for many participants, from their daughters. This gave rise to even more deeply-entrenched fears and multidirectional processing as they appear to fight to avoid what they have processed as the inevitable, i.e. that they are doomed to fail as mothers. We then see these mothers almost obsessively trying to avoid mental illness, even depression, and all

aspects of their mothers' character, illness and preferences in order to preserve positive distinctiveness (Breakwell, 1986) from their mothers. Here, we begin to fully appreciate the energy these women put into their mothering and into the active construction of a maternal identity in stark contrast to their perceptions of their own mother. This sets these women apart from mothers in general who would usually want to borrow something of the behaviour and culture of their mothers, although it would be entirely usual to wish to drop other aspects of their mothers' behaviour. It seems also that no amount of effort, as supported by the conceptual theme of 'striving' (Theme C1), is able to enhance participants' self-esteem as mothers, thereby preventing them from knowing and learning a stopping point for effort and distinguishing a healthy boundary between themselves and others. We see most mothers 'waiting to fail' (Theme C.2.iii) as a mother and forcing themselves towards positive outlooks in order to avoid mental illness. We see also many women's experience of mothering as characterised by a lack of joy and constant self-doubt. Consequences and fears in particular for their mother-daughter relationships are particularly poignant.

In Theme D, **'Making sense of my journey'**, we see the greatest implications for participants' construction of their identity. The results of the backwards and forwards processing and multi-layered processing is seen most keenly, with impact upon all relationships and clearly reflecting the construction of an identity through external field-dependent processes. This connects with the last theme described in Theme A.5, discussed above, in which participants' accounts represent their lived experience as children in their feeling that their mothers were reflected in them. In view of this, it is easy to understand the impact upon not only their perceptions of their identity as mothers, but the identity which many women feared or perceived to be relevant to them even as prospective mothers, or indeed for some as avoidant mothers. I contend that the most important finding in this research is the suggestion that counselling psychologists look to research and inform treatment and support for daughters of mothers who suffer EMHD into the possibility that these daughters would benefit from exploration and perhaps desensitising of the impact of their lives with their own mothers upon their own perceived abilities as mothers. This would facilitate a distinctive and positive identity of themselves in their own lives, although therapy would necessarily be unique to the individual and the formulation. More information is needed as to how these women may be processing their identity and the fearful position

(external to them) from which it is suggested that their processing may stem, particularly when this pertains to motherhood.

Participants' overriding emotional response to motherhood could be said to be the experience of fear, sometimes expressed more as anxiety and concerning the potential to develop mental health problems and inflicting psychological and/or physical harm upon their children. For some participants, this fear and anxiety regarding motherhood and mental health seemed to occur as early as when considering pregnancy, which may indicate the depth of this concern for women whose own mothers' mental health affected them as children. In general, it was found that participants had not shared their fears with anyone and therefore were likely to lack support. Much of their concerns were bound up with insecurity about their identity and a feeling of being 'odd' compared to other people, with some fearing that their children would find them odd or lacking as mothers. It seemed that their insecurity was largely about a fear that they would not be able to provide a positive environment, as well as the ability to cause harm unknowingly to their children.

It is notable that there was not one example in accounts in which a participant stated, 'I fear for myself' in their desperation to avoid mental illness. Without exception, the preoccupation of these women as mothers concerned their potential to cause harm which, in of itself, is suggestive of the quality of mothering they endeavoured to offer their children. It may be that they tried too hard or gave too much. However, this potential inability to bracket themselves from their children was also their strength. Each mother gave numerous accounts of not only their absolute loving intentions towards their children but their desire to give their children wholesome lives and to bring them up to care for others and for themselves. There were no instances to suggest blind overindulgence, but many instances to suggest sensitive and devoted parenting.

In terms of the implications for future research and Counselling Psychology practice, perhaps the greatest risk to participants, as illustrated by this study, seemed that of exhaustion through effort. More research is needed to ascertain the ways in which exhaustion has affected daughters of EMHD during their experiences as mothers. Further, in terms of therapeutic

support, extensive qualitative research is recommended regarding how role reversal in childhood might impact upon mothers who are daughters of EMHD when they themselves become mothers. Research already suggests that the negative effects of role reversal in childhood may be particularly poignant for daughters (Kabat, 1996; D'Arcangelo, 2004; Alexander, 2003). In line with this, accounts in this study seemed to show that despite their dedication, these mothers lacked confidence in themselves as mothers. It is recommended here that further qualitative research be undertaken into the early stress experienced by daughters of mothers with EMHD and their future confidence and subjective experiences as mothers.

Most participants spoke of difficulties in communicating their feelings to others in general and did not usually talk to anyone about their childhood. Future research into the coping mechanisms employed by these daughters when they become mothers and the role which their childhood might play could be valuable. Research would be beneficial that focusses, in particular, on helping women to accept and value their uniqueness as mothers and to place reasonable expectations upon themselves as mothers. Arguably, if an individual sets their own standards and is unable to meet these, then they have set them too high. It is common for young carers in general to lack an appreciation of reasonable limits for themselves (Aldridge., & Becker,1999/2003), often unknowingly (Smyth, Blaxland & Cass, 2010) and all participants in this study were young carers before they were adult carers. Wagenblass, 2005) found that anxiety and exhaustion were common in child carers which suggests that these children are unable to cease when tired (a simple right for a child). It may be that pushing themselves to the point of exhaustion becomes habitual also for daughters of mothers with EMHD. At least for these participants, this suggests a need for both research and for counselling support in self-esteem, facilitating communication, valuing their experiences, strengths and vulnerabilities, and dealing with related symptoms of anxiety.

Future research in relation to daughters of mothers with EMHD concerning how women's own experiences of being mothered might impact their perceptions of their identities as mothers and the value of this role and of themselves within this role (Steinberg, 2005), would be particularly relevant to future therapeutic outcomes, and for which further IPA research could be especially informative. Of particular importance, could be further qualitative study

of areas related to *role-reversal*, *parentification* and *social constructions of gender* (Kitzinger, 1987; Capdevila, Ciclitira, Lazard & Marzano, 2006).

A paradox for qualitative researchers is the need for caution in considering the possibility of addressing future research on the basis of research findings. It is easy to fall into a quantitative mode and begin the hunt for the existence of 'variables' which come to light (Silverman, 1993/2001/2006). Qualitative and quantitative methods share many common aims, but it is important to conduct research methods and to evaluate outcomes appropriately, both in terms of the method (as in the research 'tool') employed and the methodology (as in the justification for the use of the method and approach). It is also difficult to balance the need to explore accounts in IPA research, with the role of being a counselling psychologist, although as discussed above, it is important to do so. However, doing IPA can be likened to counselling in that the more examples of uniqueness that emerge the greater the 'tools' available as researcher or as counsellor. It is with this in mind that the author urges for more research in this area to consolidate and further explore the already poignant research findings concerning the long-term challenges and strengths of children who have grown up amid their mothers' mental health difficulties and specifically, their experiences as mothers. There is a research gap here concerning the absence of women's profound accounts.

5.5 Conclusion

Any conclusions drawn from the personal experiences of these participants are potentially contextual to this study and must be tentative. In view of this, it might offer further insights to interview separately in a detailed IPA study individual daughters who are mothers to further investigate identity processing. I have not focused specifically on attachment or gender identity, but would in future research, which would follow this initial understanding of these participants, though none spoke specifically about their gender this time. In speaking about motherhood, and as women, these participants were necessarily immersed within the subject of gender and attachment. Further, there was some evidence of participants' views of the value of their childhood experience in the development of themselves as a mother. It is with particular reference to the low self-esteem expressed by all participants that it would be beneficial to study the strengths that women with this experience in childhood might have as mothers.

5.6 Ethical issues

The most important feature of any study should be the attention throughout to ethical issues. The consideration of ethical implications is of greater value to psychological research in general than the findings of any individual study. The perspective of the interviewer in this study was potentially both a threat and a protective factor in terms of reflective and respectful practice. Achieving the latter, is arguably, both a factor of the integrity of the researcher and also the researcher's decision to be continually mindful of possible pitfalls. There was the potential for 'one who thinks they know' to contaminate the accounts by leading participants in a desired direction. Every attempt was made to bring to awareness potential threats to confidence and relevance (Gaskell & Bauer, 2000) in the belief that awareness could minimise unconscious threats to the most authentic representation of the view of the participants.

Of concern is the idea of a rather piecemeal necessity to offer participants information about counselling post the interview. In retrospect, a preliminary questionnaire and discussion as to whether the participant would seek counselling if required post interview would have been sufficiently protective. It may also be helpful to know specifically whether participants already had experience of counselling. The issue was that regardless of how frequently participants' understanding of consent and desire to still consent to undertake this research were checked, it was impossible to guarantee that this was informed consent. A consideration for Counselling Psychologists is that consent is, to some extent, a factor of hindsight as one can only know how they feel after they feel it.

5.7 Relevance to counselling psychology in general

This study offers further insights into some of the possible experiences and difficulties which children of parents with mental health difficulties might face in their adult lives (Huntsman, 2008). This study goes some way towards demonstrating the range of difficulties which children whose mothers have mental health problems might experience when they themselves become mothers. Although this study applies only to a small sample, it is of possible relevance more broadly to daughters, women and mothers and their experience of being

mothered. It provides food for thought in all areas of childhood and parenting and the effect of mental health therein.

5.8 Theoretical underpinning of the research

Identity processing is central to this research and its findings. Social psychological research has been traditionally divided into three general topic areas which view social interaction and its consequences from an *intrapsychic* level (focussing on self and attribution processes, attitudes and the formation of impressions), an *interpersonal* level (focussed on attraction and close relationships, and prosocial and/or aggressive behaviour) and an *intergroup* level (in which psychology seeks to understand social influence processes between groups and the impact on individuals). The participants in this study would appear by these topic areas to be prone to devise their individual maternal identities largely through interpersonal processing, having less sense of themselves intrapsychically.

In Identity Process Theory (IPT), Breakwell (1986/1996) has endeavoured to more directly address the perception of threat to identity. Breakwell borrows the Piagetian concept of assimilation-accommodation and evaluation principles and outlines four major principles of identity: self-esteem, continuity, positive distinctiveness and self-efficacy which are involved in these early concepts from Piaget. I owe much to the influence of Breakwell in my endeavour to understand the processing involved for the participants in this study and their construction of 'threat' to their maternal identity (Breakwell, 1986, 92). For these participants, future fears for their actions as mothers, rooted in their childhood experiences, constituted maternal identity threats.

Mothering is linked with notions, particularly cultural perceptions of femininity and gender (Arendell, 2000) and early studies tended to focus on the natural (as it was perceived) and the essential role which mothers play in the development of their children (Gerson, Alpers & Richardson, 1984). More recent focus has been upon the social institutions and circumstances which construct and affect the perception of motherhood for groups and individuals (Arendell, 2000; Baber & Allen, 1992; Glenn, 1994; Thompson & Walker, 1989). Less research is focussed upon the ambivalent attachment and the potential present for many of the

daughters in this study as children of mothers with mental health difficulties, and also fluid identity.

5.9 Potential model and structure

The concept of a model seems counter to a phenomenological study and therefore the outline of suggested processing studied below is offered only in an attempt to support counselling psychologists towards the understanding of the participants in this research and other women whose circumstances may in any way be connected.

5.9.1 A 'Triple' process and multi-layered reflection

Participants spoke frequently of their experience of motherhood as having several fundamental aspects. Their layered approach to their experiences could be partitioned into three primary focuses if the assumption is that motherhood triggered the direction of processing. By this thought, their preliminary processing would seem to consist of experiencing motherhood as an 'event' which caused participants to revisit their own experiences of their mothers when they were children. Whilst this may be true of all mothers, their secondary process, which consisted of reconnecting with negative and fearful childhood experiences with their own mothers, seemed to represent, for these women, the biggest impact of motherhood upon them. This in turn strongly affected how they viewed themselves and their abilities as mothers; in other words, their perception of their 'identity' as a mother. Therefore, their tertiary processing appeared to involve the impact upon identity of the continual reprocessing of the first and second processes already described (i.e. motherhood in the light of their childhood and specifically, negative experiences with their mothers). This featured strongly in their overall perceptions of themselves as mothers, in their retrospective view of themselves and their experiences as children, and the continued evolution of both. This suggested that their perceptions of their identity appeared changeable to them, as their identity processing took them through the fight against the mother they feared becoming. Participants' fear, as expressed by many, that they may have no control over negative behaviours which might emerge as a consequence of their childhood suggested an identity that phenomenologically was experienced as fluid and helpless. It is perhaps participants' inherent understanding that identity should be static that might best explain their fears.

However, the direction of participants' processing of their identity as mothers seemed more complex than the three processes described above, although the model above is likely to be initially beneficial to women in counselling if utilised within sensitively engaged Cognitive Behavioural Therapy As described, many participants appeared to initiate their motherhood journey (Theme B) with an almost phobic quality in which the 'event' that triggered all thoughts, feelings and fears about being a mother did so prior to being a mother. There were exceptions and divergences which are vital to IPA research. Therefore, the attempt is not made here to homogenise results. Where participants felt fearful of motherhood, the triggering event appeared to be childhood. For many participants, accounts suggested that their memories of their own childhoods were shaping their experiences of motherhood before the event of motherhood could be processed. There was a sense within the interviews that participants felt that their identity was constructed without their input. Such themes as 'waiting to fail' (Theme C.iii) illustrate this. While it would be unethical to pressurise daughters of mothers with EMHD into counselling, the current research suggests that as children it would be helpful if they were on the counselling psychologists' radar to support them towards a positive identity prior to adulthood.

5.9.2 A fluid and evolving identity

In the context of this research, these women's perceptions of themselves as mothers seemed fluid. Their perceptions of themselves as mothers were evolving from the continual circular reprocessing described, and were rarely stable perceptions. It seemed as a researcher as if their childhood experience was persistently changing their perception of their identity, as they processed the past and present concurrently, and with great energy and purpose, as is seen through the concept of 'striving' (Theme C1). Many women reported that they would say what others wanted them to say in order to preserve a positive identity. A positive identity in the eyes of another was a strong indicator of their own worth. However, their own deep-rooted self-doubt made it difficult for them to accept the positive judgement of others.

5.9.3 Historical view that stability in identity equates with mental health

If the triple process described above is viewed separately from the specific research question, it suggests more broadly a model of identity in which an event produces experience, which

triggers remembrance of the experience of events which the individual processes as being connected events, following which, experience and continual re-interpretation constructs identity. What arguably cannot be captured by a model and is highly relevant to Counselling Psychology, and Interpretative Phenomenological Analysis specifically, is the nature of the individual's unique interpretation of their experience. As stated, identity as a process is not in itself novel in research, nor that it is fluid in some sense but there is less description in research of identity as evolving and therefore rarely stable and yet not pathological.

Historically, identity theorists have argued that the self consists of a collection of identities, each based on the occupation of a particular role (Stryker, 1968; Stryker & Burke, 2000) which would imply a fairly static personality but within each role. In its evolution, identity theory has focused on the self as comprised of various roles (Simon, 1995) that link a person's identity (or self-attitudes) to their role, as well as the relationships and the role-related behaviour associated with these. The emphasis in research has been largely that our identity is held within a fairly solid personality. Although various research has looked at identity as more fluid, it has been thought that for identity to be too changeable and unpredictable would reflect insecurity which would possibly underlie pathology in the individual's personality. Identity conflict theory (Breakwell, 1986; 1996) in itself supports the existence of a fairly static identity from which to perceive threat to identity. Breakwell (1986/1996) suggests that a threat to identity can be defined as "occurring when the processes of identity are no longer able to comply with the identity principles and various intrapsychic, interpersonal, or intergroup coping strategies are employed in an attempt to restore feelings of self-esteem, positive distinctiveness, continuity and self-efficacy." Such views are compelling as they are strongly held within Western culture, serving to create the potential for anxiety and the need to know 'the kind of person' we are, as if this should be static and reliable in order to represent psychological health. Evaluations of this belief can in themselves affect identity as seemed the case in the women studied in this research and who showed no obvious evidence of pathology (Howarth, (2002).. Such 'thinking about thinking', or meta-cognition (Wells, 2009) as it has been described in psychological research, is central to the identity processing which emerged in the multi-layered form described here. Counselling psychologists could emphasise supporting positive change in the way that daughters of

mothers with EMHD might be ‘thinking about their thinking’ to reprocess a positive identity. It is put forward that for daughters of mothers with EMHD, there may be many co-existing multiple identities, born of the need to adapt as children which create further identity conflict for the individual. I would like to advance a new emphasis in identity research, which will be described in two IPA papers which will follow this research which concern the health of fluidity in identity. Both papers will involve the new model (or Counselling Psychology research and therapeutic tool) which I will describe which incorporates the in-depth studies I have conducted.

5.10 Self-other acceptance identity processing theory

Self-other acceptance identity processing theory’s intention is to promote healthy self-other relating and to discourage self-limiting concepts of individual or other identity and will be described in papers to follow.

Chapter 7. A Critical Literature Review in partial fulfilment of BPS Chartership in Counselling Psychology

Great expectations: Overburdened children and implications for adulthood

The emotional adjustment of children, and its predispositions and possible determinants, have been the subject of many investigations and studies. Indeed, the 'nature-nurture' debate (e.g. Klein, 2000) is long-standing, and it is generally agreed that both biological and/or genetic factors, as well as environmental processes, are involved. However, research largely supports the view that the nature of parental responsiveness is an important factor in children's intellectual, social, and emotional adjustment (Baumrind, 1971; Farrell-Erickson, Sroufe, & Egeland, 1985; Pettit & Bates, 1989; Rothbaum & Weisz, 1994; Solomonica-Levi, Yirmiya, Erel, Samet, & Oppenheim, 2001). In other words, "The ability of parents to support their children in processing and integrating complex and negative situations relates to positive emotional adaptation." (Oppenheim, Emde, & Wamboldt, 1996, p. 674).

Much research equates the inability to offer appropriate support with parental behaviour, which involves child abuse or neglect (Sports Council Northern Ireland, 2006). This could include physical abuse (the deliberate physical injury of a child, or the wilful or neglectful failure to prevent physical injury or suffering) and/or sexual abuse (involving, forcing or enticing a child to take part in sexual activities, whether or not the child is aware of what occurs, and including many non-contact activities). Moreover, a growing body of research investigates the effect of the emotional neglect (the persistent failure to meet a child's physical and/or psychological needs, which is likely to result in significant harm), and the emotional abuse (the persistent emotional ill treatment of a child such as to cause severe and persistent adverse effects on the child's emotional development). An extreme form of inability to meet a child's needs could be said to be 'Fabricated Induced Illness' (previously described as 'Munchausen's Syndrome' by proxy), in which parents, usually mothers, are said to be so damaged in their own attachment needs that they seek to meet their unmet needs by damaging their child's health, and attempt to fulfil their own pathological need for attention and recognition via the medical attention this brings (Lazenbatt & Taylor, 2011; Vennemann, Große Perdekamp, Weinmann, Faller-Marquardt & Pollak, 2006). Definitions

and further expansions can be found at the Sports Council, Northern Ireland, and the National Society for the Prevention of Cruelty to Children (NSPCC) and The Children's Society. However, insufficient recognition is often given to the probable increased likelihood for women who are left isolated as mothers to need care and support themselves, which can be almost completely absent.

Yet research is less prominent and findings are less clear in areas in which children might be neglected, oppressed, utilised, and potentially emotionally damaged because of the circumstances of their upbringing that involved them being overburdened. These children might not necessarily come to light as being considered to be at risk - although some of them will - but they are overburdened in such a way as to potentially affect the course of their personal development, and in a way that is likely to impact upon their future relating. The research explored in this Critical Literature Review involves issues relating to situations in which children have unreasonable responsibilities for the adults who, in an ideal world, would be supporting them; or children who undertake roles prematurely and routinely as children, that are usually and essentially parental roles. In other words, these children are *parentified* (Castro, Jones, & Mirsalimi, 2004; Mayseless, Bartholomew, Henderson, & Trinke, 2004; Thomas et al 2003; Wells & Jones, 2000). What remains clear, is that research cannot yet sufficiently direct therapy towards identifying consistently and comprehensively what is, or what is not overburdening for individual children and their situations, or how best to ensure that overburdened children are identified and supported **(**Chase, Deming, & Wells, 1998; Kerig, 2014).

The term the *parental child* was first identified by Minuchin and colleagues (Minuchin, Montalvo, Guerney, Rosman, & Schumer, 1967), largely in discussion of children who took on parental responsibility because of socio-economic conditions. Later, research by Broszormenyi-Nagy and Spark (1973) highlighted an alternative definition of *parentification*, as "the expectation from a parental figure that a child will fulfill a parental role within the family system" (cited in Earley & Cushway, 2002, p. 165). The difference between these two schools of thought therefore, alerts to the possibility that a child may become parentified due to either family position, or family dysfunction and expectation, and perhaps with differing long-term effects.

Chapter 8. Review focus

It is relevant to highlight that this review may focus slightly more upon literature which relates to overburdened children, as it pertains to mothers and daughters, and mother-daughter relationships (Mesidor & Mary, 2015). This represents a slant or focus in the literature, and is not actually intended to present as an emphasis in terms of this Critical Literature Review. The literature suggests that role reversal is perhaps more likely in females, which can be intergenerational (e.g. Obegi, Morrison, & Shaver, 2004), and may be potentially more detrimental for daughters (Ackerman, 1989; Agnew & Robideaux, 1998; Alexander, 1993/2003; Brown, 2001). However, future research may show developmental changes and contemporary effects upon the importance of either gender in role reversal (e.g., Pilcher, 1998). Additionally, where research exists, a further emphasis is on the experience of living with parental mental illness, and is the focus of the empirical research *(*Falcov, 1998/1999/2004*)*. The literature on this and other related issues is considered with respect to the relationship which overburdened children may have with themselves and others in adulthood.

8.1 Part 1 – The 'normal' expectations of childhood

8.1.1 The diversity issue

Considerable cultural, situational, and temporal variation exists concerning the appropriate treatment of children. This has led to much debate about what the *normal* expectations of childhood should be, and what might constitute being *overburdened* in childhood. More recent research has moved towards taking a more realistic view of children and childhood, and to discourage viewing childhood through 'rose coloured spectacles'. Such research describes that whilst it is without question that it is essential to protect children, the need to account for the variety of life circumstances in which childhood can take place in order to offer children the information they need concerning both their rights in general and the support that is most appropriate to them, figures largely (Butler & Astonbury, 2005, Dierks, 2001; Waters & Deane, 1985).

8.1.2 Diversity and setting standards for childhood

Whilst there is a need to discuss the setting of acceptable standards for childhood (Robson, 2000/2004), if it is to be useful, research needs to reflect issues of practicality and diversity in children's lives. An example of the diversity aspect is culture. Robson drew on an interview-based case study of young people in Zimbabwe caring for dependent adult members of their households. This work highlights the fact that global and cultural factors affect the subjective experience of childhood, and that the expectations upon children will vary accordingly (Robson, 2000/2004).

Robson's research is an example of the need for standards to be relevant to children's lives. Robson argues that care-giving by young people is a hidden and largely unappreciated aspect of national economies, and that young people have a right to recognition of their work as 'work'. According to Moore and McArthur (2007), Robson posits that more attention should be given to defending children's rights and to supporting them in their circumstances.

Whilst culture itself can constitute a confounding variable, so too could any aspect of diversity, and although Robson's work is specifically relevant to cross-cultural issues, it is also reflective of the fact that *difference* of itself is an important variable to consider when evaluating what the normal expectations of childhood could be considered to be. If we do not account for the extent to which certain factors define the lives of particular children, the setting of *standards* for childhood has little meaning or relevance to children. Robson's article adds to the growing literature on the geographies of childhood, which tackle the imbalance within the literature, in that research has to some degree neglected the diversity in children's lives (e.g.Macfie, Fitzpatrick, Rivas, & Cox, 2008; Smyth, Blaxland, & Cass, 2011a; Smyth, Blaxland, & Cass, 2011b).

8.1.3 Further need for caution

In addition to the diversity issue, further caution is needed when discussing the nature of the parent-child relationship, to avoid assuming this relationship to be didactic, that is, from parent to child. Many studies have explored the influence of child characteristics (Crockenberg, 1981), upon the parent-child interaction and have outlined the role the infant plays in shaping relationships with parents **(**Macfie, Fitzpatrick, Rivas, & Cox, 2008). In a

longitudinal study, Van den Boom and Hoeksma (1994) pointed out that we cannot assume a one-way influence. For example, parents who seem to be *controlling* may have irritable babies, but we cannot assume cause and effect, as with irritable infants, since interactive behaviour can become focused almost exclusively on negative emotionality, which can cause parents to become more controlling (Priel & Besser, 2000).

Care should also be taken in avoiding the automatic assumption that the roles of child-carers are necessarily detrimental to children. There are a number of factors for consideration in this debate. It is possible that a child may perform a supportive role towards their parents but is not a persistent carer and therefore may not necessarily incur any long-term effects from this. Further, it is important not to confuse the occasional or emergency caring responsibilities which young children may from time to time become involved in, with longer term *role reversal* (Aldridge & Becker, 1999; Falcov, *2004;* Mayseless, Bartholomew, Henderson, & Trinke, 2004). Not only is there considerable diversity in individual children's lives, it also lies in their needs within their families as micro-cultures (e.g., Aldridge, 2003; Aldridge & Becker, 1999). For instance, where there is a family member with a special need, other children may benefit from information which is age-appropriate in order to function within that family. Moreover, siblings may also benefit from understanding that at times, the needs of others might be greater or different from their needs (Hastings, 2003a; Macks & Reeve, 2007).

Learning about the *other* is an important part of children's social and educational personal growth. In particular circumstances, a different adult-child balance might be required according to the structure, or the nature of the family membership (Butler & Astonbury, 2005). When relating this directly to the issue of the overburdening effect upon children, it could be argued that it can be healthy for children to take on multiple roles, provided that these do not significantly and negatively interfere with their social, emotional, educational, and developmental needs, (Carers National Association, 1996). Increasingly, research suggests that respecting children's perspectives and supporting children in their lives is key to their current and also long term wellbeing *(*Aldridge, *2006;* Falcov, *2004*).

In synopsis, it is crucial not to take too simplistic a view of the complexity of the parent-child dyad. However, when a child is overburdened, their adult-related role is disproportionately large compared with the tasks of childhood, hence the child is *parentified* (Castro, Jones, & Mirsalimi, 2004; Mayseless, Bartholomew, Henderson, & Trinke, 2004; Thomas et al. 2003). More recent research has highlighted that whether or not a child is overburdened is likely to depend upon the support the child is afforded taking precedence with sufficient frequency (Smyth, Blaxland, & Cass, 2011), together with their consistent knowledge, and that of those around them, regarding the boundaries of their role in any adult care or involvement. Research into the parentification of children describes the need for children to know both when, how, and by whom their needs might be met, and when and where their *roles* and the roles of the adults around them, begin and end (Byng-Hall, 2002; Castro, Jones, & Mirsalimi, 2004; Jones & Wells, 2000). There is also a need to acknowledge children's feelings about their roles in their families, and to endeavour to support them so that their own needs can be met in connection with and outside of these roles, so that they can also differentiate and experience themselves external to these roles. This also reflects the need for a shared understanding of the limits and boundaries between children and their carers (Byng-Hall, 2002; Jones & Wells, 2000).

8.1.4 Overburdening explained

It would seem from the literature that what would most overburden a child would be the persistent undertaking of roles which replace a parent in their own life as a child, and which therefore require them to *parent*, or befriend others, in the absence of the receipt of sufficient and appropriate parental care themselves (Castro, Jones & Mirsalimi, 2004; Crothers & Warren, 1996; Elliot & Thrash, 2004). Therefore, arguably, a young person might care take without detriment, if their own needs were well met, a fact that would need to be very carefully assessed.

Parentification has been identified as role reversal, and/or a caring activity at a level which is in any way age-inappropriate and would therefore be likely, if persistent, to overburden a child. Earley and Cushway (2002, p. 165) identify that:

Another term that is also used to describe the phenomenon of parentification is ‘role reversal’. This describes a child acting as parent to their parent, or a child acting as a ‘mate’ to their parent. Parental role reversal might include defending or nursing the parent, or acting as parent to siblings [see Kabat, 1996] (Earley & Cushway, 2002, p. 165).

It is important to recognise that the literature cites both the child-as-parent and the child- as-friend to the parent, as inappropriate role reversals (Brown, 2001; Mayseless, Bartholomew, Henderson, & Trinke, 2004). The child-as-friend scenario refers to the child acting as the parent’s confidant and/or decision-maker, or indeed as an emotional partner, all of which would be *overburdening* for children.

Meanwhile, role reversal could include being a carer of an adult/s or sibling with the regularity and detail which might be considered more appropriate for an adult, as opposed to emergency care; having to comfort and care for themselves rather than be cared for; or having to care for a family member whose judgement is so impaired as to prevent the provision of emotional and physical care at an appropriate level for the child’s emotional age, such as with mental illness (e.g., Wagenblass, 2001). Both the level and frequency features in burdening a child, and also the absence of appropriate care and respite for the child themselves (Wagenblass, 2005). Role reversal could also involve gratification of the “parental figure’s sexual, aggressive or dependent needs” (Broszormenyi-Nagy & Spark, 1973, cited in Earley & Cushway, 2002, p. 165). Additionally, all forms of child abuse could also be said to overburden children emotionally, physically, and psychologically in age-inappropriate forms, and to render them highly vulnerable as children (NSPCC/GP Practice Notebook, 2017). As adults, this translates particularly to social and relational difficulties and long-term negative consequences for wellbeing (Brynner, 2001). Stated as such, this alludes to the severity of consequence for a child who is overburdened in childhood. Of high risk, is the possibility of what has been termed the *Imposter Phenomenon*, whereby children, and ultimately adults, persistently aim higher, often more than is achievable, and are persistently unable to internalise any feelings of success (e.g., Castro, Jones, & Mirsalimi, 2004).

It may be that viewing all forms of child-abuse as overburdening children inappropriately with the needs of adults and adulthood, is helpful. It could contribute towards minimising the

discomfort, pathology, voyeurism, and tainting which can surround child-abuse in general and which may feed into children's difficulties in disclosing abuse when abuse occurs (Alexander, 1993). This may also serve to avoid any kind of dismissive comparison. Naturally, this viewpoint is not intended to minimise the deeply destructive impact upon children of any form of abuse.

8.1.5 Assessing harm

It is not always helpful to see harm as a continuum but it is important to take the impact of overburdening children seriously, and to view this as having profound potential for harmful outcomes, whatever its nature, extent or context. Routine role reversal and the unreasonable expectations upon children to perform emotional or physical duties that are not undertaken by the adults in the child's world, or to undertake inappropriate involvement in the care of others, or in meeting the needs of others, has been found to constitute some or all of the following areas of neglect and deprivation, which can result in harm to healthy development:

- emotional neglect and/or lack of emotional support (including the absence of helpful interaction), or emotional deprivation;
- medical care neglect and/or refusal of a required treatment by parents of the child;
- gross safety neglect, resulting in actual or potential injury, secondary to gross lack of supervision or a hazardous home environment;
- educational neglect, which although dependent on local laws, constitutes persistent non-attendance at school or a suitable alternative; and,
- physical neglect, including inadequate food, clothing or shelter, where preventable by the parent (Earley & Cushway, 2002; Kabat, 1996).

The overburdened child is likely to be involved in role reversal and care-taking activities for which it is not developmentally prepared. The existence of harm to *normal development* as a result of being overburdened is complex to identify. On the basis of considerable research there can be a reasoned assumption that overburdening children will cause harm to healthy development, but this discussion will always be hampered by disagreements regarding what constitutes 'normal'. Even if the term *normal* is replaced by the term *reasonable*, factors such

as diversity constitute persistent and confounding variables (Becker, 2007; Moore & McArthur, 2007; Pilcher, 1998; Robson, 2000). Ethical responsibility presupposes that research has to be necessarily retrospective, which means that personal histories and perceived outcomes are the only way to assess harm to development (Farrell, 2005a; Farrell, 2005b; Lackey & Gates, 2001). However, it is perhaps the earliest evidence of the potential for role reversal to be detrimental between parents and children that presents the strongest case for the existence of long-term negative effects (Priel & Besser, (2000). Subjective experience will therefore constitute relevant support for the existence of evidence for harm or detrimental effect.

Research into adolescence suggests early evidence for the potential for long-term psychological harm. For example, research has found that adolescent young carers have been identified as having significant worries and problems in relation to their well-being, over and above any *normal* adolescent difficulties (Cree, 2003). This suggests that being a young carer might have important implications for later relationships, particularly as adolescence is a key stage for the healthy development of identity (Falcov, 2004). In relation to maternal mental health difficulties, Oyserman, Bybee and Mowbray (2002) found increased youth and adolescent anxiety and poor self-efficacy. Much research suggests a high risk of negative long-term mental health outcomes, and the potential for the mental health of a parent and low parenting confidence to negatively impact educational and emotional outcomes (e.g., Oyserman, Bybee, Mowbray, & Hart-Johnson, 2005). A large bank of research suggests that this can be intergenerational **(**Dierks, 2001; Elliot & Thrash, 2004; Oskouie, Zeighami, & Joolaee, 2011; Obegi, Morrison, & Shaver, 2004; Smyth, Blaxland, & Cass, 2010/2011; Miller, Warner, Wickramaratne & Weissman, 1999), in terms of both attachment style and self-perception (e.g. Kretchmar & Jacobvitz, 2002); However, intergenerational outcomes, may simply signify a chronic lack of appropriate support, as support has been positively related to positive self-perception as a parent (DeVito, 2007) as well as mothers' perceptions of child temperament (Priel & Besser, 2000/2002)

8.1.6 The extent

Within the last decade, a number of projects have been set up to assess the need for support amongst child carers. Research projects have found that young carers are likely to be taking

care of a relative who has a long-lasting physical illness, mental ill health, disability, a substance misuse problem, or frailty. Definitions of a *young carer* vary but most refer to considering that care provided must either be:

- significant and more appropriate for an adult and/or,
- substantial and regular and/or,
- restricting the young person's life, and/or,
- given in the absence of formal/informal support (Dearden & Becker, 1998, cited in Underhill, 2003).

Dearden and Becker (1998, cited in Underhill, 2003) surveyed 2,303 young carers from 69 young carers projects, and produced some staggering statistics concerning the number of young carers, the extent of their roles as carers, and the level of neglect and overburdening they experienced. They noted that:

- The average age for young carers was 12.
- 54% young carers lived in single parent families.
- 58% cared for their mother.
- 1 in 3 regularly missed school or had educational difficulties because of their caring role.
- 63% cared for a relative with physical health problems.
- 29% cared for a relative with mental health problems.
- 1 in 5 provided intimate care.
- 1 in 4 had no external support (other than through their local young carers' project).

(Reproduced from: *Unseen and Unheard* - based on the work of the Lewisham Young Carers School Development Project, cited in Underhill, 2003).

Accurate figures on children who are carers are difficult to obtain because of the hidden nature of caring (Becker, 2007; Robson, 2004), the differing racial, cultural, and religious needs (Butler & Astbury, 2005. Project Cork, 1996-2005), and the diversity of family structures. Dearden and Becker (1998, cited in Underhill, 2003), quote The Children’s

Society (www.nspcc.org.uk) as stating that in London there are likely to be about 7,500 young people between the ages of four and nineteen who take on caring responsibilities. Research published by the Health Services Management Unit at the University of Manchester, United Kingdom (UK) in March 1995 indicates that there are probably between 15,000 and 40,000 young carers nationally. This was based on an evaluation of the first three young carers projects on Merseyside (Bilsborrow, (1993) and suggests that in 2004 the average age of young carers in contact with projects was twelve. Indeed, one in ten of the young carers was caring for more than one person. Fifty-six per cent of the young carers were from one-parent families; forty-four per cent had been caring for three to five years, and eighteen per cent for six to ten years. A survey by Barnardo's and the Carers National Association revealed that children as young as nine are neglecting schoolwork and friends to look after parents with disabilities or mental health problems (taken from Barnardo's, 1992 in Mind Factsheets). However, in 2005, Butler and Astbury conducted an evaluative case study of *The Cornwall Young Carers Project*, and suggested that at least in Cornwall, UK, existing referrals are only the tip of the iceberg in work with young carers.

8.2 Part 2 - Great expectations: parentification and overburdening in childhood - detrimental and adaptive in adulthood

8.2.1 The longer-term effects

As stated, caution is needed to ensure that research reflects diversity. Research into parentification and role reversal has frequently failed to reflect that there are many circumstances that could cause children to become parentified. For some, this aspect of their lives may not be the worst and may even be rewarding compared with other events. Children who live in single parent families, or are orphaned and have younger siblings they care for, or who have experienced trauma and tragedy (Carroll & Kooyoomjian, 1998) might find comfort in being able to cope with adult-related tasks, especially in looking after siblings. In this sense, parentification could be viewed as an adaptive response (Stein, Rotheram-Borus, & Lester, 2007). Although an adaptive response does not necessarily equate as beneficial long-term, some research does point to the beneficial aspects of being a young carer. Seligman and Czikszentmihlyi (2000) put forward that activities, even as a young carer, can equally provide an absence of stress or distress, and be positive components of good health. Central to an overview of research findings to date is the need to comprehensively support children in their lives and to promote positive identities, and specifically, to prevent the subjective experience of shame.

8.2.2 Common effects identified in research

Research findings vary as to the perceived long-term experiences of parentified children. Common detrimental effects highlighted in the research as pervasive in adulthood include depression, which can be masked as phobia; poor self-esteem; pseudo competency; anxiety (lack of exploration and enjoyment); frustration; guilt and shame, and deep-seated anger (Earley & Cushway, 2002; Underhill, 2003; Wells, Glickauf-Hughes, & Jones 1999).

Some of the negative effects of caring upon young carers, include physical problems due to lifting, disturbed sleep patterns, emotional stress, social isolation, stigma caused by a home life that is different from other people (or by the nature of the condition their relative suffers from), poverty and low income, and loss of educational and careers opportunities (Chase, Deming, & Wells, 1998; Lackey & Gates, 2001). The stress of caring may also have a long-

term impact on the mental health of the child or young person (Aldridge, 2003/2006; Aldridge & Becker, 1999; Wagenblass, 2001/2005). There is a need for far-reaching support. Research has identified the benefit of supporting parents in supporting children. For instance, McAuley, McCurry, Knapp, Beecham, & Sleed, (2006) and Sandler (1989) indicated that supporting parents is central to improving children's lives. However, assessment of the needs of children is crucial to the provision of effective support. Distinctions need to be identified between individual children's situations in terms of their subjective wellbeing, through supplementary acknowledgement that a young carer is not always parentified, and strong support can minimise the extent to which they are. This needs to be distinguished from parentification wherever possible.

8.2.3 Shame – a specific detrimental effect

Frequently, the research suggests that parentification is detrimental, and for parentified children, in homes where the adult/s are unable to function sufficiently well as caretakers, parentification can cause long-term psychological damage to children, many of whom may have believed that they were coping well at the time (Earley & Cushway, 2002; Smyth, Blaxland, & Cass, 2011; Wells & Jones, 2000). Nevertheless, it is imperative to consider a child's day to day wellbeing, and although it is vital for research to consider long-term outcomes, every effort should be made in society and therapeutically, to maximise the quality of life of children (www.childrenssociety.org.uk).

Meanwhile, research finds that one of the most concerning effects of overburdening a child is the experience of shame (Jones & Wells, 2000; Wells, Glickauf-Hughes, & Jones 1999). Jones and Wells (1996) found a relationship between childhood parentification and both narcissistic and masochistic personality characteristics. Although findings are correlational, this potential is both logical and concerning. These findings suggest that a parentified child might come to either elevate or undervalue their worth in relation to others, with significant and enduring implications for adult relationships. As argued by Jones and Wells (2000), where the tendency is towards masochistic behaviour, parentified children would experience shame within adult relationships in relation to their own self-worth. Bradshaw's work and

research on the family (Bradshaw, 1998), distinguishes guilt from shame as follows:

- Guilt says I've *done* something wrong; shame says there *is* something wrong with me.
- Guilt says I've *made* a mistake; shame says I *am* a mistake.
- Guilt says what I *did* was not good; shame says I *am* no good (Bradshaw, 1998:2).

This suggests that shame involves the whole self and not merely the actions of part of the self. In their later studies, Wells and Jones (2000; Wells, Glickauf-Hughes, & Jones, 1999) highlighted a relationship between parentification and masochism, which is suggestive of a tendency towards self-hate and shame. For instance, Wells and Jones (2000) utilised a group of 197 undergraduate students, and found supporting evidence for the fact that children who are parentified are highly prone to experience *shame* in relation to their self-concept, because the reversal of parent and child roles, requires a premature identification with the parent(s)' expectations and needs, at the expense of the development of the child's true talents and gifts, often leaving the child feeling ashamed of the true self's unrewarded strivings (Wells & Jones, 2000, p. 19).

In this sense, the parentified child may suffer specific psychological detriment, which should not be minimised, for example, as the deficit of some elements of nurturing.

Wells and Jones (2000) alert clinicians to be aware of their secondary finding that is their predicted relationship between guilt and shame, in the context of devising and implementing treatment plans. It would therefore be significant for Counselling Psychology to consider that clients who are seeking to resolve a parentified childhood in their current relating, could be harbouring shame beneath expressions of guilt or anger. The use of a probing and qualitative approach such as Interpretative Phenomenological Analysis (IPA, Smith, 2003; Smith, Jarman, & Osborn, 1999*),* might shed more detailed light on these findings, thereby describing not simply *a relationship*, but a more in depth understanding of the nature and breadth of this possible relationship. It may also extend to how this might relate, for example, to other issues and particularly *co-dependency* (Dear & Roberts, 2005; Lyon, Greenberg, & Jeff; Marks, Blore, Hine, & Dear, 2012).

8.2.4 Co-dependency and the parentified child

The term *co-dependency* has developed largely from the writings of the psychiatrist and psychoanalyst, Karen Horney, some 40 years ago. Co-dependency concerned the proposal that "having learned to obtain approval and self-esteem by conforming to the demands of an exploitive person, women with alcoholic parents will continue to seek opportunities to help such people" (Lyon, Greenberg, & Jeff, 1991, p. 435).

Early work on co-dependency focussed upon female children of substance abusers (e.g., Prest, Benson, & Protinsky, 1998). Rothberg (1986), cited also in Dear (1994), put forward the idea that people who are *alcoholics* and their partners developed complementary relationships which fulfill pathological needs in each other. At a similar time to when the term *chemical dependent* replaced the terms *alcoholics* and *drug addicts*, the term *co-dependent* emerged to describe partners, usually women in research at that time, who were drawn towards, and potentially played a part in perpetuating their partner's chemical dependency (Beattie, 1989; Bradshaw, 1988; Cermak, 1986; Mendenhall, 1989; Rothberg, 1986; Schaef, 1986). Co-dependency was popularised in the book *Women Who Love Too Much* (Norwood, 1985). Co-dependent people are described as being drawn to people who need help, because they have learned to gauge their worth by how much others need them. It is likely that this applies similarly to children who are parentified and who experience role reversal. Perhaps they gauge their self-worth by their ability to fulfil the demands made of them (Larkin & Griffiths, 2002; Mendenhall, 1989; Norwood, 1985).

More recently, the relevance of co-dependency has broadened beyond work on substance abuse to work on family dysfunction (e.g., Prest, Benson, & Protinsky, 1998). However, work on substance abuse also alludes to the level of parentification that children whose parents struggle with substance addiction, experience (Brennan, 2014; Farrell, 2005a; Farrell, 2005b; Jaeger, Hahn, & Weinraub, 2000; Project Cork, 1996-2005, in Brennan, 2014).). It is likely that it is the role reversal/parentification aspect of being an Adult Child of an Alcoholic Parent (ACAP, Project Cork, 1996-2005) which features in co-dependency and could be most damaging to adult relationships (Macfie, Fitzpatrick, Rivas, & Cox, 2008; Stein, Rotheram-Borus, & Lester, 2007). Increasingly, research is undertaken in differing circumstances, but

there is an overreliance upon correlational evidence, which whilst being the inspiration of this research area, depends on the evaluation of co-dependency as a construct. Thus, extensive research involving *talking* to children in a relatively unstructured way is now greatly needed *(e.g.*, Falcov, *2004*). Correlational evidence and more idiographic representations highlight concern regarding shame-proneness in overburdened children (Wells, Glickauf-Hughes, & Jones, 1999), and Wells and Jones (2000) emphasise the vital role of support in health outcomes.

8.2.5 Difficulties in assessing the relevance of co-dependency research

Much of the research which relates co-dependency to having an alcoholic parent, has used inventories to assess co-dependent behaviour, such as the Friel Co-dependency Assessment Inventory (FCA), and the Personal Authority in the Family System (PAFS) Questionnaire (Prest, Benson, & Protinsky, 1998), or *loss of self-measures* which correlate highly with co-dependency (Crothers & Warren, 1996). Despite this, the concept of *co-dependency* is being revisited and studied more broadly (Marks, Blore, Hine, & Dear, 2012). There is an issue of note within this research area, that has largely been undertaken utilising quantitative methodology, and which although valuable, uses pre-existing inventories and questionnaires, through which subtleties and diversities can be missed. This produces correlational evidence, which in terms of quantitative data, does not indicate a causal relationship, and in qualitative terms, has not fully explored the nature of what participants have shared with the researcher. Whilst not a huge problem, as appropriate methods have been used by researchers in order to address the particular research aims, it is noteworthy in terms of the need for pluralism in research. Somewhat of an exception in earlier research style in this area is Prest, Benson, & Protinsky, (1998), who observed differences between controls and participants who had an alcoholic parent in *subject-experimenter helpfulness* (as a co-dependent indicator), when an experimenter was portrayed as *exploitative*, compared with *nurturant*. Findings did support the existence of co-dependent behaviour in the women with alcoholic parents. However, although an insightful and inventive piece of work which was well conducted, this was an artificial situation and may reflect more general levels of conformity, especially as this was conducted some fifteen years prior. Although there was a control group, the sample size was much smaller than in many other studies, in which this relationship was not found (e.g.,

Baker, 1997; Crothers & Warren, 1996). The bank of quantitative research underpinning the concept of co-dependency is highly informative, both in support for and criticism of the applications of its concept (Subby & Friel, 1984; Dear, 1994; Dear & Roberts, 2005). but further qualitative accounts are needed (Marks, Blore, Hine, & Dear, 2012). The need for qualitative enquiry

Crothers and Warren (1996) found significant correlations between adult co-dependency and parental coercion, control, non-nurturance, and maternal compulsivity, but correlations between co-dependency and parental chemical dependency were not significant. This and their multiple regression analysis, which identified "parental co-dependency and maternal coercion as significant predictors of subject co-dependency" (Crothers & Warren, 1996, p.1), suggests that at least the relationship between substance abuse and co-dependency is more complicated and likely, at least in women, to be intergenerational (e.g. Connor, 2006). Such research systematically guides researchers towards greater idiographic research designs, and together this enhances psychological and research knowledge. For example, where research suggests that parenting style is implicated, it may be that being a *parentified child* could be the commonality which produces co-dependent behaviour in adult relationships. This also then suggests that there is a gap in the research concerning idiographic accounts. There is a need for more qualitative enquiry, in order to explore those aspects in depth and further issues, which have been identified in research to-date, such as those effects consequential of being a child of an alcoholic parent, a parent with a disability, or with mental illness, that extensively influence adult relationship outcomes. There has been far-reaching criticism regarding the volume of IPA research that is currently undertaken, however, just as it is vital to respect the immense contribution of research today, both quantitative and qualitative, it is necessary to view that psychological research has reached a place where many psychological and social issues benefit from the process of IPA (Smith, 2011).

Indeed, as with all correlational research findings the direction of any relationship can be unclear, but important. Research suggests that healthy attachment in adulthood is often negatively impacted in unsupported parentified children, and addiction research suggests that it is the attachment style which the child develops, rather than having an alcoholic parent per

se, which determines their risk of having an alcohol user disorder (Vungkhanching, Sher, Jackson, & Parra, 2004). To place this discussion in context, a brief overview of attachment follows.

8.2.6 Brief overview of attachment

The theory of attachment was originally developed by John Bowlby (1907-1990), a British psychoanalyst who was attempting to understand the intense distress experienced by infants who had been separated from their parents. Bowlby observed that separated infants would go to extraordinary lengths, for example, crying, clinging, or frantically searching, to either prevent separation from their parents, or to re-establish proximity to a missing parent. Bowlby believed that a motivational-control system, or what he called the *attachment behavioural system*, was gradually 'designed' by natural selection to regulate proximity to an attachment figure.

Further, Mary Ainsworth's work (Ainsworth, Blehar, Waters, & Wall, 1978; Waters & Deane, 1985) produced a formal understanding of the potential individual differences in attachment style. According to Ainsworth, most children behave in the way implied by Bowlby's normative theory, showing distress when the parent leaves the room, but are easily comforted on their return. Ainsworth found that approximately 60% of the children studied behaved in this way which was deemed to represent secure attachment, and a further 20% or less were ill-at-ease initially, and upon separation, became extremely distressed and more importantly it was purported, were difficult to soothe when reunited with their parent, thus displaying conflicting behaviour. These children were labelled as *anxious-resistant*, or *anxious ambivalent* in terms of their attachment style. The third pattern of attachment, recorded in a further 20% of Ainsworth and her colleagues' study were called *avoidant*. These children did not show distress on separation, and, upon reunion, actively avoided seeking contact with their parent.

Ainsworth documented that children who appeared insecurely attached (either anxious-resistant or avoidant) often had parents who were insensitive to their needs, or inconsistent or rejecting in the care they provided. Despite many, perhaps obvious problems with this work, for example, child temperament (e.g., Crockenberg, 1981) and the two-way effect of this and

the then contemporary assumptions regarding the role and influence particularly of mothers at that time, these basic distinctions have pervaded, and remain a helpful framework from which to discuss attachment in both adults and children (Hsu & Fogel, 2003; Solomonica-Levi, Yirmiya, Erel, Samet, & Oppenheim, 2001).

8.2.7 Parentification, co-dependency and attachment

There exists an imbalance in attachment research, in that mothers are more often the subject of enquiry, and it is important to remain aware of this fact and of the complexities in attachment. Shulman, Becker, and Sroufe (1999) reported that mothers of anxiously attached children described a family history of an emotionally intense relationship with the father and, to some extent, a 'role reversal' between themselves and their own mothers. The intimacy developed in the families of these mothers served their needs (Shulman, Becker, & Sroufe, 1961/1999). In this example, Shulman, Becker, and Sroufe are making reference to role reversal for mother and daughter, but also the influence of the attachment to the father. This is suggestive of a potential cycle in attachment style, in that having been a parentified child is implicated in mothers' *avoidant* or *anxious resistant* attachments, which in turn might be implicated in a tendency for them to be coercive and their children to form insecure attachments, creating the potential for intergenerational transmission (Sroufe & Fleeson, 1986; Shulman, Becker, & Sroufe, 1999).

Shulman. Becker, and Sroufe's (1999) work reported a complex interplay of mother and child characteristics within an adult-child interaction. Interestingly, mothers were observed to be more involved with, and to express more anger toward, insecurely attached children, **e**specially when their own child was classified as insecure. Inspection of children's initiatives revealed that children preferred to turn to adults whose family history corresponded to the family history of their own mother. This has implications for co-dependency, in that children are picking up signals which relate to familiar, and not necessarily positive, attachment interactions and they are likely to carry these preferences with them into adult relating (Fraley & Shaver, 2000)..

8.2.8 Factors which may affect adult attachment in an overburdened child

According to Bowlby, the attachment experience of a securely attached child is that of a *secure base* from which to explore (Bowlby, 1980) and to which to return if in need of reassurance and comfort. This may be unlikely to be the attachment experience of an overburdened child, who is often providing a safe base, prior to age-appropriateness, to someone else and is less likely to be receiving this themselves. In order to more fully explore what the attachment experience of an overburdened child might be, it would be necessary to know their circumstances and to appreciate in what way they were fearful, anxious or avoidant, and actually happy. Thus, some circumstances and emotional responses which might be relevant are briefly discussed below, utilising some of Ainsworth's (Ainsworth, Blehar, Waters, & Wall, 1978*)* and Levy and Orlans's conceptualisation (Levy & Orlans, 1998).

8.2.9 Overburdening children: anxiety, anger, loss, and attachment implications

Children's life situations and relationships are unique and often complex; not least concerning the limits upon their control over events. A child who is overburdened by, for example, parental mental illness might form an *anxious-avoidant attachment* style **(**Levy & Orlans, 1998), which they would then carry into adult relationships. This could depend upon many things, not least the nature of the mental health problem, but, for example in the case of a child who has a mother suffering with manic depressive illness, this child might become her mother's carer when her mood is low, and then, perhaps suddenly be the focus of her mother's unrealistic expectations, ambitions or ventures, and perhaps aggression, when her mother's mood becomes high. This could cause the child to become fearful of closeness to others (Aldridge & Becker, 2003). Laying low and opting out when possible might be an adaptive strategy for an overburdened child in this position, and this could affect their adult ability to be intimate. This could also be common in children who are overburdened by physical or sexual abuse (Alexander, 2003; NSPCC; The Children's Society; The Irish Sports Council).

An overburdened child who has harboured long-term anger, perhaps due to unmet needs or being overburdened by having been left to be a child carer to other siblings, might form an

anxious-resistant attachment (Levy & Orlans, 1998), whereby their anger is unresolved and unvented. They may for example, have spent long periods of time longing for their attachment figure and have wanted to punish them for this agony, but found them rarely available for them to do this and/or antagonistic or confusing when available. As an adult, this child might continually test their partners and push intimacy away.

As a strategy for dealing with loss, a *dismissive attachment* style (Levy & Orlans, 1998) might develop in an overburdened child, where for instance, an attachment figure has a problem with substance abuse, and they are unreliable and/or rarely available to depend upon (Macks, & Reeve, (2007). In preference to this unrequited longing, the overburdened child might convince themselves that they do not need intimacy with their attachment figure, and ultimately become dismissive in their adult relationships.

8.2.10 Overburdening and inconsistency

Disorganised attachment typically stems from inconsistency in the attachment, or irregularity in the presence of parental figures (Levy & Orlans, 1998). Unpredictability of family circumstances and expectations has been shown to relate to parentification. The reasons a child is overburdened are probably unique and the effects varied, but it may be the unpredictability and the reasons for this which most affect development and attachment. Burnett, Jones, Bliwise, and Thomson Ross (2006) examined whether parental alcoholism and family unpredictability contribute to the development of parentification. Their analysis supported independent contributions to childhood parentification of *family unpredictability* and *parental alcoholism*. However, again there can be problems with findings which utilise scales and screening tests and adopt multiple regression analysis, in their ability to explain processes in depth.

It could be argued that for many parentified children, the experience of attachment would be inconsistent, which would be likely to produce disorganised attachment (Brennan, Clark, & Shaver, 1998; Hazan & Shaver, 1987). This can easily be understood in terms of Skinner's original concept of *intermittent or partial reinforcement*, a condition in which repeated responses are reinforced only some of the time (Skinner, 1957). It may be this inconsistency, which is most reinforcing and most damaging to attachment and later relationships, as this

hooks children, and ultimately adults, into unhelpful patterns of relating. Parentification in itself is unlikely to be consistent. It is common for parentified children to have unrealistic expectations made of them concerning aspects of caring which are inappropriate for their age, but would still be chastised in whatever way is deemed appropriate in their family circumstances and in line with whatever is believed to be age appropriate. It is unlikely that parents own circumstances – even with substance abuse – make them consistently needy of their children. Therefore, a child who is overburdened in this way has to make sense of contradictory messages and has to create a consistency from inconsistency, especially where they may be caring for an adult or sibling with a mental health difficulty (Bibou-Nakou, (2003). This could make it extremely complex for them to form, understand, and develop their adult attachments (Lieberman & Zeanah, 1995). Most research reflects the probable involvement of parentification and the overburdening of children in their early lives.

8.3 Drawing research findings together

The parentified child has been linked to both co-dependency, shame-proneness and low-self-esteem (Wells, Glickauf-Hughes, & Jones, 1999). These authors indicated that shame-proneness, self-esteem, and parentification are significantly related to co-dependent characteristics, and that guilt-proneness is inversely related to co-dependency. The researchers' hypothesis was that co-dependency reflects shame and not guilt and therefore is a much more entrenched characteristic which is pervasive in relationships, as it represents the organisation of the whole self, rather than an aspect of it. This could suggest that it is the helplessness element of shame and, as the literature suggests, of co-dependency, which might shape the parentified child's adult relationships. Kaufman differentiates between guilt and shame, which Kaufman argues reflects "painful feelings of depression, alienation, self-doubt, loneliness, isolation, paranoia, compulsive disorders, perfectionism, inferiority, inadequacy, failure, helplessness, hopelessness, narcissism" (Kaufman, 1996, p.45). Kaufman states that: "Shame is a sickness of the soul. It is the most poignant experience of the self by the self, whether felt in humiliation or cowardice, or in a sense of failure to cope successfully with a challenge. Shame is a wound felt from the inside, dividing us both from ourselves and from one another." (Kaufman, 1996, p.45/46).

If co-dependency has been related in terms of correlation to being a parentified child, and shame has been linked to co-dependency, this would suggest that in the frequent absence of appropriate support, shame may be an important and significant outcome affecting the adult relationships of parentified children. Kaufman (1996) claimed that the human response in relationships to feelings of *guilt* was to offer atonement, which suggests a higher power-base, in the sense that there is a belief that it is possible to correct mistakes and that these do not represent the whole self by which the individual might be judged. This would suggest that shame has a greater and detrimental influence on self-esteem, which could lead children and adults who have been parentified to view themselves as less worthy than their partners. However, to simply refer to shame as an overriding concept, even though it may be highly relevant to parentification, would be to quantify something complex and reduce it artificially, by which process alone, meaning may be lost; meaning which has been established through correlational evidence, but is complex, and is important to transfer and explore in terms of therapeutic and research considerations.

8.3.1 Therapeutic issues - the reward of exhaustion

There has been considerable research relating a parentified child to what has been termed the *Imposter Phenomenon.* This is the tendency to believe oneself to be a *fake*, who will be discovered for being lower in capability or value than others think them to be. Research suggests that the Impostor Phenomenon can be explained, in part, as "a significant long-term effect of childhood parentification" (Castro, Jones, & Mirsalimi, 2004, p. 205). The Imposter Phenomenon is also suggestive of a dislike of the *real self* in parentified children, which would make intuitive sense, as the parentified child is perhaps unable to discover, or to develop their real self, and was rewarded for parentification, and not for childhood. Therefore, the child comes to expect to be overburdened, since much of the child's tasks are beyond its developmental stage and the child is rewarded by the parent's need for it to be parentified; therefore, the child *copes* and then comes to experience their exhaustion as rewarding.

The child may learn to gain positive reinforcement from exhaustion and so continues to experience a feeling that they could always give more, or should try harder, which might

encourage co-dependency in their relationships. Continued research into perfectionism, self-esteem, and the adult relationships of children who were parentified is integral not only to supporting children, but also adults, who often do not realise how they view themselves until significant adult life events bring this to the fore, for example through such life events as divorce (King & Raspin, 2004). Yet as King and Raspin enlighten, all events may present with both lost and found parts of the self, with costs, and certainly benefits to find.

8.3.2 Shame as a feature of the adult relationships of parentified children

It is likely that a child who is parentified and required to behave in ways which are beyond their developmental stage, is likely to experience a sense of failure and perhaps be conditioned to experience shame as routine. In terms of co-dependency, this may mean that being a parentified child underpins co-dependency because shame has been internalised into the child's self-concept, creating the belief that there is no real self to value or rescue, and that self-worth is only achieved through rescuing other worthier causes. Where shame may have been inherent in the family dynamic, such as is likely where mental illness is concerned, and a child was also parentified, shame may be compounded (Corrigan & Miller, 2004). For counselling psychologists, perfectionism/reinforced exhaustion is important to explore in therapy, within which an individual seems to have been overburdened as a child, and especially where the mental illness of a parent has underpinned their childhood experience.

8.3.3 Lack of support and the risks of disorganised and insecure attachment

More qualitative research is needed into insecure attachment and parentified children (Jaeger, Hahn, & Weinraub, 2000), with an emphasis upon the fact that to overburden a child constitutes emotional abuse (Evans, 2002). Levy and Orlans (1998) cautioned that children with insecure anxious-ambivalent/resistant, anxious-avoidant, and disorganised attachment relationships will have problems with their own relationships as children and adults. Insecure attachment behaviours which are *functional infantile coping mechanisms* (Breazeale, 2001) will no longer be appropriate in adult relationships, although the inner working models formed will pervade adult relating (Sroufe, Carlson, Levy, & Egeland, 1999, cited in Breazeale, 2001). Research suggests insecure attachment can result in anxious and dependent children and adults; and some research has suggested that anxious-avoidant or

anxious-ambivalent children may be narcissistic and socially incompetent in adulthood (Sroufe, 2000a, cited in Breazeale, 2001). Aggression and depression has also been implicated as stemming from insecure attachment (Levy & Orlans, 1998). Self-concept, particularly in women, has been shown to be negatively affected. For example, Jaeger et al. (2000) found that daughters of non-alcoholic parents would describe themselves as more disposed towards compulsive care-giving than non-Adult Daughters of Alcoholic Fathers (ADAFs), suggesting also by this research, that females are not simply potentially at greater risk due to their identification with their mothers.

More qualitative research such as IPA and narrative research would be valuable, in order to explore the lived experience specifically in connection with being, or having been a parentified child, or a young carer, and also attachment/insecure attachment styles in overburdened children as adults. This would seem to be both relevant and pressing, as a means to inform therapy.

8.3.4 Symbiosis and parentification

As explored briefly above, some research has been conducted which relates parentification in childhood to insecure attachment (Jaeger, Hahn, & Weinraub, 2000). In addition, and connected with insecure attachment research, is the concept of *symbiosis*. Schiff and Schiff (1971, p. 71, cited in White, 1997, p.1), described symbiosis as "experienced by both the mother and the child as a merging or sharing of their needs." Schiff et al. (1975, cited in White, 1997. P.1) defined symbiosis as, "[…] when two or more individuals behave as though between them they form a whole personality." Intuitively, one of the graver consequences of parentification could be symbiosis, as a child who is parentified has little chance to become attached and dependent, and then to detach in order to live life separately from their attachment figure (White, 1997). There can be an *over attachment*, which leads to an excessive attachment to the other person. In couples, Bader and Pearson (1988) called this "symbiotic enmeshment' (Bader & Pearson, 1988, p. 63). Symbiosis and its relationship to parentification is also worthy of qualitative research input.

8.3.5 Supportive interventions

Research expounds the view that supportive connections help buffer an individual against the worst effects of trauma (Herman, 1992), and serve as *inoculations against adversity* (Schimmer, 1999). The greatest threat to resilience is ***not*** forming secure attachments, as strong attachments are thought to lead to successful children, both emotionally and socially (Luthar, Cicchetti, & Becker, 2000; Masten, 2001; Wyman, Sandler, Wolchik & Nelson, 2000).). Current reviews of resilience research have identified a small number of factors that were found to be the most critical for promoting resilience, including:

- positive connections to caring and competent adults within a youth's family or community;
- development of cognitive and self-regulation abilities;
- positive beliefs about oneself;
- motivation to act effectively in one's environment.

Also, more research, and particularly qualitative research, is needed into the benefits of these factors and others for overburdened children and for therapists, as are client-therapist interventions in Counselling Psychology. Qualitative research is needed in order to ask individuals themselves about the kind of help currently needed, or that might have been needed in the past. Alternative attachments, or attachment modeling by Counselling Psychologists, could make a positive difference to the adult lives and relationships of parentified children (Bibou-Nakou, 2003), as, according to many writers, early attachment patterns invariably continue to affect adult relating (e.g., Fraley, 2002; Fraley & Shaver, 2000).

8.3.6 Promoting resilience and self-efficacy

It seems important to be alert to the well-known positive and healing effect that even one successful attachment can have on a vulnerable young person or adult (Schimmer, 1999; Kegan, 2014). Counselling Psychology's input is needed, both in terms of research and

therapeutic intervention, for children who are overburdened and their adult counterparts.It can be vital to promote an increase in a sense of self and self-efficacy in children who suffer damage to their self-esteem through adversity. There are clearly many opportunities for Counselling Psychologists and other welfare professionals to help young carers and parentified children to develop a greater sense of self (Sandler, 1989) by involving them in decisions which affect their lives and by helping them to rehearse and develop coping skills and strategies for later life (Gilligan, 2000). Both recognition of existing resilience and promotion of greater resilience is necessary in therapeutic interventions; for children and for adults (Padesky & Mooney, 2012).

8.3.7 Being proactive

There is a need for overall and far-reaching support. Research has identified the benefit of supporting parents in supporting children (e.g., McAuley, McCurry, Knapp, Beecham, & Sleed, 2006). Therefore, long before the effects of being overburdened in childhood are the focus of repair, proactive help in the form of support for parents who are struggling could pre-empt later difficulties. In any event, assessment of the needs, and also the views of overburdened children are crucial if effective support is to be provided. Supporting parents has been reinforced as central to improving children's lives and assessment of needs, however, it is particularly crucial to the effective support provision (Wagenblass, 2001/2005).

8.4 Synopsis

There is also much to learn by continued research into why some children have good outcomes despite adversity (Fraser, 1997; Saleebey, 1997; Stattin & Magnusson, 1996), and how this might relate to the circumstances in which a child was overburdened and parentified, with differing subsequent implications for adult relationships. Circumstances could indeed be at least partially a factor of the one attachment which made a difference, but certainly most research suggests that positive outcomes would be a factor of support, and also timely and appropriate interventions from all relevant agencies, but certainly from Counselling Psychology. In order to fully assess how best to support overburdened children, it is vital that IPA research is undertaken to analyse the individual dialogues of these children.

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Appendix 1 - Questionnaire

Are you a mother?

And…

Did *your mother* experience

depression, anxiety

or any other mental health issue when you were a child?

if so……

I would really like the opportunity to talk to *you* about your experience of being a mother

I hope that this research will be of benefit to many people like you

If you think you might like to tell me your story, please call Annette for an informal chat, without obligation to participate.

This research forms part of my Practitioner Doctorate in Counselling Psychology.

Project supervisor - Dr D. Rafalin at City University in London

Appendix 2 - Information which you might find helpful

The aim of this research is to explore the views of women whose own mothers suffered long-term depression, anxiety, or any other ill-health which affected them psychologically. This might include schizophrenia, personality disorder, manic-depression/bi-polar disorders, or perhaps drug or alcohol addiction, or eating disorders.

I am interested in how people's experience of how they were 'mothered', might affect how they feel about themselves now that they are mothers. The type of research I am conducting will enable me to report as accurately as possible what you say about what you feel.

I hope that you will feel free to enquire about participating in this research, secure in the knowledge that:

You will put under no pressure whatsoever to participate.

You can withdraw at any time.

You are welcome to enquire about any aspect of this research by calling Annette, the researcher,

without obligation to participate.

This research forms part of my

Practitioner Doctorate in Counselling Psychology.

Project supervisor - Dr D. Rafalin at City University in London

Appendix 3 – Research Consent Form

This research is being carried out as part of the researcher's Practitioner Doctorate in Counselling Psychology at City University. If you have any questions regarding this project, please call Annette Gensale (the researcher) or Dr Deborah Rafalin, (the research supervisor) at any point. The details of this research have been ethically approved by City University and that the researcher adheres to the British Psychological Society code for ethical practise. The aim of this research is to gain further understanding of the experience of becoming a mother for people whose own mothers experienced mental health problems.

You will be asked to take part in an informal interview about your experience of motherhood. The interview will be recorded on audio tape, and used only for the purposes of this research, to quote people's experiences as examples. However, you have the reassurance of the researcher that your identity will be protected, as your name, location and any identifying details of anyone you mention in the interview will be changed before anyone other than the researcher reads anything related to what you have said.

Please do not feel under any pressure to answer any question, or to comment in any way other than you feel comfortable to do. You may alter or withdraw anything you say within the interview, or indeed withdraw from the research at any time during this interview if you feel for any reason that you do not wish to continue.

Please read the following and, if you are in agreement, sign where indicated:

I agree that the purpose of this research and the nature of my participants in this research have been clearly explained to me in a manner that I understand. I therefore consent to be interviewed about my experience of motherhood. I also consent to an audio tape being made of this discussion and to all or parts of this recording being transcribed for the purposes of research.

Signed……. Date……...

On behalf of myself and my supervisor, I undertake that professional confidentiality will be ensured with regard to the audio tape made with the above-named person, whose anonymity I will protect.

Signed……. Date…….

Appendix 4 – Biographical Details:

Name:

Age:

Education:

Work:

Area in which you live/lived as a child:

Age and gender of children

Age when you had your/each child:

Relationship status:

Details of siblings:

Brief description of your mother's mental health problems?

Was this throughout your childhood or at particular stages of this?

How is your mother now (age - if alive)?

Appendix 5 – Interview Guide - Warm up

Have you ever talked to anyone about your experiences?

How do you feel about the idea of talking to me today about your experience of becoming a mother?

I am wondering if you have anyone particular with whom to talk through any feelings you might have after today's interview. Do you have anyone whom you might talk to?

Interview Guide

Question 1

How would you describe yourself as a person now?

Prompts:

What roles do you occupy?

How do you imagine yourself in each role?

How would you describe your emotional reactions to things?

Question 2

Would you have described yourself similarly or differently prior to being a mother?

Question 3

How do you think you felt about the idea of yourself as someone who was about to become a mother?

Prompts:

How did you feel when you found out you were pregnant and during pregnancy?

Did you feel differently about yourself?

Question 4

How did you feel that others reacted to you during pregnancy?

Question 5

How did you feel about yourself as a person when you became a mother?

Prompts:

Did your feelings change over time and if so, in what way?

Are there any particular thoughts or feelings which have stayed with you?

Question 6

How would you describe yourself as a mother?

Prompts:

How much of your life is taken up in this role?

Are you similar in this role to other roles?

Question 7

How do you imagine others might describe you?

Prompts:

People who know you

People who see you in the street

Question 8

How do you imagine other mothers feel?

Question 9

Could you describe in your own words how you experienced your mother when you were a child?

Question 10

Do you think about your own childhood much now?

Prompts

Were you a happy child?

What emotions come to mind when you

think about your childhood?

Question 11

How do you feel your childhood and your own experience of being mothered fits into how you feel about being a mother yourself?

Prompts

Are there any particular things which you feel made the experience of motherhood different for you than for other people?

How did you manage your feelings as a child?

Question 12

Do you think that your feelings about your mother affected your own experience of becoming and being a mother, and if so, in what way?

Question 13

Have you ever met anyone else whom you felt really understood your experience?

De-brief.

We are coming towards the last 15 minutes or so of the interview now and I will switch off the tape shortly. So…is there anything which comes to mind; any questions which you would have liked me to ask you about your experiences.

I am wondering how you are feeling after talking to me today?

Is there anything you want to tell me?

Do you feel any differently than you expected to?

Appendix 6 – Participants

Each participant's initial description of themselves and their mothers. The participant details were given to me on the day of the interview and vary in detail. Participants are described in age brackets of early, mid and late in each decade.

Participant 1 – Carmen

Carmen is a mother to one female child age five and is in her late thirties. She is a part time college lecturer. Carmen achieve motherhood through IVF treatment and experienced many miscarriages. Carmen lives with her husband, who is the father of the child. She is the middle child of three female siblings. She is the only one of her siblings who will speak with her mother. Carmen's father left when she and her siblings were under 10. She described mother as having Personality Disorder. Carmen experienced her mother as cruel, aggressive and unpredictable. Carmen has infrequent contact with her mother

Participant 2 – Sarah

Sarah is mother to two primary school aged children (one female and one male) and is in her mid-thirties. She does not work outside of the home. She lives with her husband, who is the father of the children. Sarah's mother also lives her and Sarah is her carer. Sarah used to care for her mother as a child along with her father. Sarah's father died when she was in her early twenties and had not long had her first child. Sarah has one brother who is supportive mostly by telephone but is uninvolved in her mother's care

Sarah describes her mother as suffering extreme periodical, depression, for which she receives strong medication when this occurs. There seems to be no pattern and no known underlying reason, however, her mother. Sarah has a good relationship with her mother, who is a trusted carer herself of her grandchildren when well but is completely incapable when in bouts of depression and needs round the clock care in terms of all personal care and nutrition. A number of different drugs can be utilised during these depressions in an attempt to bring her out of this totally debilitating depression. During these bouts of depression which can last months, she is completely dependent on Susan and life is extremely stressful for Susan.

Participant 3 – Kye

Kye is a mother of two children, now aged 17 and daughter 15 (described as hyperactive). Kye is in her mid-forties. Kye is in full time education. Kye lives alone with her children and is divorced. She is currently struggling regarding the loss of a relationship. She is the middle child and has two brothers. She is the middle child the only girl. Kye believes that her mother became ill after her birth with post-natal depression but thinks that her mother was diagnosed as Paranoid Schizophrenic when Kye was ten years' old

Kye recalls the day when her mother was said to have had her 'first breakdown', which was during a family holiday when Kye was seven years. Kye described her mother as kind and devoted to her children. Kye has never believed that the diagnosis was correct Kye stated that her mother was terrified of her father, as were all the family. Kye blames her father's domineering character for her mother's illness. Kye's mother died two years ago and she is grieving for her. Kye does not have and does not wish to have any contact with her father

Participant 4 – Paula

Paula is a mother to three grown up children, one female and two male (one has Asperger's Syndrome, but is described as 'high functioning' and in a 'high powered' job). Paula is in her early seventies. Paula is divorced and lives alone but has an amicable relationship with her ex-husband, who divorced her when in her early thirties. Pauls did not want the marriage to end

Paula described her mother as a paranoid schizophrenic Paula described her mother as abusive and extremely psychologically and physically cruel and unpredictable. Paula did not ever know her biological father but lived with her mother and stepfather, who was also very cruel and extremely aggressive but she believes was not mentally ill.

Paula is a retired theatre nurse. Paula gave birth to five children, two of whom died. One child died in utero and the other in early childhood with a hole in the heart. Paula 's mother died in 1991. Paula nursed her mother, who had Alzheimer's at that time, for 6 weeks until she died

Participant 5 – Caroline

Caroline is mother to three grown up children, two female and one male. Caroline is in her mid-fifties. Her husband died suddenly when the children were under five years old. She has never remarried. Caroline is one of two female siblings. Caroline's sister is eight years her junior. Caroline and her sister feel that their father died of exhaustion as their mother's carer

Caroline and her sister were very close to their father. Caroline describes her mother as agoraphobic and highly anxious, controlling, manipulative and selfish, although she is reluctant to criticise her mother and has some warm memories of her. Caroline describes her father as 'long suffering'. Caroline works full time in administration. Caroline's mother died a few years ago and her father died about five years before her mother

Participant 6 – Della

Della is mother to two children of primary school age, one male and one female. Della is in her mid-thirties. Della lives with her husband and their two children.

Della's father left shortly after she was born and she lived with her mother, grandmother and sister throughout her childhood. Della describes her mother as always having suffered from depression. She experienced her as dismissive and somewhat self-absorbed. Della works part time running her own sales business. Della has infrequent contact with her mother.

Participant 7 – Elenor

Elenor is mother to three grown up children, one male and two females. Elenor is in her early fifties. Elenor lives with her husband who is the father of their children. Elenor is the middle child of three siblings and the only girl. Elenor's youngest brother died of an illness the previous year. Elenor describes her mother as having possible Personality disorder. She experienced her mother as terrifying, cruel and loveless. Elenor is in full time education. She has contact with her mother now but previously she refused all contact with her mother.

Participant 8 – Melanie

Melanie is mother to two primary school aged children, one male and one female. Melanie is in her mid-thirties. She lives with her husband and her children. Melanie is the eldest of three

children. She has a brother and a sister. She is close to her brother but has not spoken to her sister for 6 years. She describes her mother as an alcoholic who was completely incapable in the home and extremely neglectful and cruel when she was a child. Melanie felt close to her father in her childhood but feels in retrospect that he was collusive and did not protect her enough. Her father died in her late teenage years

Melanie has contact with her mother but feels that this continues to be a relationship involving her in role reversal

Participant 9 – Gabrielle

Gabrielle is mother to two children, one male and one female. Gabrielle is in her late forties. Gabrielle lives with her husband and two teenage children and her mother lives in an annex to the home. Gabrielle has one brother who is uninvolved in her mother's care. She describes her mother as having personality disorder (late diagnosis in adult life). Gabrielle describes her mother as frightening and aggressive in her childhood and as manic, depressed, needy, personally insulting, scary, embarrassing and unpredictable in her adult life

She works full time but is also her mother's primary carer

Appendix 7 – Annotated transcript.

1	Participant 7: Initial observations only	R = Respondent I = Interviewer Bold = equals potentially rich themes, utilised in analysis	Initial themes only
2		**INTERVIEW: Elenor**	
3			
4		I… about how it might affect people.	
5		R No.	
6	*Counsellor view skewed should not have said*	I … you know and in our field … I wonder where it's best (tape reorder) … I've never had much luck with my … (laughs)	
7		R Put it on the shelf.	
8		I I just want … I want it to get yourself more than me.	
9		R I tested with mine and I put mine on there.	
10	*Connecting on skewed view*	I Yeah? is it one of these things?	
11		R Yeah	
12		I Cos digital are better aren't they?	
13		R read the instructions how to get the stuff off there.	
14		I I know. It's supposedly … supposedly should be easier. But you've got to have the time to look into how to do all these things.	
15		R Oh it's just incredible, I just bought one of those in the end.	
16		I Okay so um … there was nothing here that (reading interview information sheet) …	
17		R No. no. no. I'm happy with that.	

18		I And. you would be most welcome to read this whenever I finish it.	
19	*Interest in research*	R Yeah. Yeah no I'd be really interested to read it.	
20		I Keep that so you've got both numbers.	
21		R Okay.	
22	*Check anything inaudible and ? marks. Adjust only to show sense – verify with another colleague where this takes place*	I If I could just take … some of your biographical details which I'm going to ask you. But what I end up doing with about 10 people who I'm going to talk to, I would just say 'all aged between so and so and so and so', you know general things as a group. So your age?	
23		R I'm 50 (circ) with three children	
24		I And educational level prior to this.	
25		R (laughs) Got GCSE Art.	
26	Connecting – potential to skew	I I got CSE.	
27		R Yeah	
28		(laughter)	
29	*Still relating through education – perhaps necessary for process*	R I've got one of those too. Yeah.	
30		I And um so your work currently	
31		R Well … yeah I'm not employed. I'm training (counselling)	
32		I And the area in which you grew up?	
33		R Um, xxxx London.	
34		I And the age and gender of your children?	
35		R My children? Um, yeah xxx is 26 … uh, xxxx 24 and xxxx's 21	
36		I So your age when you had the children - were you 24?	
37	*Changed for anonymity*	R Yeah. 24, 25 is that right? Yeah. Oh my maths is	

		appalling … 24. My birthday's October (xxx). so I think I was 24	
38		I Okay. And there was 2 years between	
39		R Well yeah, about 2 ½	
40		I Do you remember how old you were when you had your second child and your third child?	
41		R xxxx I was 29, cos he was born (xxx)	
42		I And your relationship status now?	
43		R I'm married to the same person.	
44		I To the same person.	
45	*Judgement?*	R Yeah. Yeah, I'm one of those rare people. Married to the same person, the father of my children.	
46		I Any siblings?	
47		R Um … I've got … I had two brothers, my younger brother died a couple of years ago. My elder brother's 54 … 53 … and my younger brother would have been 46.	
48	*Awkward empathy*	I So he died?	
49		R Yeah.	
50	*Why wouldn't it be?*	I So is that 'with' you?	
51		R Um … it always will be, but it's much better now than it used to be. It always will be with me, but I'm coping. Yeah, I hate it, but I'm over the worst of it.	
52		I Well feel free to talk or not talk about that. Um … and a brief description of your mother's mental health.	
53		R Um, like I said to you on the phone I mean … she was depressed, definitely depressed. But nothing was ever … what's the word? …	
54		I Diagnosed.	

55	*Hospital* *Separation* *No one said*	**R No nothing was ever diagnosed. She spent some time in hospital - on and off really, she was in and out of there. But we were never told what was wrong with her**	No one explained Absences No diagnoses
56		I And what was she like to you? I mean.	
57	*Cruel* *Distant aggressive* *Empathy* *Retrospect* *Justifying mother*	**R Um, to me in particular she was … sometimes she was cruel, she was never loving. She was very distant, cruel and aggressive as well. But - now I know now she did the best she could - she couldn't have done any better – that was it.**	Lack of love Cruelty Relationship with mother now
58		I Right.	
59		R Yeah that was it.	
60		**I Is she alive now?**	
61		R Yeah. yeah.	
62		I Do you have a relationship now?	
63	*Improved but not good relation ships* *Speaking terms*	R It's better than it ever was. It will never be great, but it's better than it ever was. We're just two totally different people. And um … it's better now, you know I'm able to converse with her.	Long-term consequence for Relationship with mother
64	*Death of brother* *Changed mother*	But, but since my brother died. I think she actually – it was a bit of a wake-up call… when he died she actually woke up, it was a terrible for her and I think she realised it's important I think, we are important.	
65		I Yeah	
66	*Other side of mother*	R Yeah. yeah, and she was absolutely devastated because - she was just devastated. And I think that's it, now she appreciates us more … and she tries harder, she does try harder.	Mother now
67		I Was she depressed throughout your childhood?	

68	*EMHD* *Evaluating childhood* *Child's view skewed? – is that true? Her world view*	R Um … from my recollection I'd say most of it. But then you know I was a child and you just … you just seem to remember the bad stuff, you know. But there were good bits, you know. We'd go on holidays and stuff like that, there were nice bits. So not 24/7. But then I don't know whether that was drugs kicking in or what, you know. But she was very, very changeable	Long term maternal illness impact
69	*Client stated this in phone call*	I So would you see it as possibly manic depressive? Have you looked into sort of what sort of type it was?	
70	*Re-listen audibility – make sense – more clarity possible*	**R I have, but because I was never told anything, because she won't talk about it now either, and I can only go on what my experience was. I mean a child's perception when you're so little, it's difficult to say** and my dad was always in denial. I And, then he would anyway. You know what I mean? He would deny and … you know. He would object to that.	Never told Father's role
71		I What was your experience of your father?	
72	*Father hero* *Supporter*	**R My dad was my hero. When I was little my dad was the one that kept us going, kept us sane.** Only I think now as I've got older and I've sort of gone through therapy and stuff like that I've realised that (pause) he wasn't as great as I thought he was I idealised him.	Importance of father Idealisation
73	*Not my place to say this – although this created connection - attention analysis*	I I don't know what … that's you know relatively common. towards a father. and I wonder about the effect of that.	

		I have no idea what could be the effect, just the fact that…	
74		R Yeah.	
75		I Have that hero	
76	*Guilt empathy Retrospect Objectivity subjectivity*	R **Yeah, yeah. Yeah there's a certain amount of that. But I do feel … I do feel bad that I preferred my Dad to my Mum now I am a mum. I favoured my dad so much, because I don't think you should. And I do feel bad. And then when I'm objective about my dad he was good in comparison**	Hindsight Father Guilt towards mother
77		I In comparison.	
78	*Comparing father*	R In comparison. Because he never did that – be cruel you know he was kind, he was friendly, he was you know …. *there.*	Good by comparison – father and others?
79		I (inaudible)	
80	*Concept of the time Concept of The marriage combination*	R You know he was a man's man you know really. And I appreciate that you know my mum and dad are a bad combination. It might well have been he that made her like that.	Who's to blame?
81		I Retrospectively.	
82	*Father's role in hindsight in mother's EMHD?*	R Yeah. It might well have been the way he was and their relationship was that made her. Cos he was … I remember I mean he wouldn't have let me go out when I was 15 or 16, because I was a girl. But my brothers could. Now he had those dogmatic views with me, and he was like that with my mum … then that could have been partly what drove her depression	Father relationship Hindsight Who's to blame
83		I Yeah.	
84		I Or sometimes it's the type of man, or a different type	

		of man might have made a difference.	
85		R Mm absolutely yeah.	
86		I To her?	
87		R Yeah. He was very much 'Do as I say'. 'That's what I say you do, that's what you do. I look after you.' 'I am the man, you do what you're told.' And I don't think that's healthy (inaudible)	
88		I And becoming a mother yourself when you, as you said, feel that 'I don't think I should prefer my father to my mother, was that in any way, has it affected being a mother?	
89	*Guilt in the light of being a mother* *Guilt towards own mother* *Relationship in family Dynamics*	R Oh no, That goes through my mind all the time, and I feel bad towards my mother, now I am a mother - my mother all the time. Lots and lots … still now I still … and it's a kind of silly joke, family joke, that they often said I was Dad's favourite … like even when they were babies they used to say to me tease me about it. And always still now … even as adults now they joke and try and trip me up - strong feelings maybe. I was quite clearly my Dad's favourite and that brings the animosity that I got from my brothers.	Guilt towards mother Father in hindsight
90		I Mmmm	
91		R Absolutely. So I sort of – well it's) bad for their relationship with each other. So yeah I do feel bad.	
92		I So has that … is that one of the ways in which your parenting from your mum and your response to that has affected you?	
93	*Childhood impact*	R I'd like to think it hasn't, but I suspect it has. Because it's	Effect on mothering

		always been in the back of my mind. It's one of those things like I just … I don't know – it goes on , favouritism	
94		I Yeah. It goes on.	
95	*Fear* *What have I been like as a mother* *Did I harm?*	R Yeah it just goes on, and I just think … um, but it scares me. When I get my rational days when I think well what could I have done differently? I suppose when I look at it rationally, I don't think I treat them differently. So I don't think it's in reality.	Fears as a mother The mother I was Sibling effect Fear of harm as a mother
96		I Is it something that preoccupies you generally? Not specifically that specific aspect of it, but because of how you were mothered do you find yourself …	
97		(Doorbell? Device turned off)	
98	*Keeping myself in check*	I Um … it's very difficult in research not to lead a question but to encourage it if it's there. So, if I say anything that sounds like I'm, you know, trying to lead you – do say if you are uncomfortable	
99		R Okay.	
100	*Question is directive but also tentative and preceded by clarification*	I But what I was going to ask – whether there was any sense in which as a mother now you've found yourself or find yourself preoccupied with your mothering in the light of the way you were So 'I don't want to do this because …' or you know that kind of … do you find that it figures very much?	
101	*Avoid* *Not logical* *Impulsive?* *Reactionary to childhood*	**R Not so much now. But when my kids were younger all the time. All the time. I made a conscious decision not to do things simply because she'd done it. I mean I didn't want three children because I felt …**	

		in my mind then I thought that was the problem, it was that number. You know I didn't want any repetition at all of my childhood … anything that could be compared. So … and the fact that I had three children you know … why did that happen? … but then I could equate that because I had two boys and a girl and not the same order that me and my brothers were. So that was okay, that was all right then. If it had been the same, well - I would have done anything to change it.	
102		I So quite a strong sense of not wanting to repeat a lot of … almost all of what you had.	
103	*Emphatic language – vehemently against*	**R Absolutely totally always. Always. Specially when they were young. It was always I am not going to do that because that's what she did, it was that way for us and I would do the opposite. Even though sometimes it was you know not the rational thing to do.**	Determined to be different
104	*Is this leading or connecting*	I Whereas you might imagine that people who had a different background might take forward into their mothering 'Oh I do that because my mum used to do that.'	
105		R Yeah, yeah.	
106		I The reverse.	
107	*Model children give Children opposite to me* *Total avoidance*	R Absolutely. I mean my girls joke and laugh about it now. One of my daughters moved last Friday and my eldest daughter … it was my middle daughter moved, but my eldest daughter was putting things away in the kitchen. And she	Avoidance absolute – determined to be different to mother

		was saying to xxxx Where shall I put this, where shall I put that?' She says 'Oh just put it like mum does'. Cos I'd just changed mine, xxxx said 'Oh where do you put this now?' 'In the cupboard.' 'Yeah but what shelf?' And I said 'You're mad' cos you know where things are. Now I am totally the opposite (inaudible) totally bizarre to the extent that if my mum kept the porridge on the top shelf I'd keep it on the bottom!	
108		I That's says so much doesn't it?	
109		R Yeah.	
110	*Encouraging her to open more on this*	I I mean what is your idea of how you want your children to be? You know do you think 'I want them to have good experiences' and then you have all these and so your … you kind of … it sounds as if you're kind of trying to construct your mothering the opposite of what you had.	
111		R Yeah.	
112		I Rather than … you might imagine some people just mother.	
113		R Yeah.	
114		I Or just copy or just …	
115	*Not natural* *Kicking against* *Rebellion* *Stops natural mothering* *Mothering reactionary*	**R Yeah. It was … and at times it didn't feel natural, because it was like I was kicking against something. It wasn't something conscious … it wasn't a thought out thing but I made a conscious effort not to be the way she'd been. And that stops like natural things just happening sometimes, just interrupts because I was obsessive I just so didn't want it to be like my**	A reactionary model of mothering

		childhood I really didn't. And I hadn't told anyone. I didn't tell my husband till 2 years ago when I broke down, well … about 3 years ago. He knew something was strange, he knew that my mum and I didn't get on. He knew that she wasn't quite right but well, and my brothers never spoke about it either	
116		**I Yeah**	
117		R I mean it took something to bring it out	
118		I Right, so it did come out	
119	*Anger* *Realisation* *Final straw* *Explode*	R Yeah totally. I mean I just erupted, I don't know … I do know now what brought it on. Um … I had to go into … I had to go into hospital for an operation on my legs and at the time … I was scared they had to break my legs. And you're scared cos you don't know what's going to happen. But the thought in your head is they've got to break my legs you know. Horrible. And I told my mum I was going into the hospital (inaudible) I went into the hospital, had this operation, and my husband came up to see me. I had two letters, one from his mum and one from my mum. The one from his mum was a little card with a picture of a garden. You know telling me about how she hopes you feel better you know?. The one from my mum was, well,Nothing about my legs, nothing asking me how I was, nothing - it was just about her. **And I just … I think that was the final straw, that was just I can't forgive her. You know even if she'd**	Sudden realisation of impact

		said something like 'I hope the operation goes okay' anything, anything. But not a word. And that was in the June. That was in the June. And then by November I think I was stewing away, I just exploded. You know my husband said something to me about going to see my mum for Christmas you know and I just exploded.	
120		I What did you explode with? Tears, anger?	
121		**R Anger. Totally angry, absolute anger. Complete rage. I mean he just sat there**	
122		**and he just said 'I can't believe you never told me …I suppose you know, I'd never spoke about it and I must have obviously not been making any sense at all.**	
123		**Because it was I hate her and stuff like that. He said I can't believe you never told me**	
124		I Yes	
125		**R Yeah.** **He thought…And I think that's the idea people had, and that was it. I mean I just went into a complete breakdown. A complete breakdown.**	
126		I So did you actually feel you had a breakdown?	
127		R I don't know, I don't know.	
128		I Mmmm	
129	*Impact – it had to come out*	**R It had to come out. I suppose you know I'd kept it in. Never spoke about it, just kept it away from the kids. Very, very careful to keep her away from my kids never babysat them. Yeah, I**	I did not tell an anyone either – relate to childhood No one said Secret

		suppose at some stage it had to come out. And, then a really good friend of mine at work, a friend of mine, I suppose maybe all the stuff that I valued	
130	*Verification – counselling interview – attention in analysis*	I Then when you think of it being what we used to call a breakdown, out of control and that it's not an over-reaction, what you described to me sounds like a kind of completely appropriate reaction to having to deal with this and lie about it, pretending … you know to stop doing all the things you were doing that were just keeping your life	
131		R Yeah.	
132		I Was a natural response. To be furious, to be completely absorbed by that emotion for a period of time	
133	*Not wanting to seem mentally ill.* *Exploded justification*	R Yeah, yeah I mean yeah. I didn't do anything that bizarre although in the context of my normal behaviour then it was bizarre, it was odd. But um … but yeah I was just so angry, and I got scared as well,really, really scared that my husband was going to go and confront her	Scared when spoke out Scared of mothers reaction
134		I You fear her reaction?	
135		R Yes because I always did	
136		I Because you'd feel that as a child.	
137	*Loneliness childhood* *Shame* *Friends not visiting* *No friends or family* *Surreal –* *Mum disappearing* *No one said*	**R Oh yeah, absolutely. Friends wouldn't come back to the house, I never knew what she'd do. I would always go to friends' houses. I mean – I don't know if they knew? I suppose, it must have been…yeah my aunty knew, my Nan knew, Dad's mum. My mum was an only child. Her mother was completely**	Surreal mother Disappearance No one explained

		bonkers as well. So there was never … you know I didn't have a relationship with her, or anyone on that side. So my Nan was great and she kept us safe, my Nan, she was very very, nice (Dad's mother). And in summer my dad would take us up north to stay with my aunt. We'd stay up there. My mum just used to disappear. The minute we used to go - she'd be gone. You know it was like me and my little brother arriving home and he would just be gone.	
138		I How did you feel you know	
139		R Mmmm	
140		I And then when you become a mother and you see children at an age where you were left on your own, or whatever. I mean how did you feel, did you worry…	
141	*Opposite fears stated later*	R For me it was never going to happen to me - I knew I wouldn't do it to them … you know nothing, I wouldn't do that.	Determined to be different
142		I You felt secure from that?	
143		R Yeah, yeah. That would never happen to me. So it wasn't a worry for them, you know they weren't going to experience that.	
144		I How did you feel? do you know what I mean you are trying desperately to make that nothing ever happens. You know working so hard	

145		R I never ever thought about it consciously because at that time with my eldest daughter it was fine. It was just there in the back of my head, nobody knew about it.	
146		I You never confided in anybody?	
147		R No. My brothers knew, but we never talked about it.	
148		I And now?	
149		R Um, occasionally yeah. Since my younger brother's died things have changed. And we've both changed I think as well. Yeah occasionally. We went out for dinner a couple of weeks ago. And I just said oh yeah and he said oh yeah and that's so different to how it used to be… you know and even, my husband was surprised. And that for me in a way as well is an affirmation as to why …I feel like I do	
150		I A recognition.	
151	Ongoing healing – impact still there	R Yeah. So you know … but that still happens, that still happens. Scary but I am still scared no-one will believe me … they don't believe me, you know. Making all this up. My mum always used to say that I made the story up. But I never ever related my childhood to the childhood she told me I had	
152		I Can you picture yourself as a child?	
153		R Um a bit better. A bit better when I compare … yeah.	
154		I Since you had that …	
155		R Yeah.	
156		I … realisation. And …	
157	Therapy Healing	**R Yeah. But I mean I had a good sort of 18 months of**	Effectiveness of therapy

		therapy and it really did help, you know, it really did. I kind of worked through it all there.	
158		I Would you say that person was particularly good?	
159	Feeling understood Containing safe Guilt towards mother	R I felt that she had understanding never felt that she wasn't listening but I did feel very sort of contained and very safe, you could say anything. And then during the time I was going I confronted my mother, so then I had a huge guilt there	Value of therapy
160		I You hadn't said any of this before	
161	Wrath of siblings	R I hadn't said any of it at all. A year before, I hadn't said anything. I was the one that said it out loud, you know. I was the one that told someone else and that broke our secret. And then at first my brother was very angry	Breaking up the image Sibling response
162		I (inaudible)	
163		R Yeah.	
164		I (inaudible)	
165	Mother's surreal behaviour	R Well it's weird cos then my younger brother got ill and I thought if I hadn't said it in my diary. A bit of me thought if I hadn't said anything he'd be alright totally irrationally … but he had a brain tumour, you know, he was going to die no matter what I feel. Um … so there was a bit of that going on. She just carried on, not done anything.	
166		I Mmmm	
167	Timing of therapy	R Yeah, yeah. But now I'm really grateful that I was already going there when he died because then she was able to help me see things rationally. So that was a good … that I was already down there. But I spent	

		2 years … was it 2 years? … I can't remember, it was about 18 months where I didn't speak to my mum. All the time my brother was sick, not even for my brother. My husband used to go if she ever wanted to go. He'd take her down.	
168		I Do you feel okay with the fact that you couldn't do that?	
169		R Sorry?	
170	*Not my place to ask this – pay attention in analysis to own processes – need to heal in clients*	I Do you feel okay with the fact that you couldn't do that at that time … you said 'not even for my brother I couldn't do that'?	
171	*Positives of anger* *Straw that broke*	R Yeah, yeah, I do yeah, cos he understood. Yeah he understood. He knew why. And I thought you know I'd just had a broken leg and she didn't even send me a card. But then maybe – I was if I hadn't have been so angry, I would never have dealt with it at all.	Anger Value of anger
172	*Verification overdone* *Pay attention in analysis*	I One of the things can be when … you know when a mother is, there's that part of the child, the grown up child, that thinks well that's a thing that's a thing. And that anger is really waiting, that anger (inaudible) your own right and your own justifications.	
173		(doorbell? - tape turned off)	
174		I So anger is so needed, like you say of yourself	
175		R Yeah.	
176		I And that is so necessary and has been very necessary to your own feelings really, your own …	
177		R Absolutely.	
178		I … ability to kind of, you know talk to yourself about it,	

		talk to others about it. Have it there and not.	
179	*Confidence gained to know what's real – therapy?* *Motherhood?* *Giving them what I could not have*	**R Yeah. It doesn't matter any more if people believe me or not, because I believe in that. I think all the time I was ignoring it or forgetting it and never thinking about it. It got to the stage you know I couldn't keep it in I just exploded. So you had these sort of conversations with yourself. But that's the way it was, you know, that's the way it was, and I ain't going to change it. I spent all those years wanting things to be so different. I wanted to have a childhood like the one my kids had. That's what I wanted, and I never got it. And I'm never going to get it.**	The mother I am Regrets for myself
180		I How do you feel about that?	
181	*Regrets* *Healing*	**R I feel quite sad actually, I do feel sad about it now. But you know I can't change it. So … and that was part of the deal really about healing. And it's made me who I am.**	Regrets
182		I Who you are now.	
183		R Yeah.	
184		I Is that very different?	
185	*Healing* *Therapy* *Friends* *Family* *Right to speak* *Confiding in others* *The right to speak*	**R ah since I think … like the past 4 or 5 years I've changed so much. Since I've stopped … just acknowledged what my life is about. And since you know I've sort of worked through all that stuff with my families, told everyone how I feel. Like my best friend knows - my children know now. Whether it was right to tell them or not I don't know, I feel maybe I**	How I changed Speaking up Healing

		shouldn't have done it, but I did it. But then I think they've got a right to know, you know. So … and I've changed an awful lot.	
186	*Dual life* *Before and after* *Life I was told* *Dark secret* *Pretence* *Me in their eyes* *Reconciled*	***R. I'm not* … I think the thing is that I always felt like I had two lives going on. I had this one that everyone saw but then I had this dark secret that nobody knew about, nobody realised and I was pretending that the two were one … that I wasn't that person and that I was someone else. But I'd never spoken about anything like that at all .... ever. Really really strange you know. It's like you started your life, as a friend's said you are, you know at 16 when I left home. And now I just feel that the two people are one, that I'm complete now. That I am who I am. And I'm quite happy … I haven't got this fight going on any more.**	Dual life Pretence
187		I So there's a lot more self- acceptance there.	
188		R Yeah. Totally yeah. I still get my moments though, I still …	
189		I What happens in those?	
190	*Worry about being rejected by children* *Needing approval* *Apologising in advance* *They don't know* *I don't know* *Fears for them* *What have I done?*	**R Oh I just sit and … I just worry, I suppose I worry that … especially with my kids, I worry that I put them off me(?). And I do … I know I do it too much and then I check it out with them and I apologise to them. You know, I worry about things … I say things like 'Look I've probably screwed up somewhere' Because you know you never find out until**	The mother I fear I am The mother I fear becoming Fear of harm Needing them to make me feel better

		it's too late. You get this baby and it's not until it's too late that you realise you've done things wrong. When they're an adult and they've got problems and issues You just don't know when you're that size, do you? So I kind of apologise in advance in case I've screwed their lives up. And if any of them has a problem, I mean. I worry I caused it. You know and I do check it out too much. And that's me being needy, that's me needing them to tell me that I've done it okay.	
191	*Reaffirming – counsellor again*	I How wonderful that you know that. When you think of the blindness of your mum.	
192	*Despite the counsellor – not side tracked – telling her truth* *Self-doubt* *Fears re my mothering* *Waiting for the bad*	R Yeah. Yeah. And they're fantastic. Even saying it now I've still got that percentage in my head where I think I have got it wrong,they are going to blame me or not like me for something I did - evidence shows that they do. But my self-doubt as a mother makes me think they will blame me, maybe in a couple of years and I'm kind of waiting for it to happen.	Fearing badness in me Waiting for the showdown
193		I So is that underlying fear that you're going to go wrong?	
194	*Fear in pregnancy* *Fear I would repeat* *Out of my control* *The monster in me*	**R Mm. All the time. When they were tiny I was so scared, scared still, really scared stiff. When I first found out I was pregnant I was so frightened. And again and I was just so frightened, so so frightened … that I wouldn't be able to help myself. That it didn't matter how hard I tried that something would happen when you had this baby, some**	Fear of the mother I could be helplessness

		kind of hormone would kick in that turns you into that monster. You know what are you going to do, what am I going to do if that happened to me.	
195		I Do you look back now and think maybe the opposite that awareness… that you worry so much? That maybe that's (inaudible)?	
196	*It's already happened – self fulfilling* *I am her* *I controlled it* *Realised I have missed a concept – so much effort. I have only just realised what I have been feeling – hard work, determined to be different. Is it just me – check – attention in analysis*	R Yeah maybe, maybe. I just don't know. I don't know now I've got three. I know the first … I remember … I think I spoke to the girls. So when xxxx was here and I remember being in our old house in their bedroom, so trying to get them to do something and I remember standing in this room screaming, and just screaming, screaming, screaming at them to do something. And then just all of a sudden I just stopped. It was weird. What am I doing, this was happening then, this is what she was doing. And when I thought about it I thought (inaudible) and it's like it had happened and I must have been doing it … maybe I'd always done it, maybe it had just crept up on me from having one baby to having two small babies that it had just overtaken me. But I just remember that moment of clarity thinking 'Oh shit, this is all going wrong. You are her, you are doing what she was doing'. And then I just had to stop, I just had put so much effort.	Controlling the monster in me So much effort
197		I And that was the sense in which you weren't your mother because you were able to…	

198	*My ability to control myself – not like my mum?*	R Yeah, yeah. And I did, and I stopped and I said to myself you know, who's actually listening to the shouting – nobody. They're not listening, they're not going to enjoy that. You're screaming, you're getting all upset and stressed, they're not going to enjoy that. And then what's happened is	Turning into her
199		I How did you feel about that then?	
200		R Then? What when I was doing that, in that particular incident?	
201		I In that incident, or as a young mother?	
202	*Terror* *Copying others* *No model for mothering?*	R I was just so scared, I was so scared. So scared that that had happened. And I wasn't very confident. I wasn't very confident at all, didn't have much experience of babies. And I didn't really have anyone (inaudible) husband's mum was very good, she had 8 kids. So she was very good, she was sort of (inaudible) She'd be able to talk about it. And I suppose like my eldest brother had had a baby a couple of years after as well, so I had like my sister in law around, and we kind of got through it.	Model of mothering Copying to cope
203		**I But none of them knew,**	
204		R No.	
205		I (inaudible)	
206	*Terror of turning into her*	R No. I was just terrified, I told no-one I was terrified that it would creep up on me and I wouldn't know. And then …	No control The mother in me (her)
207		I So what would you say was the essence there of how being mothered by your mum affected you in your daily life?	

208	*So much effort* *Trying so hard* *Desperate* *Fear no control*	**R It just took over my whole life you know. I thought I've spent all my time thinking about her and she was the last person I wanted to think about. Because I was an adult, I'd got away from her when I was 16, 17 and I weren't going back, you know and I didn't want to. I didn't want anything to do with her really. But I had to keep up this pretence that it's like happy families. And all I was doing was thinking about the one person that had bloody terrified me (inaudible) was terrifying me even now. Terrifying me that I was going to turn into her.**	Terror of turning into mother Helplessness Pretence
209		I You still have some very similar feelings.	
210	*Check last line* *Terror of her, terror of turning into her*	R Mm. I spent my whole life being terrified of her. Terrified she's going to be, terrified I was going to be her. And it's only now, you know, the past 3 or 4 years, that I can actually feel some sympathy (or 'something different') for her. I do feel sorry for her because she's not happy	Fear of the mother I could be Fear of her Empathy sympathy for her
211		R Not an awful lot.	
212		I No.	
213		R Not generally.	
214		I And, not for what you have come through? Over time was there any change that happened?	
215		R Well	
216		I That kind of shaped your feelings ?	
217	*Self-worth grown* *How I have changed* *Last consideration is me*	R Realising I am ok, well in comparison. And realising that I am important and it does matter, what I think … it does	Sense of self No sense of self

		matter what goes on inside my head does matter. That's quite recent. But I think … I think when the kids were younger I was just … I didn't think about me much at all really. **You know I was always last on the list (inaudible) I didn't exist**	
218		I You were busy trying after what happened to you, you tried so hard to be different.	
219	*Fear after fear*	R Yeah I just wanted it to be different. I just wanted them to … to be happy for the kids you know, fun and laugh and things … and not be scared. And so I never really thought about me. I never really thought about how I was feeling about doing it.	Desperate to be different No thought for me
220		I How do you feel you got your skills as a mother?	
221	*I don't know how I did it*	R It's a question that I just don't know. I don't know. I searched that one so often, the best answer that anyone could come up with is that I picked up stuff from … the positive influences from my dad and from my nan. But I don't know, I don't know.	How I coped Copying others to cope
222		I It also sounds as if you were shaping your mothering in response to the bad example.	
223		R I knew it was wrong.	
224		I And it makes you wonder how can a child know what's wrong, even if you yourself, you haven't got any power. You know you grew up knowing what was wrong.	
225	*Thought all families are like that* *Realising* *I knew it was wrong* *I knew mothers weren't like that*	R Yeah. I mean I did think for a while that everybody's family was like that, that's what all families were like but then something must have told me it wasn't, because I did know that	Child knowledge Child insight

	Separation not normal – I knew	was wrong. All the time I knew it was wrong even though I was really small. I knew that kids (inaudible) that mothers weren't supposed to be cruel or disappear you know. The kids weren't supposed to come home to empty houses. She went once for about 18 months	
226		(End of side 1)	
227		(Start of side 2)	
228	***Surreal experiences I just coped***	**R … you were supposed to not question it and not ask where she'd been, and not wonder what was going to happen next. And as kids we just did it, you know I just did it! But now I just think how silly. You know your mother goes away and you come home one day from school and she's not there, and then 18 months later you come home and she's sitting there, and you just carry on (laughs) just nobody says anything, like 'Oh hello, how are you, not seen you for a while.'**	**No one explained I didn't ask Message not to ask**
229		I And yet you've tried to have this communication open all the time. As you say with your children, checking in with them …	
230		R Oh yeah yeah.	
231		I … have I done that all right, or has that affected you. Whatever … however you've done it. okay to do that.	
232		R Yeah …	
233	*Verification – attention analysis*	I But that is also a very positive thing, that's actually opposite to disappearing and not coming back for 18 months and not communicating	
234	*It's not all me*	**R I do, I do. I mean my eldest daughter's said to me**	Learning through daughters

	Even my daughter knows – not all me *Daughter's teaching*	**recently you know, I was apologising for something … something she'd done she said 'For God's sake mum, some of these things are me. Not everything I do is down to you.' You know 'Stop beating yourself up. There <u>are</u> other people in my life.' I said 'Mm?' So I'm kind of … all of their faults I will take on as being my fault.**	Learning to let go of blame
235		I You've also clearly given her a good sense of herself if she can say that.	
236	*It's not all me!* *Fixing* *Saving* *Get clarity - audibility*	R Yeah. I hope so. I mean she's lovely, she really is lovely. And she's right, it isn't all down to me is it? But I do, I take ownership of everything. Just everything, it's all down to me. For a long long time I was a great fixer, I was going round fixing it all, you know. **To the point where it was silly. If you give them a letter to post and they get outside the front door and lost it, it loses benefits. And if they lost their mobile phone I just buy another, you know you're never going to learn if someone fixes everything you know I get another one out of the cupboard, you know. So that … you know the recent thing as well.) And then now I think, what have I done to them? It isn't supposed to be like that.**	Letting go Fixing all The rescuer
237		I But have you now … is there a sense in which now you have a bit more confidence?	
238		R Yeah.	
239		I You know I've given up …	

240	*Healing* *Lack of trust in me* *Lack of trust in them*	**R Yeah yeah I'm getting better at that, I am getting better at that. But when they were younger I'd love to have had that, when they were younger to have that level of confidence and trust their lives. That it would be ok, that they had a part to play but I couldn't, I couldn't. I couldn't trust it because …**	
241		I Sorry you said … I thought you said you would love them to been able to trust your life	
242	*Couldn't trust what children say or mean – mothers let you down* *Wishing her dead*	**R No for me to trust theirs. Because in my eyes mothers let you down mothers, you know. They didn't - Cos I mean now I'm thinking all the time about my mother. I mean there's times when I wish she'd just drop down dead you know. Just stuff like that. And if I hear of someone that died … big train crashes and I'd wish it was my mum - that's what I thought about my mum, and that's what'd be going on in my head.**	
243		I So it made your own self-worth as a mother poor	
244		R Mm.	
245		I Your identity.	
246		R Yeah. Yeah I wasn't very …	
247		I You didn't value yourself.	
248	*Didn't value me* *Lying – pretence as child* *Doubting my children* *Doubting myself*	**R No, no I didn't, I didn't value myself And I just … I was very suspicious about them as children. Because it didn't matter what they said … I would wonder what was going on in their head … because whatever I said wasn't**	

		really what was going on in my head. I'd say what people wanted to hear. Whatever she wanted to hear I'd say. Just to keep her off my back. That was the thing … but I doubted that I'd got it right. Even though I knew that I was doing the best I could I still really doubted that it would work. I doubted I'd got it tight ever. I didn't value myself as a mother.	
249		I Would you have described yourself differently before you were a mother, to how you'd describe yourself now? Would you have described yourself as a person any differently?	
250		R Yeah.	
251		I What was different?	
252	*Missing jigsaw – motherhood Overwhelmed*	**R What was different? It was just like for me it was just like getting the missing piece of a jigsaw. It was just 'So this is what this is about'. You know having that first baby and just thinking … and just being so totally overwhelmed. I don't think I've ever experienced love like that in my whole life until I had that baby. Cos I hadn't, I mean my mum … my mum, there was nothing there. My dad, it was different, you know it was my dad. But not that kind of really focussed (inaudible) just totally focussed on one person**	No love with mother Comparing love as mother
253		I Do you think that might be something that?	
254		R Do you mean?	
255			
256		I Not really … I don't mean to suggesting they	

		couldn't cope, but that that they'd be completely overwhelmed. You described it yourself …	
257	*Joy of mother* *Opposite stated later*	R Yeah, yeah I was. I was totally overwhelmed. But it just felt positive. It just felt like good stuff.	
258		I Right. What about (inaudible) the fear you had before? When did the fear kick in?	
259		R I had been terrified before	
260		I The idea of having children.	
261	*Terror of being a mum*	**R The idea terrified me. The idea of being a mum, looking after them also yeah, terrified me. And I just thought … I used to sort of think 'Well you've managed this, you've got this far', you know 'You've managed to get this far in life so' So … and I just kind of wing it really Yeah okay. She's not going to go away, got to do something with it. You know.**	Fear of the mother in me Fear of the mother I could become
262		I But the reality of the children were kind of in your face all the time.	
263		R Yeah. I think like anyone	
264		I Yeah kids are just different from you and you imagine	
265		R Yeah	
266		I Did you imagine that for you, with your background did you imagine it being different?	
267	*Different for me* *Lack of joy* *When did I enjoy it* *Always checking* *So much effort*	**R Yeah I suppose I did think it was different for me. I suppose other people just did it, thought it was easy, (inaudible) try. I had to try, I**	Easier for other mothers Not burdened Lack of joy Always trying

		really had to try. All the time. check things out with her. I don't know maybe I thought other people weren't burdened with all that stuff as well, they could just get on and enjoy it. And think it took me a long while to enjoy it. You know and my life changed the minute she was born. I couldn't imagine never having her. So it was hard work, and I didn't enjoy it. I don't think I enjoyed it … I don't know maybe … I can't think when I started to enjoy it really, when I just thought. Oh well - I think it just kind of crept up on me.	
268		I And maybe	
269		R Mm.	
270		I And yet you know when you sort of think of someone perhaps not checking	
271		R Oh absolutely yeah. I just wanted to prove that it could be done.	
272		I So once that role arrived, it took over your life.	
273		R It took over my life Yeah. Yeah pretty much yeah.) she was gorgeous. Once, it was just great.	
274		I Are you similar in other roles do you think to you being a mother, or different?	
275	*Drawn to care* *Empathy with children* *Relating to children*	R Um, no not as … being a mother is something completely different, you know. I'm a lot more detached now in my work (inaudible) **You know all the jobs I've had, loads of jobs, all with people, loads of young people. Most of the jobs I worked where it was care leavers in xxxx. Social**	I am just like them

		Services. And they were … that was a fantastic job, brilliant. And I suppose I have that empathy with those kids because my mum was shit as well, so … not that I ever told them, but there was that understanding, that level of understanding. And then, you know, no matter how much care. I was good at it and I could do it, because I know exactly where they're coming from.	
276		I (inaudible)	
277		R Yes	
278		I Do you ever wonder how you got that empathy?	
279	*Don't know how I did it How did I mother Bewildered*	**R All the time. (laughs) I don't know. I don't know where that's come from. I don't know where any of this has come from. Why I'm so different. I don't know. And that's one of the things that continually baffles me**.	
280		I And about how well you are able to kind of offer to your children	
281		**R Totally … don't know how that happens.**	Can't believe I managed
282		I inaudible	

283		R Yes.	
284		I It kind of makes you doubt that you have to be that good as a mother. It's that kind of … trying to be so good and yet arrived without anything.	
285		R Yeah.	
286		I And you've arrived with empathy as a mother.	
287		R Yeah.	
288		I inaudible	
289	*Check audibility*	R Does it really matter . Cos Really my childhood was garbage	Relating my childhood to my mothering
290		I Why as an adult	
291		R I don't know.	
292		I Quite amazing isn't it really.	
293	*Bad childhood Does it matter?*	**R I wonder if it <u>really matters</u> what childhood you have, I have spent all this time trying to be perfect. Well I didn't have that did I? […]Yeah cos […] … me mum being shit, I turned out <u>okay</u>.**	Did I need to be a good mum?
294		I Not that it matters to you, but does it matter …	
295		R In the greater scheme of things.	
296		I Does it matter how good you are now as a mother?	
297		R I hope so.	
298		I Cos you're very good as a mother.	
299		R Yeah.	

300		I But you could say …	
301	*I hope it matters*	**R I hope so. Because then they'd have a complete package. Because I feel I've only had half of it. That my childhood was crap and anything that I've had now I've made myself. But they've got the opportunity, they've got the potential … that whole shabang … they could have a great childhood and now they're adults they can do what they want.**	Regrets Hope it was worth it Hope mothering matters
302		I Without the baggage.	
303	*Baggage* *Struggle* *Easier for them* *Trying so hard*	R Without the baggage, without the struggle, without the constant thinking, without your head working 24/7doubtingyourself	It's easier for them (others)
304		I And that's (inaudible)	
305	Self-doubt	R It is. Not the constant self-doubt the whole time.	
306		I Is it any better now how you're feeling about you?	
307		**R Yeah, a lot better now.**	
308		I How you view yourself.	
309	*Check*	R Yeah yeah. I think it's changed a lot. So I didn't really give it a lot of thought when they were younger. I didn't spend any time thinking about me … you know you're just a mother All my time was spent thinking about them as children. My own thought would be the practical things that I did, but not how it was for me.	
310		I No.	
311	Proving it could be done – good mothering Proving I can do it I did not matter	R I never ever gave it a second thought whether I enjoyed it. It didn't matter to me whether I enjoyed it. If it was complete torture it still had to be done, just to prove that it could be done.	Proving it can be done Joy did not matter

312		I And for you to feel okay about	
313		R Yeah yeah, absolutely.	
314		I And how do you imagine that differs?	
315	Easier for them Effortless for them Copying to cope Not natural	**R I don't know, I just always think … when they were younger I just used to think that everybody else would just do it, you know. It's just effortless. And I suppose maybe a lot of my stuff I just copied things from others I saw … copying friends and family, you know, it was never quite natural. And I suppose I just got on and did it. That was how it was to be**	Easier for them Not natural mothering
316		I So this relates to like now … the prompt that I've got here, this is my guide, and other than that I'm kind of going by what you say … I mean my specific questions are there any particular things which you feel made your experience of motherhood different for you than other people? You've described that constant struggle and reassessing all the time am I doing okay … it almost sounds like there's another person working, with you as kind of physically being the mother, but the other person's checking you, and checking you all the time. And you were tiring yourself with doing that. And having to do that because you don't feel you've got this internal mother, that would say 'Just do that' just do that.	
317		R No yeah I think that's probably right. I had to check it out	
318		I And you still do?	

319	*Its more natural now* *Pretence of hindsight*	R Um … maybe a bit, maybe a bit, but I think it's a lot more natural now. But maybe a lot of that's to do with the fact that I've kind of sorted myself out, I've changed, you know. Dealt with my rubbish, so I'm a lot more relaxed about it. I'm also not keeping up that pretence any more, which is … you know alongside everything else that happened when they were young, I also had to keep up this pretence.	
320		I Which is exhausting in itself.	
321	*Basic relationship with mother possible now – possible for children* *No need to protect them from her now*	R Yeah. Yeah. 'I'm so pleased we're going to see nanny', you know. Because they would wonder why do we see granny and not nanny. So there was that going on. But no I don't keep that pretence up any more … and they're a lot older. And they know now as well.	Mother now
322		I Do they ever try to talk to each other about it?	
323	*Daughter supporting* *Daughter analysing*	R Well my middle daughter does, yeah. Yeah she does. Quite a lot. She's very interested in psychology. Why we do what we do – she's very… Yeah. I mean… I can't even remember how the conversation came up, but she just said … I was talking about when I was a kid…and she said 'Well it probably wasn't all bad'	Mother daughter relationship
324		I (inaudible)	
325		R Yeah. Maybe not all bad but it wasn't great. It wasn't great.	
326		I And she can't imagine	
327	*Childhood* *Daughter's interpretation*	**R No. She even makes connections as well. She even traces back. Because if I give**	Over parenting

	Compensatory parenting	**her … if I'm talking about something in particular she'll then be able to say. I had this thing as a child that I would have to eat the same thing every day of the week, whether I liked it or not. You know I had horrible fried sausages. Every Wednesday there would be sausages, you know. And even though I said 'I don't like sausages' they would still appear on my plate and I would have to eat them. And if I didn't eat them then she would go mad and there'd be a wallop, So … and we were talking about … and I know she did that, it was the only way she could cope, because for her, for my mum, being a good mother was you had to feed your kids. So she fed us. But it was very inflexible and it was very routine,f what she needed to do as a mother. But she couldn't cope with anything outside of those parameters, she just couldn't. And that's where it would go wrong. So if I'd ask for fish fingers she would have had a bloody breakdown, so you just don't, you eat the sausages. And I said that to my daughter, about the sausages. She said ' No wonder you know? Cos I would say to my kids 'What do you want for your dinner?' and if one of them said roast dinner and the other one said fish and chips that's what they would have. And she said it was like a café sometimes in my house. And if a friend came to tea she said**	

		my friends used to love coming to tea cos they could order what they wanted, and you'd cook it. So …	
328		**I Did you want their friends to like you?**	
329		R No I just wanted them to come to the house. I just wanted the kids to be able to …have children round	
330		I Because you never had any.	
331	*Compensatory parenting*	R No. I wouldn't ever have invited friends. I wanted them to be able or to want to ask their friends round. I didn't really mind what they thought of me. The fact that they asked their friends round, it made it for me.	Healing through mothering?
332		I Did you ever imagine what people thought of you as a young mother or as an older mum even?	
333	*Guided by my children*	R Yeah. More-so what they thought than what the kids thought.	Pleasing my kids
334		I (inaudible)	
335		R Yeah.	
336		I You had no real sense of yourself then?	
337		R Not really.	
338		I It was governed by whether they were happy	
339	*Needing approval*	**R Yeah. Yeah I'd have to go on the kind of things they'd say feedback I'd get from them, yeah I'd just be guided by them really. My kids and other mothers.**	Needing approval Needy parenting
340		I And now do you feel more able to kind of tell yourself what.	
341	*What will they be like*	**R I'm getting better at it. Yeah. I'm getting better at it. I still have … and then I get …to think they don't like me.**	Future from my parenting

		I'm intrigued as to what they'll be like as parents as well.	
342		I How would you cope if you'd done something wrong. I don't know if it's happened but you realise something you did actually affect them, not necessarily ruined their life or anything like that … but how would you cope with what some mothers might say it's obvious, obviously going to affect them, some things that they'd object to, and they'd come to you and they would say 'You know it really hurt me when you did that' … how do you feel your confidence and your tendency to self doubt would deal with that … now?	
343	Protective children *Would they tell me* *They know what I am like*	R Now? I wonder if they'd actually say it, because they know how easy … how important it is to me. So I wonder sometimes if they can tell me because they don't want me to start doubting… they know how I am about that.	Would they tell me
344		I Yeah.	
345	*I can cope with what my children say - realisation*	**R Um … but then thinking about it, yeah they have said a few things. Initially I get quite hurt, quite sad, but then after I've reasoned it out, thought about it, I'm okay with it. But I think my initial reaction is that I am hurt. But then … yeah. And a couple of things I've actually … especially with my middle daughter I've actually sort of said to her 'I wasn't too happy' cos like … I think I'm able to talk to her about it. Cos she's just (inaudible) about it. And my son as well, there's**	They have told me Apologising for harm

		stuff I did to him that I wasn't too proud of, and explained really why I did what I did. All I can do is apologise now 'I'm sorry I did that'	
346		I And would you have been more devastated years ago if that happened … more critical of yourself?	
347	*Healing* *I can cope better now*	**R Yeah I think so. Yeah maybe. But I don't think I ever … I don't think I ever reflected on stuff too much then, I was just kind of getting on with it, in the moment you know.**	
348		I It sounds like you've done incredibly well	
349	*Still unsure* *Ongoing healing*	**R I've still got this voice going on 'I'm not sure, I'm not so sure.'**	
350		I But then maybe it's good to think that you know other people don't have that voice. Maybe that voice.	
351		R I know that voice	
352		I Did you … I know you worried about… did you worry about their illness or anything like that? Did you worry about your own children?	
353		R What do you mean worry?	
354		I Your mother's illness.	
355	*Never worried they would get ill*	**R Oh my mother's illness. No. No. I've never ever worried about them. Isn't that strange? I worried that I'd turn into her but I never thought of it as an illness.**	Amazed at what I don't worry about
356		I Right. So did you always think of it as her	
357		R Yeah, I thought that's the way she was, yeah. Never thought of it as an illness really.	

		I suppose because we were never told, you know.	
358		I That was very common wasn't it?	
359		R Yeah. I would have thought you know if they'd told us, if they'd said what … or maybe they did at the time originally… maybe I would have been able to see it that she was not a well person.	
360		I And as a partner, you know the husband of wife or somebody who you know is challenged by mental illness these days, hopefully there's more information to say you've (inaudible) and there might be … the hope is that there would be less pretence on the part of the dads for example if the female was not well. Whereas there used to be a huge you know, pretence that it wasn't happening.	
361	*Pretence* *Pretence re mother* *Minimising mother's behaviour*	R Well this is what we did. Yeah. Was just pretend she was just having a bad day.	Pretence in childhood
362		I inaudible	
363		R Yeah.	
364		I inaudible	
365		R Yeah.	
366		I You know which is quite unique to other difficulties and the lack of information. It doesn't sound as if your dad was saying 'Look you know mum's not well, we'll have to manage this' and whatever.	
367	*Surreal childhood*	R Exactly, and there she was just either disappearing or just gone!	Unexplained absence
368		I Mmm	
369		R Yeah.	
370		I (inaudible)	

371	*Shouting mother*	R Yeah either that or she was shouting, having one of her turns.	Mother in childhood
372		I Incredible you never told your husband either, you were so just dealing with it on your own.	
373	*We dealt with it* *No one knew* *No support* *We weren't supposed to say*	R Mm, well that's what I did, that's what we did in our family, just dealt with it on our own. And it was kind of like we weren't supposed to say because it was our secret. And I think my elder brother was quite annoyed when he realised that something was up.	
374		I Was that a given or had you actively said that to each other?	
375		R I think we'd actually said it. I think the three of us did had actually say it	
376		I And what do you think was the reason for him being upset? Was it about you making him think about it Or …	
377		R Probably yeah, probably. It was very much so.	
378		I He didn't want it.	
379		R No he didn't, he didn't yeah. And even when my little brother was dying and he just very much that's the way it was. I mean the other amazing thing is that all three of us, all three of us have got married and all three of us have been married to the same person.	
380		I So you've tried very hard for your relationships?	
381		R Yeah yeah, just because my daughter was born. (inaudible) so young.	

382		I What do you feel has been the biggest effect of your mother upon your mothering?	
383		R What do you mean?	
394		I On how you've been mothered when you were little and how you mother – is there anything positive?	
385	*Nothing positive about my mother in childhood* *No model to follow*	R (angry) So what's positive about that? There wasn't anything positive about it. It was just, I just wanted to be … I just wanted my kids to have the childhood we should have had. I just wanted them to be good people, just do all the things that kids do.	No model to follow No good model of mothering
386		I Do you think looking back that (inaudible)?	
387		R About what?	
388		I About you wanting their childhood to be good.	
389		R Yeah.	
390		I Mmmm	
391	*Compensatory parenting* *Maybe I wasn't balanced as a parent*	R Yeah absolutely. I think their experience of childhood has been a positive experience. They all say now that they've had a great childhood. And sometimes I think I probably overdid it. You know maybe I gave them too much, maybe I did too much. Maybe it wasn't a balanced you know … a balanced effort. But I just wanted them to do all the things that kids should do.	Lack of balance Giving them what I did not have Determined to be different
392		I I think it's probably important also to bear in mind (inaudible) and if anything you tried so hard to bring them up in a good way	

393		R Yeah. I mean I look at the evidence now I mean they're all healthy, they're all law abiding, they've all got a good sense of morals, they've all got a knowledge of what's right and wrong. They're not rude. That's the one thing that I would not tolerate from them is rudeness. So they can be polite to people, they've got social skills. They're working or they're at university, you know. And I didn't … not just them … but it's given them the foundations of confidence … they can make into whatever they want.	
394		I Okay, we're coming towards the end now and I'm wondering how you're feeling about how you talked about it.	
395	*Interview* *Checking wellbeing*	R Um … I'm okay. Bits I felt quite sad. Yeah I felt quite sad. I sort of do feel sad about it. Um … yeah I'm okay with it now. Because it's not a secret now I've said it. And I don't mind talking about it.	
396		I Do you think it's helped?	
397	*Insight* *Positive interview* *Recognition of skills*	R Yeah. I mean I know they talk about like children that have had abusive childhoods very often go into helping professions. In every job I've ever had I've been doing that, fixing people.	
398		I If it wasn't for people like you there'd be nobody out there.	
399		R Yeah (laughs)	
400		I Is there anything you want to tell me or you think I should have asked you?	
401		R Um … no I don't think so. I had no expectations of what	

		you were going to ask anyway. There's nothing for me that …I can't think of anything that would give you a very different picture of you know how it was for me as a kid and how it was for me as an adult.	
402	*Counselling*	I I know that I don't know great details about how it was for you as a kid. But I have a good idea of (inaudible) but I know we haven't talked in great depth about that and that I guess is because of the time and became the focus of this part of my research is (inaudible). But I've already done one part of the research which was more about the experience of childhood (inaudible) but I'm wondering if you feel that generally to a counsellor you've said enough about how it was at the time.	
403		R Yes yeah.	
404		I Stuff left unsaid there or …?	
405	*Good experience of counselling*	R No I think that's it, I went through the whole shabang. I've dealt with everything that I want to deal with really. If there's anything … you know little things come up every now and then. Because of the college course I still have to go anyway.	Benefit of counselling
406		I To personal therapy?	
407		R Yeah. So …	
408		I It's the same person is it?	
409		R No, no, it changed.	
410		I Did you?	
411	*Still in therapy*	R Yeah. I kind of got to a crossroads in a way, I thought yeah you'd probably know more about them than anyone else (?) go to someone that you know … I've unloaded all that, all that	

		crap, I want to go now to a different personal therapist now.	
412		I Mm, so you want to talk about you now more?	
413		R Yeah yeah. You know I feel as though I've changed. Accepted it, I'm not angry about it any more. I'm disappointed. It would have been nice, it would have been nice (inaudible) and had a nice childhood, but I didn't and that's not going to change so …	
414		**Yeah. It doesn't matter any more if people believe me or not, because I believe in that […] I spent all those years wanting things to be so different. I wanted to have a childhood like the one my kids had. That's what I wanted, and I never got it. And I'm never going to get it**	
415		I Mm. But that is a loss isn't it?	
416		R It is a loss, it is a loss yeah.	
417		I And I personally feel that that's something that some counsellors don't appreciate. And it sounds that the counsellor that you had appreciated more what you went through. One of my hopes is that through research like this, cos I will be emphasising how counselling can help, cos I'm researching as a counsellor, that you know research like this will give the information to counsellors that they don't have (inaudible) the number of people, you know people I've talked to who've been to counsellors who really haven't understood	
418		R Yeah.	

419		I I mean I haven't had anything in my training that would prepare me to help people with that.	
420		R Yeah.	
421		I But not that torture and that trickiness of having been parented, mothered by a mind that is destructive	
422		R Yeah.	
423		I no sense of yourself.	
424	*All about her*	**R No absolutely not. It was just … that's it, I mean she just didn't have any idea of what it was like. You know what I mean? And it was all about her.**	Self-absorbed mother
425		I Yes.	
426	*Impact on daughter* *Mother still self-absorbed* *Over my head*	**R All about her. And that's one thing that (inaudible) And that's one thing that infuriates me I mean she still does it now, she still does it now. But now I'm able to think … cos I've changed that much … I mean daughter's getting … xxxx getting married in August and my mother's not well. So where are we now April? And she's already emailed me to say 'I don't think I'll be able to see the wedding cos I've got a virus' If that was me I would probably. She's got no perception of how that must feel for xxxx. You know her eldest granddaughter getting married, first marriage. And that's the way it was, you know. And when I told xxxx was quite hurt. And I just dismiss it, cos it's always been like that.**	Current impact Current relationship Impact on children
427		I And your expectations are low.	

428		R Very low, yeah very low. Cos it's always about her.	
429		I And that's actually one of the key things for poor self-esteem for a child. In that situation the children … you know because there's nothing that would show you	
430		R Yeah.	
431	*Talking too much? – not like a counsellor though – like a daughter who wants to be interviewed – pay attention in the analysis*	I When you think of what you have given to your children, you are giving them a boundary all the time, even if they have a (inaudible) I'm all right.	
432		R Yeah.	
433		I Don't worry about me too much. Is the complete opposite to disappearing.	
434		R Yeah yeah I mean …	
435	*I am reacting to her thoughtfulness – talking and finding it difficult to just sit with. Fish out of water – used to counselling situation*	I So it's never perfect, you know I think there's probably the tendency to try harder, you know there's so much that's good about that really. And it's … you're so open because what you were saying, you're open to them saying 'Mum you did that wrong'.	
436		R Yeah.	
437		I Deeply as it might hurt you, you actually want to know.	
438		R Yeah.	
439		I Because you're	
440		R Yeah (inaudible)	
441		I I hope that that … I hope at some level you can be proud and that you can gain enough kind of … or are gaining that self-respect.	
442	*I did my best Appreciation of me*	**R Yeah I think I've really tried I think yeah at the end of it, at the end my days I know I did my best … I know I did my**	Me today

		best. Oh yeah there's little bits I could have done better.	
443		I You did your best but you also are huma And you know you've even described your mum more than anything she was doing her best. Her best was terrible, but maybe that's all she could do.	
444		R Yeah absolutely.	
445	*Reassurance after she has given me so much genuine and honest communication*	I But you've done your best and you've done so many great things, so if you find done something that wasn't perfect it'd be really nice to think 'Well, I'm just a human being.'	
446		R Yeah.	
447		I Really tried, really really tried, and that's so important.	
448	*Compensatory parenting*	**R Yeah. Yeah I mean I know, the other day. Like moving my daughter I was absolutely dead on my feet and still trying to put things away and (inaudible) When my other daughter asked me something and just turned to her and said 'Look you know she'd sleep in the hall standing up if you ask her, so leave her alone.' So you know even though (inaudible)**	
449		I You would have loved a mother like that that made you think.	
450		R Oh God yeah.	
451		I Whenever you doubt yourself think	
452		R I would do.	
453		I (inaudible)	
454		R I would have done. I mean xxxx was to take 6 days off work with the move and she went back to work yesterday, and I've seen her every single day. And I never get to see my	

		mum 6 times in a year, let alone 6 times every single day. And when she went back to work yesterday. You know I don't see my mum 6 times (inaudible) She'd email me to tell me about this leg and that she's ill and I said oh I will come down to see you.	
455		I There's no joy for you in how you've parented	
456		R The only thing that'll get me (inaudible)	
457		I Do you think you'll ever get to the stage where you appreciate yourself ?	
458		R Yeah. Yeah.	
459		I Do you imagine without having been a parent yourself how it might have been?	
460		R I can't imagine. It's horrible.	
461		I So it's given you a lot.	
462	They have given me everything	**R Oh God yeah, it's, the best things in my life. Totally. It's given me everything. I just wouldn't want to do anything else than be a mum**	**Being a mother is everything**
453		I And I can see that made you very sad.	
464		R It did, just thinking about it.	
465		(End of interview)	